PROFESSIONAL POWER AND THE STATE

A STUDY OF FIVE PROFESSIONS IN STATE WELFARE AGENCIES IN THE U.K.

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ABSTRACT

The thesis defines a profession as a group of workers who have been authorised by the state to determine aspects of their own work, training and organisation,usually,but not necessarily,as a result of their specialist expertise. It argues that knowledge about professions would be advanced by examining the social structures and processes of regulation and management of different professions, rather than by concentrating on the particular characteristics of the work or of the workers. Following this approach the thesis presents research into the different national regulatory structures, and local management structures of five "welfare service" professions in the U.K. In explaining the differences in structure the thesis shows how each occupation exploited characteristics which provided power in particular situations to establish organisation and control advantageous to its interests,and how characteristics such as specialist knowledge ,status,and income were stabilised and further developed as a result. It also examines the complex involvement of the state in legitimating, advancing and limiting professional power.

The main contribution of the thesis is to develop Freidson's theory of professions through logical critique and by reference to empirical evidence about five U.K. welfare professions, and by,

- showing that national regulatory structures do not define a division of labour or provide the absolute autonomy which Freidson proposed,
- showing that different types of professional autonomy are institutionalised in local management structures, usually on central government recommendation, and by providing a typology of professional autonomy based on empirical research,
- showing that characteristics of professions are related to, but not, as proposed by Freidson, determined by professional autonomy,
- developing Freidson's general perspective to accommodate the empirical evidence by reconceptualising the nature of professions in terms of professional authority, rather than autonomy, and by developing a model of the authorisation of professional power.

In developing Freidson's theory the thesis also contributes,

- to knowledge about professional organisation within state welfare bureaucracies, mainly by providing detailed descriptions of differences and changes in management structures,
- to the methodology of action research by developing the theoretical basis of a method for investigating the legitimation of authority in establishing management structures.
- to knowledge about the details of the relationship between the state and welfare professions, mainly by providing evidence of the involvement of the state at national and local levels in decisions and structures which profoundly shape the nature of practice, relationships with clients, and futures of welfare occupations.

PROFESSIONAL POWER AND THE STATE

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CHAPTER 1: INTRODUCTION

PART 1: THE SIGNIFICANCE OF PROFESSIONAL POWER AND ORGANISATION

Throughout history specialists have always posed problems,as well as providing benefits for societies. Until recently the problems posed by specialisation and explored by social philosophers have been problems arising from an increasing "breadth" and fragmentation of the division of labour. Although the division of labour required each person to specialise,the nature of each person's work and their competence could usually be understood by other ordinary members of society. Over the last 100 years the significant changes have not been so much in the continued fragmentation of the division of labour ,but more in the "depth" of specialisation. New occupations have emerged to apply and develop scientific knowledge,and to exploit systematic methods to meet human needs. A more highly educated and scientifically-knowledgeable work-force has been required to apply scientific advances.

Most of the problems posed to society as a result of the rapid growth of "depth" specialists have arisen because of the "inaccessibility" of their expertise to the non-specialist. Although the "mysteries" of the crafts created a dependence for clients who needed their specialist skills, the crafts were "transparent" to the client in a way in which the work of "depth specialists" is not. "Depth specialisation" brings many benefits to society ,but also requires more complex arrangements for training and regulating such workers ,and is thought to require that such workers control aspects of their own organisation. It has led to the state taking responsibility for ensuring a supply of "depth specialists" through education ,and for regulating their practice and labour markets. In the case of "welfare professions" in state welfare societies,the state also employs and organises entire occupations.

Knowledge about professional power ,organisation, and the relationship between professions and the state is of practical significance because it can contribute to developing new ways in which specialist and scientific expertise can be deployed to meet human needs. Such knowledge is of use in considering the extent to which free-market philosophies may be applied to improving consumer choice in fields where professions have previously controlled their own services.

The is a further practical use of knowledge about the organisation of "welfare professions" in particular. Many professionals are employed by, or have contracts with, state employing authorities. In recent years there has been an increase in the number of professionals employed in public services, and an increasing professionalisation of many occupations in these services. At one time bureaucracies were viewed by many professionals and social scientists as inhospitable or impossible environments for professional work. The principles and practice of professional work were seen to be in conflict with those of bureaucracies. However, the private independent professional practitioner is now the exception in the UK, and most professionals organise their work and their professional associations along "bureaucratic principles".

In the UK most health and social services are provided by the state as part of welfare state policies. Most people rely on public services for help with health or social problems which are serious or even life-threatening. The quality and quantity of the help they get depend on the resources available, but also, and perhaps more importantly, on the way in which professionals and their work are organised.

Public health and social services in the UK have been shaped by professions, and professions themselves have developed and changed as a result of expansion of employment in these services, especially over the last 40 years. For better or for worse, the state, welfare bureaucracies and professions are mutually dependent, and exert a profound influence over each other.

Without a market mechanism, public services aim to apportion resources to different client groups according to a socially-constructed conception of need and on a democratic and rational basis. Professionals are employed by such services to make expert judgments of need and to help to decide how resources are distributed. The way in which professionals are organised within such services and their position in the executive structure determine how much influence they will have in such decisions, and the balance of their power in relation to consumers, and elected representatives.

Once democratic decisions are made by the state and its employing authorities about the type and amount of different services to be provided, it is professionals who interpret and carry out the policies. Professionals have power to obstruct or advance democratic policies, and frequently believe that they better represent, and have a higher duty to their immediate clients. Their involvement in the formulation of policy and in decisions about their work organisation is crucial. What social processes and structures exist to balance the different interests, powers, and requirements, and what are the implications of different arrangements?

One social mechanism which influences the type of services available to a person in need, and which regulates their relationship with the worker providing for that need, is state regulation. The decision by the state to authorise a national body to decide qualifications, training, and discipline provides that body with an indirect control over markets for services and labour. The nature of the authority of that body and the reasons for it being established are of significance because their decisions determine the type of help which is available to people in need.

This thesis also proposes that the nature of practitioner relationships with clients is directly and indirectly influenced by aspects of organisational structure. In particular, that there is a correspondence between the type of relationships between practitioners, and between them and their superiors, and the type of relationships which they establish with clients and which are so important to adequately meet clients' needs. The thesis argues that the "resonance" of authority relationships is particularly significant in therapeutic types of professional work.

Thus improvements to services and democratic accountability requires a knowledge about state regulation ,about professional organisation in public services, and about the consequences of different forms of organisation for clients.

The way in which professionals' work is organised also has consequences for the practitioner and the profession as a whole. This study proposes that many features of professions such as social characteristics, education, the nature of practice, size of the profession, and the rate and direction of development, are profoundly influenced by the management and regulatory structures established in public services. The research discovered that a variety of decisions relating to, or about, professional organisation (e.g. pay grade structures, client access to records, information systems) were made in a piecemeal fashion without either professionals or bureaucrats understanding the implications for the future of the profession, or the impact of the decisions on practitioners in the workplace. Knowledge about professional organisation in public services is therefore also of practical significance for professional practitioners and is relevant to their work satisfaction, the quality of their working life, and their future career and life opportunities.

PART 2: THE RELEVANCE OF RESEARCH INTO PROFESSIONAL ORGANISATION FOR THE SOCIAL SCIENCES

From the point of view of this study, however, the main significance of professional organisation is the contribution which a study of this subject can make to developing social scientific knowledge about professional occupations and the role of the state in modern society.

In a review of research into professions (Ch2) and professional organisation (Appendix 3) the thesis identifies a set of questions, which were explicitly or implicitly addressed by previous studies:

- are professional occupations and professionals different from other occupations and workers and, if so, what are the main differences, and why do they exist?
- what is the nature of relationships between the state and professions, and the significance of the state's role in the U.K. as the main employer of welfare professionals ?
- are conflicts occurring between professionals and bureaucrats any different from those occurring between any workers and managers?
- what are the differences between professional and non-professional work organisation and why do these differences exist?
- what are professional power and authority and how are either achieved and sustained?
- has there been a decline in medical dominance in health services?

The review also notes a lack of empirical research into the details of professional organisation, into the differences between professions in their organisation, and into how professional organisation is established and changed. Previous descriptive studies have tended to be single-profession case histories,and have neglected "formal" organisation structures and their significance as well as the organisation of professions in state bureaucracies. Few studies have related empirical research to the central, and frequently untested theories about professions.

The Aims and Argument of the Thesis

The first and more limited aim of the thesis is to contribute to empirical and conceptual knowledge about professional organisation. It presents the author's research into how professions are organised at the national level through a study of state regulatory structures and professional associations (Ch3), and at local levels through research into management structures within employing organisations (Ch5 and Ch6). The conceptual contribution is threefold: a conceptual framework for analysing and specifying management structure, concepts of different forms of professional autonomy, and a typology of three distinct models of professional management structures (Appendix 4).

Although empirical evidence of these structures and the processes through which they are established is of value in itself, this thesis argues that such knowledge is of wider significance: comparative descriptive knowledge about the differences between professional organisation is of value, but more so if related to theories and hypotheses about professions. The second aim of

the thesis is to contribute to theoretical knowledge about professions, and about the role of the state in modern society. It aims to do this in three ways:

Firstly, the thesis proposes that differences in organisation are associated with, sometimes produce, and certainly reproduce, the oft-quoted differentiating characteristics of occupations [Goode (1960)]. In so doing the thesis questions Freidson's theory that these characteristics are determined by autonomy. By examining evidence of associations between aspects of organisation and occupational characteristics, the thesis advances a theory to explain differences between occupations (Ch8).

Secondly, through research into the processes and structures of organisation of "state welfare occupations", the study shows that the proposition that the state directly determines a social division of labour [Freidson (1970)] is inaccurate, and that local management structures have a far greater influence over occupational boundaries and conditions of work than has been recognised in the literature. The thesis research shows that the state in many different ways in its role as regulator and employer, has played a key role in creating and emphasising differences between occupations, often without intending to do so.

Thirdly, through a study of professional organisation the thesis aims to contribute to a theory of professional power and authority. Through reference to the thesis research into the process through which the structures were established, and by developing and applying concepts of power and authority, the thesis shows that professional authority is established and based on other forms of power apart from "specialist knowledge". By emphasising the concepts of power and authority, rather than autonomy(Freidson (1970)), the thesis centres attention on the social processes and relationships which establish professions and professionals in various positions. This approach provides for the analysis of perceptions of power, how perceptions are changed, and for an analysis of how judgments are made about client vulnerability and conditions of trust. These factors are shown to be as important as imputed specialist expertise in establishing professional authority.

The introduction now presents an outline of each chapter of the thesis, and shows how the study proposes to review previous research and to develop the thesis arguments.

PART 3 : OUTLINE OF THE THESIS

Chapter 2 begins by considering common usage of the terms "Profession" and "Professional". This discussion introduces the general theme of the study by suggesting that professions both

contribute to and exploit common sense understandings of the terms to establish their position in society and in the workplace. Turning to social science perspectives, the chapter notes many of the issues raised by later studies in the works of Marx (Are professions a distinct class?); Durkheim (1933) (professions as the basis of social order and moral values), and Weber (1947) (professions as status and economic interest groups). A discussion of early studies of professions shows how social scientific ideas were influenced by the social issues of the time, and how professions were initially proposed as a way of promoting individualistic values and freedoms as an alternative to fascism and communism.

With the rise of professions, especially in the USA, attention turned to defining characteristics of professions, and the chapter reviews a series of "trait" and "definitional" studies. These were followed by a "continuum" approach ,where many studies examined the degree to which certain occupations exhibited some, or all, characteristics [Moore (1970)], and to typologies of professions [Etzioni (1969)] and studies of "professionalisation" [Goode (1969)]. More recent studies viewed professions as power and interest groups and considered the ways in which professions established and advanced their claims and interests [Freidson(1970);Krause (1971); Parry & Parry (1976) Johnson (1972)]. The thesis proposes that this latter perspective provides the most fruitful approach for developing new knowledge about professions in the 1980s.

Having identified the power and interest group perspective as being the most relevant for the study of contemporary professions, Chapter 3 presents a critical review of one study using this approach [Freidson (1970)].By arguing that professional autonomy was the fundamental feature of professions, and that professions attained autonomy through state sanction, Freidson established a new approach to the study of professions. His second major contribution was to show how, within one field (or "market area" as Johnson viewed it), one profession - medicine - had attained a position of dominance and established a division of labour and an "hierarchy of institutionalised expertise".

The chapter presents the author's criticisms of Freidson's theory, but accepts the overall thrust of his argument. The main logical criticism is that Freidson's conception of autonomy is not sufficiently well defined for such a central place in the theory . Neither does Freidson provide empirical evidence to support his theory. The chapter considers the theory in relation to the author's research into the national regulatory structures of five "welfare occupations" in the U.K..This evidence throws doubt on Freidson's general theory of professions and on his theory of medical dominance.It shows that ,certainly in the UK, no professions could be said to "control" the content, pay or conditions of work, and that state regulation does not define the division of labour between occupations.

The thesis pursues Freidson's line of enquiry by further investigating the nature of professional autonomy, and the different social processes which regulate the work of practitioners. It proposes that a study of the management structures for professionals established by employing authorities could provide evidence of institutionalised autonomy and of the relationship between professions and the state. The chapter proposes that Freidson's insights can be preserved and developed through an examination of forms of institutionalised control at local levels, and through a study of how local management structures are established and their consequences for professions and clients.

Chapter 4 describes the research method and the operational concepts which were used in the research to investigate institutionalised autonomy. The concepts which were used to study the autonomy of individual practitioners defined the nature and specificity of bureaucratic (and professional) rules and regulations, the nature and frequency of supervision and evaluation, and the nature of accountability and sanctions. The chapter distinguishes the three types of research evidence which are presented: (1) government statements and reports, (2) descriptions of existing and future management structures, and (3) critical instances or events. The research sources and field research documents are listed in an index in Appendix 1, and are available from the author. Appendix 2 provides more details about the research method and its strengths and weaknesses in relation to the purpose of the thesis research.

Chapter 5 presents the research findings for each profession in turn. Chapter 6 provides a summary and a comparative analysis of the research findings. It first distinguishes different types of professional control and autonomy institutionalised at the national level, and in management structures at the local level. This analysis provides a framework for summarising and comparing differences and similarities between the five professions, in terms of the autonomy and control institutionalised by the state and its employing authorities.The research reveals that there are many different types of professional autonomy, and that there have been changes in autonomy over the last 25 years.This evidence also casts further doubt on Freidson's theory of medical dominance.

The different management structures of each profession which were discovered in the research are not directly relevant to the argument of the thesis,but provide important descriptive knowledge about professional organisation which is not documented in the social science literature.The findings are therefore summarised in Appendix 4, in terms of a typology of profession-management structures: "Autonomous Professional Managerial Structures" (Type 1); "Autonomous Departments and Practitioner Autonomy" (Type 2); and "Joint - Management Structures" (Type 3).

Chapter 7 then considers Freidson's central proposition that attributes of professions were a consequence of their autonomy, and sets out to explain the differences which were discovered in the research. The explanatory hypotheses which are examined were derived from a review of the literature about professional organisation, which is included in Appendix 3.

The chapter first considers the type of explanation which could be presented, and then outlines the format which is used to examine systematically the determinants and consequences of structure and autonomy. It then considers in turn factors which previous research found to influence structure and autonomy, and which the author's research suggested were important. These include the political nature of the state employing authorities, accountability, size, values, technology, economic and political factors, occupational power, and characteristics of workers and of their work. It concludes that there is an association and complex interaction between institutionalised autonomy and key features of each profession,but no evidence for Freidson's theory that autonomy determines the differences.

Chapter 8 presents the conclusions and the final argument of the thesis. It summarises the criticisms of Freidson's theory, and aims to develop his general approach by emphasising the significance of professional authority rather than professional autonomy. The theoretical perspective of the thesis is presented, which draws on and develops previous conceptions of power and authority to understand the nature of professional authority and how it is achieved,and the nature of state involvement.

It proposes that only if the power of expertise is recognised does it become authorised expertise, and that professionals achieve different types of authority for reasons other than their claimed expertise alone. It also argues that "professional authority" is not qualitatively different from "rational-legal authority" (Weber(1947)), as has been assumed by all previous studies ,but is a variation of the latter type of authority. It argues that by juxtaposing "bureaucratic" against "professional" authority, previous theorists have upheld professional ideologies and claims and overlooked the basis of professional authority and autonomy. This is state sanctioning of competence to practise (and manage) resulting from a rational process of evaluating "requirements" for autonomy and institutionalising it through various structures.

The chapter concludes that there are certain necessary objective conditions before an occupation can attain particular forms of authority and autonomy, but that much depends on the active political action of the occupation and its organisation. In addition, that the structures examined in the research are both influenced by characteristics of the occupation, and themselves condition future features of the occupation. A summary model is presented of the relationship between professional power and the state (Fig. 8.1).

The introduction now turns to a brief descriptions of the five occupations which were studied.

PART 4 : FIVE "STATE WELFARE OCCUPATIONS": SIMILARITIES AND DIFFERENCES

"Welfare occupations" were chosen in order to investigate the relationships between the state and occupations in a field where the state had the greatest involvement, and five were chosen to enable comparisons and the development of general propositions. The particular occupations were selected because of the variety of their work, organisation and membership, and because each had been intensively studied in the author's field research projects.

The occupations of nursing, social work, physiotherapy, clinical psychology and medicine all have as the object of their work the health and welfare of human beings, rather than the production of material objects or financial or other services. This type of work often involves practitioners in direct contact with clients in situations where people's lives are at risk or in crisis, or where practitioners have an important role in helping to solve problems which are of critical concern to their clients. The study shows that this type of work requires, and gives rise to, certain types of organisational structure, but that many other aspects of organisation, and occupational interests are similar to those of other occupations.

The five occupations differ from many other occupations in that the state is effectively their sole employer. Opportunity for private practice in each profession varies, and,over the last 40 years in the UK ,only a minority of practitioners have viewed self-employment as a realistic or an attractive option.

However, there are a number of differences between the five occupations which makes it possible to develop and test generalisations about professions and professional structures. At this point it is useful to provide a brief profile of each occupation (Table 7.1 in Chapter 7 provides a comparative summary of occupational characteristics on salient variables).

Nursing

Hospital nursing involves providing basic physical, social and psychological comforts, and carrying out nursing and medical procedures which may be required or prescribed for individual patients. The occupation includes health visitors and midwives who have separate professional associations. Approximately 360,000 nurses were employed in the NHS in 1980 [DHSS (1980)].

There is a large number of unqualified and part-time workers in the occupation. There are some alternative employment opportunities in private hospitals or as a private nurse.

Social Work

Social work has been described as, "(a) the planning, establishment, maintenance and evaluation of the provision of social care, and (b) counselling in face-to-face communication with clients to help clients tolerate or change some aspect of themselves or their world." [Barclay Report (1980)]. As the Leaper Report (1980) noted, "Anyone can call himself a social worker and undertake activities which he describes or the public believes to be social work." The three common ways of estimating the number of people in an occupation are particularly unreliable in social work: number qualified (many social workers are unqualified, no reliable statistics are available, many qualified do not practise social work); membership of professional association (many social workers are not members of The British Association of Social Workers (BASW), and numbers employed as social workers (there are no national statistics). Various surveys would suggest that local authorities in the UK employ between them approximately 49,000 qualified social workers (20,700 field workers, and 28,300 residential and day care staff), and about 13,000 social workers are employed or work in voluntary agencies [CCETSW (1980) estimates].

Physiotherapy

Physiotherapy has been defined as ,"the use of physical means to prevent and treat injury or disease, and to assist rehabilitation, using methods such as therapeutic movement, electrotherapy, hydrotherapy, manipulation and massage." [Levitt (1976) p 149]. Many physiotherapists work part- time, so that the DHSS (1977) statistic of 5,768 (WTE) is only a rough guide to the total number of physiotherapists employed in the NHS. About another 4,000 practising physiotherapists work in other settings. Approximately 90 per cent of the profession are women.

Clinical Psychology

Clinical Psychology has been defined as, "the application and development of psychological theory and techniques to improve health and prevent illness" [Øvretveit (1985c)]. Methods include a variety of psycho-therapeutic treatments and assessment systems. The work involves individual and group treatments, consultancy, assessment, research, teaching and administration [Watts (1985)]. In 1981 the NHS in England employed 1,106 qualified psychologists (WTE), but many work part-time and some are self-employed in private practice. In the UK there are probably about 2,200 clinical psychologists.

The Medical Profession

Medicine can be defined as the application and development of biophysical and psychotherapeutic theory and techniques in the diagnosis, prevention and treatment of illness. The professional practice can be divided into hospital practice, community medicine, and general practice. In the early 1970s about 62,000 doctors worked in the NHS, 24, 844 of whom were general practitioners (GPs) and were "independent contractors" [Levitt (1976)]. The profession is the oldest established of the five in terms of active professional association and state regulation. A number of Royal Colleges have been created to develop specialisation and training, but the main union is the British Medical Association (BMA). The main divisions of interests and practice are between GPs and hospital doctors, and between consultants and junior doctors. Opportunities exist for private practice, either full-time solo practice or in private employment, or part-time private practice in addition to work for the NHS.

Even a brief overview of these professions suggests a variety of types of work and work settings, and differences in the size, social composition and organisation of the professions. These differences and the part played by structures in creating and sustaining the differences are examined more fully in later chapters of the study. Chapter 2 now turns to professions in general in a review of the social scientific literature on the subject,before returning to the relationship between the state and professions, and relationship between the state and welfare professions in particular.

CH. 2 : PROFESSIONS AND PROFESSIONALS : A REVIEW OF THEORIES AND RESEARCH

PART 1: INTRODUCTION

This chapter presents a general review of social scientific knowledge about professions. It identifies the different perspectives used to study professions, the main questions addressed and issues of debate, and the main theories and hypotheses advanced. The organising principle of the chapter is an historical one, adopted to highlight and explain the difficulties of defining a profession. The chapter considers "trait" and "continuum" approaches to defining "profession", functionalist and inter-actionalist role studies, the professionalisation/proletarianisation debate and the more recent "power" perspectives. It concludes that a comparative approach, which recognises organisational context and other aspects of occupations, is more likely to produce useful insights into the nature of professions than general studies of one profession, or of all occupations claiming the title.

The starting question of the chapter is, "What is a profession?" Before considering social scientists' answers to this question, it is useful to look at common usage of the term.

PART 2: COMMON USAGE

A frequent everyday distinction is between "professional" and "amateur". The terms are often used to describe the outcome of someone's efforts: a "professional job" is a job well done, with attention to detail, which is lasting and which suggests that the person was a capable, experienced and skilled expert. An "amateur job" is shoddy, makeshift and poor work, often as a result of the "amateur's" lack of expertise and skill, but also their indifference to the task in hand. Amateurs cannot be trusted, whereas professionals are "responsible". In this sense "amateur" is a derogatory term, and "professional" is its polar opposite, connoting something and someone of social value.

However, it is possible for an amateur to do a "professional job", in which case they are to be congratulated for overcoming their inherent deficiencies, for "mastering the art", and for producing an outcome that seems, on the surface, to be "as good" as an outcome which a professional could achieve. Nevertheless, they are still an amateur and everyone knows that their success was due to a large amount of luck, helped by using "professional tools and techniques".

What was important was that they aspired to "being professional" and to professional ideals.

In the above characterisations the term "professional" evokes the notions of skill, experience, trustworthiness, and commitment. "Amateur", at its worst, evokes something which is a threat to the social fabric and to social values, and at its best, a well-meaning attempt to "do as well" as the professional. Proficiency at the task, which is to be explained by the years of experience, practise of skill, and dedication and commitment, distinguishes the professional from the amateur. In this sense many workers in "non-professional" occupations such as railway workers, carpenters and others who take personal responsibility and find satisfaction in their work are regarded as "true professionals". It is rare that "professional" is used in a derogatory sense, as a member of a "conspiracy against the laity".

The common view of a professional is of someone not only personally committed to "doing a good job", but who is also dedicated to a way of life. It is perhaps only in recent years that task commitment has tended to supersede the notion of commitment to an ideal which was fundamental to earlier notions of profession. Previously the idea of "professing a faith" was central. A professional was someone who received a calling. They found their true vocation at an early age: as an author, bus driver, or chimney sweep. Their "profession" was work which they could give their entire being to, and which they always wanted to do. A notion usually involved in the idea of a "calling" is devotion to,and service for others, with its origins in the notion of religious devotion to the salvation of others' souls. In this sense the first professionals were priests, monks and nuns and the first professional organisations the different churches and faiths of world history.

The notions of a life-time vocation, allegiance to,and application of,a specialised body of knowledge, becoming a member of a special order, and putting others' interests before personal interests are features central to organised religion which have also been said to characterise the secular professions.

The idea of "the professional soldier" developed by advertising agencies perfectly exploits the ambiguities and multiple meanings of the concept of "professional". It draws on more recent connotations of skill and status, but also the idea of devotion to higher ideas, of devoted service to country and to commanding officer.

In anticipation of the later themes of the study, we may note that the church and military are examples of the earliest "professions" which were and are also bureaucracies. There was no "professional association" separate from the "work organisation", and furthermore both were often part of state and government organisation. The sign of a professional in these cases was

complete loyalty, and independence of thought or action was viewed as a lack of professionalism. We also note that,at times,church and army leaders acted against the state by evoking loyalty to higher ideals, and by claiming to represent the true interests of the people .

In this inventory of common uses of the term, it is also important to note ideas about payment for professionals. On the one hand payment for services does not appear to be relevant to the notion of a professional. The professional is dedicated to pursuing ideals and to perfecting their practice - payment is secondary and all that is required is sufficient to allow them to follow their calling. To bargain with a professional is almost to question their integrity.

On the other hand, the professional/amateur distinction also suggests one who practices a craft for a living as opposed to one who is not paid for what they do. Although closely related to other ideas of "a living" and "a calling", there is a sense in which the common usage of the term professional indicates someone who takes part, usually "full-time", in a formal market for the exchange of goods and services, and possibly a labour market. For example, the amateur sportsman cannot be paid, or treat sports-related income as their sole source of income - they have a nine-to-five job. Recent debate about the definition of professional and amateur sports struggles to retain this meaning.

Thus there is a sense in which "professional" means someone who is paid for work and who takes part in formal market economy, as opposed to an amateur who is not paid and who does not sell their amateur services in a labour market. The use of the term "professional housewife" thus challenges a number of common meanings of the term "professional", implying full-time occupation, but no income;participation in a labour market, but outside of a formal economy; as well as devotion to the "calling" of housework, and suggesting the need for skill, experience, and recognition.

A consideration of everyday usage and connotations of the terms "profession" and "professional" suggests that there are common meanings attached to the terms, but also that the meanings change over time and vary between different social groups. The way in which the terms are used, and the popular view of what constitutes a profession are of significance for workers and occupations who wish to be thought of as "professionals", and to acquire some of the privileges which accrue to professionals in modern society.

The answer to the question "what is a profession?" is of material interest to many groups of workers, and occupations have exploited the ambiguity of the term and have themselves influenced its meaning to pursue their own interests. In reviewing social scientists' answers to the question, the chapter will show how social scientists' definitions have influenced the

strategies of occupations attempting to become professions. In addition, that social scientists' attempts to arbitrate and impose a definition reveal much about their own endeavours to attain professional status and power. The review finds that social scientists have not been able to agree a clear answer to the question,"what is a profession ?"

PART 3: PROFESSIONS AND OCCUPATIONS IN THE WRITINGS OF MARX, WEBER AND DURKHEIM

The chapter will return to the question of definition, after considering the place of professions in the writings of early social scientists. Although professions as a distinct social form were not considered in depth by Marx, Weber and Durkheim, their views on the subject and their general theoretical perspectives serve as an introduction to the perspectives which were developed by later social scientists to understand both the rise of the professions, and the development of bureaucratic and professional organisation. A review of their ideas also shows how a study of professions can illuminate aspects of social life and of social structure,such as how social groups regulate the power of individuals on whom they depend.

Professions : The third "class" in the capitalist Mode of Production?

Professions were incidental to Marx's theory of history and society. His concern was with the material conditions which gave rise to social classes and with class conflict which lead to new social forms. Although class and class conflict were central to Marx's theories, he did not provide a systematic analysis of the concept.

The last part of Marx's theory of capitalism, and his final work, finished at the point where he considered, "how many classes are there?" His answer was,wage labourers, capitalists and land owners. However, he noted that in England, where capitalist society was most developed, "the stratification of classes does not appear in its pure form. Middle and intermediate strata even here obliterate lines of demarcation everywhere." He then asked, "what constitutes a class? At first sight - the identity of revenues and sources of revenue. There are three great social groups who live on wages, profit and ground rent respectively." (Caute (1967) p 63). He then put the objection that this identity criterion would make, for example, doctors and civil servants into separate classes, but the passage finishes at this point.

Most subsequent writers have concluded that "identity of revenue and source of revenue" does not of itself constitute a class. The main thrust of Marx's analysis was to demonstrate the

increasing polarisation of social groups into the two great classes, those who own the means of production, who purchase labour power as a commodity and who sell the produce of that labour power for a profit, and those who have nothing to sell but their labour power. Professionals who were not wage labourers were not classified by Marx as part of the capitalist owning class, but as members of the petite bourgeoisie. They were occupations of a secondary or derivative character because of their "negative contribution to surplus value".

Later neo-Marxist writers developed features of the Marxist perspective to understand professions from an economic and materialist perspective [Parry and Parry (1977), Larson (1979)]. From this perspective the main considerations were: do professionals constitute an "economic class" in the Marxist sense, or are they to be thought of as part of the working class, and are professionals increasingly becoming "proletarianised"? [Oppenheimer (1973), Haug (1973)]. For Marxists these questions have practical implications - if professionals constitute a class, the objective conditions exist for successful political activism.

Professions as Status Groups

Weber analysed classes in terms of economic markets, and this approach provided the possibility for a variety of types of classes,

> " "Classes" are not communities; they merely represent possible and frequent bases for communal action. We may speak of a class when, 1) a number of people have in common a specific causal component of their life chances insofar as, 2) this component is represented exclusively by the possession of goods and opportunities for income and, 3) is represented under the conditions of the commodity or labour markets."
>
> [Weber, in Gerth and Wright Mills (1958)].

Weber, like Marx, emphasised the importance of an economic market in the formation of social groups, and the importance of members of those groups becoming aware of their collective interests. Weber's more pluralistic conception of classes accepts that a profession or a group of professions could constitute a class. However, it is Weber's concept of status and of the importance of social groupings based on criteria other than those stemming from market situations which distinguishes Weber's analysis from that of Marx,

> "In contrast to the purely economically determined "class situation", we wish to designate as "status situation" every typical component of the life of men that is determined by a specific, positive or negative, social estimation of honour. This honour

may be connected with any quality shared by a plurality."

[Weber, in Gerth and Wright Mills (1958)].

Through the concept of status Weber emphasised systems of differential distribution of esteem according to the possession of valued characteristics (or property) as bases of social order, which cut across and were not determined by economic situation. Weber used the concept of status to analyse a variety of social phenomena such as religion, education, and political behaviour. For Weber classes and status "communities" represented two possible and competing modes of group formation in relation to the distribution of power in society. From this point of view a profession, such as the medical profession, could represent both a class and a status community.

Weber also proposed a categorisation of occupations as part of his analysis of social and economic organisation. He defined occupation as, "the mode of specialisation, specification and combination of the functions of an individual so far as it constitutes for him the basis of a continual opportunity for income or for profit." [Weber (1947), p 250]. He distinguished between an, "heteronomous assignment of functions and provision of maintenance within a corporate group regulating economic activity - the unfree differentiation of occupations", and an, "autonomous orientation to the state of the market for occupational services - free differentiation of occupations". His second distinction was between "specification" and "specialisation" of functions, the latter being the division of tasks according to bureaucratic requirements determined by consumer market forces. The third distinction was between "autocephalous" occupational specialisation as independent businesses (e.g. "a physician, a lawyer, or an artist") or an "heterocephalous" occupational position (e.g. "factory worker and government official").

Weber's discussion accounts for variations in the occupational structure of a social group in terms of, a) the degree of development of a set of "well-marked" and stable occupations, b) the degree of specialisation, and, c) "the extent and kind of continuity of change in occupational status", which in turn depends on the amount of training required and the degree of stability of opportunity for earnings. Independent and stable occupations could only form around functions which required a certain minimum of training and which provided "opportunity of continuous remuneration".

As Parsons comments in his introduction to Weber's writing on the subject(Weber(1947)), it is notable that the concept of occupation is considered by Weber at the end of his discussion of the division of labour,rather than at the beginning. Weber's analyses were of a system of market relationships in a modern economy, which in turn was geared into his overall concern with how economic systems impinged on the political power system of the modern state. He did not view occupations as a significant feature of the power structure of society. Later neo-Weberian writers

have proposed that market factors are more important and analytically useful concepts for understanding professions than the Marxist concept of class, which is linked to ownership of the means of production. In this view the way that professional occupations are able to control markets through gaining a monopoly of the provision of service is of central significance.

Occupations were more central subjects in the writings of Durkheim, who emphasised the functional dependency, and "the moral value" of the division of labour in society. Much of Durkheim's writings addressed what he viewed as the breakdown of social order, and the isolation of the individual. He saw socialist programmes as being unable to resolve the problems of modern society or to meet the needs of individuals, and occupational associations (not trade unions) as a possible integrative social mechanism.

For Durkheim the occupational group was, "close enough to the individual for him to be able to rely directly upon it, and durable enough to be able to give him a perspective." [quoted in Giddens (1971), p 103]. To fulfil this role new types of occupational associations would need to be established as legally constituted groups which, "play a social role instead of expressing only various combinations of particular interests", and which would play a role in the political system, as electorial units, as well as being a focus for education and recreation. [Giddens (1971)]. Durkheim held the view that, "Where the state is the only environment in which men can live communal lives, they inevitably lose contact, become detached, and thus society disintegrates. A nation can be maintained only if, between the state and the individual, there is intercalated a whole series of secondary groups near enough to the individuals to attract them strongly in their sphere of action, and drag them, in this way, into the general torrent of social life."

PART 4: DISTINGUISHING THE PROFESSIONS: EARLY TWENTIETH CENTURY STUDIES

In general, professions were peripheral to the concerns of nineteenth century social scientists, but the perspectives they established formed the basis for later studies which considered the place and development of professions in modern society. In the first part of this century social scientists attempted to understand the emergence of professions as a social force ,mostly by describing the development of professions and by attempting to define what constituted a profession.

The earliest serious attempt at definition was by Flexner (1915) who asked, "Is Social Work a Profession?", and proposed six objective criteria for distinguishing a profession: professional

activity was intellectual and carried great personal responsibility; it was learned, based on considerable knowledge and was not routine; it was practical rather than "academic"; its technique could be taught and formed the basis of professional education; a profession was strongly organised internally; and professionals were motivated by altruism, viewing themselves as working for the good of society. (Source: Becker (1962) p 88). However, Flexner went on to qualify this definition, possibly feeling that his audience - social workers at a "National Conference of Charities for Correction" - would be unhappy with the answer to the question.He ended by emphasising the "vocational" aspect,

> "What matters most is professional spirit. All activities may be prosecuted in the genuine professional spirit. Insofar as accepted professions are prosecuted at a mercenary or selfish level, law and medicine are ethically no better than trades. Insofar as trades are honestly carried on, they tend to rise toward the professional level.
>
> The unselfish devotion of those who have chosen to give themselves to making the world a fitter place to live in can fill social work with the professional spirit and thus to some extent lift it above all the distinctions which I have been at such pains to make."

The idea that the attitude of "professionalism" could raise an occupation above "trade status" and overcome "objective factors" combined the aspirations of many occupations of the time with social scientists' liberal interest in possible social structures which were alternatives to communism and fascism. Thus Tawney (1972), like Durkheim, argued that "professionalism", which stressed the ethics of a "moral community", could counter extreme economic individualism.

Similarly, Carr Saunders and Wilson (1933), in a landmark study, put forward professions as a defence against, "crude forces which threaten steady and peaceful evolution", and as a major force for stability in society. They saw scientific advances as inevitably leading to more professions and that, "the extension of professionalism over the whole field seems in the end not impossible", (p 494). For Carr Saunders the, "chief distinguishing characteristics of the profession" were, "the application of an intellectual technique to the ordinary business of life, acquired as the result of prolonged and specialised training" (p 491).

Parry and Parry (1976) suggest that at the time the belief in the moral superiority of professionalism was a peculiarly English phenomenon, which perpetuated elements of the 19th century medical profession's wish to attain "gentleman" as opposed to "businessman" status.

Certainly it is true that American social scientists did not take up quite the same crusading stance. At this time (1930) Parsons was drawing on the perspectives of Weber and Durkheim to develop a

structural-functionalist theory of society. In his perspective professionals and workers in other occupations shared the same values and orientations of a market society. For Parsons "service orientation" or "altruism" was of secondary importance, a set of additional norms which was required to regulate the intimate relationship between professional and client (Parsons (1964), originally (1939)). Parsons (1951) suggested that professional ethics were specific to the relationship and not generalised to the wider society. Parsons' wider theoretical perspective in part prevented him from reproducing some of the ideologies of the professions, the latter being a weakness of the "trait" studies which followed.

Later examples of the "trait" approach to defining professions are Cogan (1953), Greenwood (1957), and Goode (1957). Such studies started with a general discussion of the meaning of the term, noted typical "man-in-the-street" conceptions ,and attempted to offer more precise definitions, testing them against empirical examples to decide whether or not an occupation was a profession according to the proposed definition.

Functionalist studies proceeded in a similar fashion but confined their analysis to those traits which were thought to make a functional contribution to establishing a relationship between professional and client or to the maintenance of society. Thus Barber (1963) described as the four "essential attributes of professionalism",

> "A primary orientation to community interests rather than individual self-interests; a high degree of self-control of behaviour through codes of ethics internalised in the process of work socialisation, organised and operated by the work specialists; and a system of rewards (monetary and honorary) that is primarily a set of symbols of work achievement and thus ends in themselves, not means to some end of individual self-interest."

He went on to propose that the attributes, "define a scale of professionalism, a way of measuring the extent to which it is present in different forms of occupational performance."

Millerson's (1964) summary of the definitional studies proposed that, although few authors cited exactly the same characteristics, there was agreement on certain typical characteristics of professions. These included: a theoretical knowledge base (both pure theory and theory of practice); a required education and training, and adherence to a code of conduct; and loyalty to an occupational organisation and to an ideal of altruistic service. Hickson and Thomas' (1974) analysis also noted common elements and summarised the elements included in most of the main studies in a table reproduced on the next page (Table 1.1).

An Analysis of Elements Included in Various Definitions of Profession

	Skill Based on Theoretical Knowledge	Required Education and training	Competence Tested	Organised	Adheres to a Code of conduct	Altruistic Service	Applied to Affairs of Others	Indispensable Public Service	Licensed Community Sanction	Definite Professional Client Relationship	Fiduciary Client Relationship	Best Impartial Service Given	Loyalty to Colleagues	Definite Compensation (fee or fixed charges)
Bowen	x		x	x	x									
Carr-Saunders & Wilson	x	x	x	x	x									x
Christie		x			x		x							
Cogan	x					x	x							
Crew				x	x	x		x						
Drinker	x					x					x		x	
Flexner	x	x		x		x	x							
Greenwood	x	x		x	x				x					
Howitt		x	x		x	x				x				
Kaye	x		x	x	x									
Leigh	x	x												
Lewis & Maude		x	x	x	x						x			
Marshall				x		x								
Milne	x			x	x	x		x						
Parsons				x					x	x				
Ross	x			x	x	x						x		
Simon		x	x		x									
Tawney			x	x	x									
Webbs							x					x		x
Wickenden	x	x	x	x										

Table 1.1 Elements in Definitions of Professions

[Reproduced from Hickson and Thomas (1969)]

Continuum of Professionalism

Goode's (1960) and Millerson's (1964) papers marked a point where studies moved from trying to define what was, or was not, a profession, to trying to assess to what extent certain key characteristics were present or absent. This "scale" or "continuum" approach addressed itself to the question, "How professionalised in identifiable respects is a particular occupation?" [Hall (1968)].

A series of studies drew on the definitional studies to examine "professionalisation' and the historical stages by which occupations become professions. Caplow (1954) proposed a four-step process. Wilensky (1964) studied eighteen occupations to demonstrate a typical five-stage historical process of professionalisation. He traced the dates at which the occupations first became full-time occupations, then acquired training schools and university schools, formed local and national professional associations, were "protected" by law, and ultimately adopted formal codes of ethics.

Pavalko's (1971) more recent work also applied the continuum approach to analyse a wide variety of occupations. He proposed that the "voluminous" literature had produced a consensus about, "key features of work groups that appear to occur in combinations and clusters that function to differentiate "occupations" from "professions" ". His aim was ,"not to develop a scheme whereby some kinds of work can be labelled "occupations" and others "professions" ", but rather to focus on ,"differences of degree" and to ask, "To what extent is a particular work activity a profession?" A page later, however, he proposed, "eight characteristics of work that can be considered as crucial in differentiating occupations from professions". (Theory or intellectual technique, relevance to basic social values, training, motivation, autonomy, commitment, sense of community, and code of ethics). All studies of professions have at some point to deal with the question of definition.

Hickson and Thomas (1974) noted the lack of systematic research on the subject, and suggested that,

> "The continuum might well form a scale in terms of the characteristics of professions commonly cited. Yet it has remained hypothetical, agreed but not demonstrated, and comparisons along it have been couched only in fairly general terms."

They tested the adequacy of the concept of "professionalisation" as a unitary variable or continuum by operationalising the concept to provide a measure of "professionalisation", and by applying it to a number of professions. One finding was that the age of the qualifying association

was strongly related to "professionalisation". The study noted that the assumed causes of "professionalisation" had not been studied empirically, and an international comparison using the measure was suggested.

Goode (1969) proposed that there were limits to the extent to which certain occupations could "professionalise", mainly because society did not accept that some occupations had sufficient of the two core elements of knowledge base and service ideal .Goode's (1960) study proposed that the two "core characteristics" were ,"a prolonged specialised training in a body of abstract knowledge and a service orientation", and that as occupations become professionalised they manifest features of these core characteristics. He listed ten which formed a "continuum of professionalism".

In addition he argued that the "four great person professions" of law, medicine, the ministry, and university teaching, in an important sense, "get inside the client" (p 307). He suggested that the client was "more likely to get emotionally involved with their professionals", and would be more vulnerable, which in turn required a strong adherence to a set of norms and ethics. The "semi-professions" did not have the knowledge, skills or service value to exchange for the public trust.

For Goode, "the crucial difference is whether the substance of the task requires trust and therefore autonomy, and therefore some cohesion through which the occupation can in fact impose ethical controls on its members." Consequently, "If we place the various professions along this continuum - the extent to which the client must allow the professional to know intimate and possibly damaging secrets about his life if the task is to be performed adequately - a fairly clear ranking emerges."

Moore (1970) proposed that the professional role could be conceptualised by a series of traits, each of which was a component of a complete continuum, with professionalism at one end and non-professionalism at the other. He held that the concept (ideal type) of "professional" was a useful sociological category and defined a profession as involving the existence of, 1) a full-time occupation, 2) a calling which implied "the treatment of the occupation and all of its requirements as an enduring set of normative and behavioral expectations", 3) a formalised occupational organisation, 4) specialised education based on the acquisition of useful knowledge and skills, 5) a service orientation, and, 6) personal and collective organisation "restrained by responsibility".

Putting Moore's definition together with the many others, it is possible to regard "calling" and "organisation" as derivative of 4), 5) and 6), and closely related to the assumption of autonomy, or

"trust" granted by the public [Hughes (1963)]. In short, that the fundamentals of the ideal type appear to be a knowledge base, a service ideal, and autonomy or public trust.

At first sight the literature reviewed seems to be unable to agree over "essential traits", regardless of whether the purpose of defining these traits is to arbitrate between "real professions" and "other occupations", or to construct an ideal type or the end of a continuum. However, the disagreement is more apparent than real, and mainly concerned with deciding which trait or characteristic is more essential, and which are derivative.

The studies reviewed in fact have much in common. There is a tendency to accept the claims of several self-appointed traditional professions, rather than to carry out research into their practice and organisation. There is a lack of awareness of the continual changes to which occupations have to adapt, and of how they continually negotiate their relationships with other occupations. Many of the "essential characteristics" cannot be isolated, but more serious is the lack of attempts to theorise about the relationship between the elements. The decision about which elements to include depends on which profession is viewed as having professional status, and is largely arbitrary.

There is little distinction made between "a profession" as a social institution with an association, and the attitude or characteristics of "professionalism" and of a "professional". Øvretveit (1985) also argued that whilst many occupations show similar tendencies and developments, the professionalisation perspective implies a single and inevitable process towards an ideal type. (c.f. Goode's (1969) "Natural history of professionalisation"). Conscious imitation by aspiring professions, rather than any structural or other causative process could explain this tendency. Finally, as Johnson (1972) showed, "the professionalisation process" is historically-specific and culture-bound.

Typologies of Professions

One development which took place in the 1960s was to separate categories of occupation. General studies of occupations in society distinguished between fields and types of occupations for the purpose of presentation and analysis. Those specifically concerned with professions distinguished between types of professions. Recognising some of the limitations of the trait approaches, some studies distinguished certain types of professions and focused on their particular features. The "continuum" and historical studies already mentioned distinguished "would-be-professions" from "new professions", "near- professions" and "professions" (Carr Saunders (1955)); Marshall (1965) distinguished "new" from "traditional" professions; Goode

(1969) categorised a group of "aspiring professions"; and Hughes (1958) classified "professions", "near-professions", "enterprises", "missions", "arts", "crafts", and "jobs".

Etzioni [(1964) and (1969)] defined the "semi-professions" of nursing, social work, and teaching, whose,

> "claim to the status of doctors and lawyers is neither fully established nor fully desired ..... Their training is shorter, their status is less legitimated, their right to privileged communication less established, and there is less of a specialised body of knowledge and they have less autonomy from supervision or societal control than "the" professions."
>
> [Etzioni (1969) p v]

He later notes as an aside that almost all "semi-professionals" are employed in organisations, and are women.

Forsyth and Danisiewicz (1985) further subdivided two types of semi-profession: the "client-autonomous "(education),and the "organisation-autonomous" (nursing and social work). They also added a category of "mimic professions", which ,"may have a code of ethics and other trappings of professions but they have no power".

Etzioni's typology, whilst continuing to judge occupations in relation to "real professions", was part of a trend towards developing social scientific categories for analysing occupations which did not depend on a concept of an ideal-type of profession, or on the claims of the traditional professions.

Halmos' (1970) categorisation of "personal", as opposed to "impersonal", service professions cut across the conventional "true" versus "non- profession" distinction. He proposed that the principal function of clergy, doctors, nurses, teachers and social workers was to, "bring about changes in the body or personality of clients", and that this group were importantly different from lawyers, accountants, engineers and architects. We note that Halmos' thesis is in direct disagreement with Goode's (1969) definition of "the four great person professions",and Goode's proposition that unlike these professions the semi-professions did not need to "get inside the client" and win trust.

Bennet and Hokenstad (1973) also argued that a different way of conceptualising occupations to the professional / non-professional approach was more likely to advance knowledge. They

proposed, 1) that the nature of "human services work" (first defined as such by Reissman & Pearl (1965)) raised questions about the trait and continuum approaches, 2) that the "professional model" was not appropriate for describing "modes of people working", and, 3) that "progress" in human services could not be assessed in terms of a rank on a single continuum of professionalisation.

They suggested that "people working professions" were a distinct group because the object of their work was, "the client himself, his personality, behaviour or relationships, rather than a third party or thing" [Halmos, Ed. (1973), p 34)]. Fundamental to their distinction was Benne's (1970) notion of "expert", "rule" and "anthropogogical" authority, the latter involving submission to authority in the hope of becoming like the bearer of that authority. They developed this notion to suggest that the knowledge of "people working professions" is about producing change in clients in order that clients may themselves solve their own problems in the future.

Bennet and Hokenstad's categorisation therefore differed from Halmos's (1970) in excluding many doctors who, "deal with parts of the body in rather impersonal ways". They, like Etzioni (1967) and Hall (1968), noted that, "people workers" functioned in bureaucratic settings and were salaried employees rather than entrepreneurs. At first sight the nature of the work of "people workers" would appear to require a type of relationship with clients which was in conflict with this type of work setting. This issue is considered under the subject of the "bureaucratic-professional conflict" in Appendix 3 and Ch. 4.

Freidson's (1970) theory of professional dominance was not intended as a categorisation or typology as such. However, he did distinguish between "dominant professions", such as medicine and law, and a range of subsidiary or "para-professions", whose work was structured around, and ultimately controlled by the dominant profession. This theory will be reviewed in detail in Ch. 3. It is noted here as one of the studies of this period which proposed a subdivision in the study of professions, but unlike most others, was also linked to a theory of the structuring of professions, rather than the mainly descriptive approach of the typologies mentioned above.

The conclusion of the review so far is that, in general,the way in which professions are categorised depends on the purpose of the study : the professionalisation and continuum approaches categorise new and aspiring professions as opposed to established or traditional professions; other studies such as Halmos's separate a group of occupations which share elements in common which are more important than their ranking on the scale; and Freidson's category of "para-professions" is linked to a theory of a professionally-ordered division of labour. Such typologies are an advance over earlier studies in, a) documenting new groupings of occupations, b) developing categorisations which promise to open up new areas of investigation and are less

influenced by the claims of professions themselves, and, c) beginning to link empirical research to theories of professions.

PART 5: PROFESSIONS AS OCCUPATIONS: THE INTERACTIONIST AND POWER PERSPECTIVES

The nineteen-sixties marked a time when both social scientists and the public adopted a more critical stance towards professions. Social scientists' theoretical perspectives and research revealed some of the similarities between professions and occupations,rather than the qualitative difference which had been emphasised by earlier studies.

The Chicago school of symbolic interactionism produced the most well known of the earliest studies which took a "debunking" approach. The perspective focused on individual practitioners and clients, and examined the meanings of certain situations for the actors and how understandings were negotiated - as Dingwall (1976) describes it, how "profession is accomplished in interaction".

Becker's interpretive approach proposed that "profession" should be regarded as a symbol, and that social scientists should not confuse the symbol with reality [Becker (1956)]. He proposed an answer to the paradox of,on the one hand,an apparent unanimity to definitions of "profession", and on the other hand,the continuing disagreement about an "authoritative" definition. His answer was that laymen used the term in a "morally evaluative" sense with "unselfish devotion as the key criterion", but that social scientists constructed a concept to isolate an "objectively discriminable class of social phenomena". The attempt on the part of social scientists to incorporate common usage into the social science concept would inevitably lead to problems, as common usage would continually change,"the laymen's sense of which occupations are "really" professions continually changes".

Becker's (1962)answer to the question of definition was to view, "professions simply as those occupations which have been fortunate enough in the politics of today's work world to gain and maintain possession of that honorific title. In this view there is no "true" profession and no set of characteristics necessarily associated with the title. Becker proposed that social scientists should study "profession" as a "collective honorific symbol" or "folk concept". He outlined a general characterisation, emphasising the interrelation of the oft-noted elements, and considered the role the symbol performed in society. He noted that the symbol contained an ideology which provided a justification and rationale for "complete autonomy": only professionals could judge

how good their work was, and whether unsuccessful work was due to incompetence or other causes.

In comparing the symbol with reality, Becker noted that, in practice , medicine and law failed to match the symbol because neither held a monopoly over esoteric knowledge or functions. He suggested that the symbol had become not only inaccurate but harmful in ignoring,

> "the lack of homogeneity within professions, frequent failure of clients to accept professional judgments, the chronic presence of unethical practitioners as integrated segments of the professional structures, and the organisational constraints on professional autonomy".

Hughes' (1958) early work took a largely interactionist perspective and laid the basis for much of the later American occupational sociology. Taking a broad range of occupations he considered the relationships between individuals,their personal careers,and their occupational groups and employment settings. His approach was to note the problems and tensions created by work and social situations and to consider how the worker dealt with the problems. "Deviant" occupations were of particular interest because a study of the coping strategies which they used could illuminate the strategies of individuals in conventional occupations.

Trust and Confidentiality

Hughes' (1963) article on professions emphasised the service and trust components of professional practice over the knowledge aspects.He proposed that in the ideal situation the professional asks to be trusted and is granted this trust - rather than the business motto of, "let the buyer beware" (caveat emptor), that of the professional is ,"let the buyer trust" (credat emptor). It is this approach which the thesis later adopts to understand the authority of professions. Related to trust is one of the distinctive features of a profession mentioned by Hughes, the "licence to delve into the personal affairs of others, or to make "impositions" on them, which are not normally acceptable." Hughes related the community mandate of a profession (the willingness of a community to allow practitioners to do their work unsupervised) to the degree of licence allowed. Thus if a group had no independence from community or organisational evaluation and control, it would also not have the sanction to delve into personal areas. In essence it was a community's acceptance of the profession's claim to expertise (the faith which they profess), and the community's granting the profession a mandate, which was fundamental.

Freidson was later to develop this insight in his theory of professional autonomy ,which will be considered more fully in the next chapter. A more recent and critical discussion of trust within the

client-professional relationship can be found in McKinlay (1973) ,who questioned the grounds for professionals' claims to trust. He argued that the view that it was safe to trust professionals because they had been specially selected, or "called" to profess a faith, was not borne out. In McKinlay's view the "calling" in the USA was the call of cash, and the "special selection" was as much a market control mechanism as a safeguard of quality. Secondly, "altruism and service orientation" was not central to professional practice: work practices were usually for the convenience of professionals. Thirdly, the view that the unique training of professionals warrants extra trust could not be sustained: the training may be longer, but in McKinlay's view it is not different to many service occupations. Finally, there was the view that trust should be accorded because the public was unable to evaluate professional work. However, although the public may not be able to evaluate process, McKinlay argued that consumers could and did evaluate outcome.

In questioning whether clients could or did trust professionals, McKinlay's discussion tended to minimise perhaps the most important feature of trust in the professional-client relationship: that the professional requires the client's trust (and faith) to carry out their work (and to provide their livelihood), and that professions establish a variety of conditions to achieve client trust. As Bidwell (1970) noted,

> "For the professional, trust as the sole basis of his moral authority, is essential for effective performance. Unless he enjoys his client's confidence, he may be denied access to the client's person, or to the full range of necessary but often covert information about the client, while the client may not follow the professional's directives or counsel. Hence the professional cannot fulfil his responsibilities to the client, or to his peers for the client's welfare, unless the client trusts him. Thus the responsible professional must reject the client who will not trust him." (p 40).

Trust is central to professional work and the important question is, how is it achieved? The traditional professions (medicine, law, the ministry) view client confidentiality as a necessary requirement for establishing and maintaining trust in the relationship. Whilst there are good reasons for this condition, it is also important to note the consequences of this requirement. Chief amongst these is that absolute confidentiality protects professionals from evaluation, and enables them to escape accountability and justifying their actions to anyone apart from the client, who already trusts them. It maintains a particular type of autonomy. Secondly, it creates a dependency in the relationship: the client has disclosed intimate secrets and thereby comes under the power of the professional. Although the professional has sworn not to break confidence, the client is dependent on the professional's decision not to do so - the professional has gained power where he had none.

A study of confidentiality in social work and in multi-disciplinary teams [Øvretveit (1986a and 1986b)] showed that absolute confidentiality was rare, and that professionals, as a matter of routine, exchanged "confidential" material. They only invoke "confidentiality" in their own interests; not in the interests of clients (e.g. when insisting that other professionals act on the information , but that they can not disclose the professional source because it would supposedly damage that professional's working relationship with the client).

It is the view of this thesis that the professional-client relationship is best conceptualised as one of mutual dependence, and that an understanding of how trust is established and maintained in the relationship and of how the power of both parties is regulated, may reveal differences between occupations.

Hughes and the Chicago school,then, recognised the drawbacks of addressing the question of, "is this occupation a profession?", and instead asked, "what are the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people?" (Hughes (1963)). Two strands developed out of this approach.

The first concentrated on socialisation and individual interaction (Strauss et al (1963), Becker (1961)), and tended to neglect wider historical processes and structural issues. One such study was by Goldie (1977) who considered how occupational groups in the mental health division of labour defined their work situation. His study showed the different ways in which members of the same occupation would deal with recurring "problems" such as medical direction.

The second strand used insights developed within the interactionist frame of reference to understand wider social processes. Bucher and Stelling (1967) used the perspective on a broader structural level to consider the diversity and conflicts of interest between "segments" within supposedly homogeneous professions.

Power Perspective

Freidson,who was originally a student of Hughes, took professional autonomy to be of fundamental significance, and laid the foundations for what was later to be loosely termed a "power" perspective for the study of professions. Freidson's (1968) study advanced Hughes' ideas about the service and trust reciprocation at the centre of professional practice. Freidson used the term "profession" to refer to a way of organising work rather than to refer to an orientation towards work (professionalism) or a body of knowledge (Freidson (1970a) p.155). From this

starting point he distinguished between "dominant professions", who directed others in a division of labour and who were autonomous, and other "para-professions".

Freidson (1970a, 1970b) and Johnson (1972) initiated an approach to the study of professions which focused on the structures and processes at the societal level by which occupations acquired and maintained power. They viewed professions not as occupations which exhibited many elements of an ideal-typical "full profession", but as a means of controlling an occupation: "occupational organisation and practice are to be understood only in terms of the prevailing type of control to which an occupation is subjected." [Johnson (1972), p 90]. Chapter 3 examines their theories in more detail.

A similar approach was taken by Krause (1971). For Krause, as for Durkheim, the significance of the study of occupations for the social sciences was their function as the main mediators between the individual and society. His basic question was, "What changes have there been in the historical role of major occupational groups?", a question which he explored from four standpoints: the historical, the biographical (e.g. "socialisation" and career), the functional, and the conflict-of-interest approaches.

The study drew on Durkheim's analysis of the division of labour to highlight the interdependence of occupational groups, and to consider the function of the group for society as a whole and its consequent power. Krause suggested that professions shared with all occupations the features of, "central skills, code of ethics, group culture, occupational authority, and permission to practise on the part of the community", but had these features to "a very high degree". What distinguished them was firstly, that they were,"functionally powerful, or near to "key places" in the division of labour", and this was reflected in their political power, prestige, and material rewards", and secondly, that they dealt with basic needs, where the absence of their skills would lead to individual or social crisis. From this perspective "professionalisation" was only possible where an occupational group had a crisis-serving function, autonomy and power bestowed by the community, and the capacity to manipulate the work situation and the laws governing practice to its own advantage.

Drawing on these four standpoints, Krause analysed various "occupational fields", and came to a number of conclusions. The first was the importance of how and why a group identifies itself as an occupation, and used the concept of "occupation" to act as a cohesive group. The second was that the state and "power elites" opposed the functional power of occupations. For Krause the concept of functional power, as the potential of an occupational group to coerce a society through the withholding of its services, had to be refined with the understanding that,

> " "functional" occupational group power and "state" power may be ideal types rather than actually different, and we may need to look at the picture in terms of the "occupational quality" or the "governmental quality" of a type of power. In general, far more research needs to be done on the definition and specification of power as it relates to the functions of occupational groups in the social system." (p 351).

Krause's third conclusion was that in modern society occupational groups could not be understood in isolation from technological change and work organisation. Social changes altered the meaning of "functional power" for different professions.

The studies of Freidson, Johnson and Krause established a new and more critical approach to the study of professions. Subsequent work using this "power perspective" examined the political and historical processes through which occupations are created, develop ,and maintain their claim to being a "profession" [(Jackson (1970), Eaton and Webb (1978), and Larkin (1982)]. Parry and Parry's (1976) historical study of the medical profession considered the profession in terms of class mobility, viewing "professionalism" as, "a strategy for controlling an occupation in which colleagues, who are in a formal sense equal, set up a system of self-government."

These studies criticised the assumptions of the earlier trait and functionalist studies. They proposed that it was not special features of professional work or of professionals which were important, but how professionals and professional associations use certain features to advance or maintain their interests. They held that to search for distinguishing features was to perpetuate the ideology of professions that their work and values are intrinsically special, and to ignore the strategies by which an occupation uses these features to its advantage.

The "Deprofessionalisation" and "Proletarianisation" Theses

With the abandonment of "profession" as an ideal type, and as a result of changes in the work setting, studies also took a different view about the future of professionalism. In contrast to the eulogistic and optimistic tone of studies such as Carr-Saunders and Wilson in the first part of the century, more recent studies note trends which not only limit the professionalising aspirations of new occupations, but "deprofessionalise" the traditional professions. Trends which have been viewed as undermining the professions are the development of corporate capitalism, the use of management sciences to increase productivity and control of professionals employed in capitalist and other enterprises, and the increasing reliance of professionals on expensive technology.

Haug (1973) proposed a "deprofessionalisation" hypothesis, citing as contributing factors the computerisation of academic knowledge, the accessibility of experiential knowledge to "less

schooled persons", and the challenge to professional detachment and the erosion of professional autonomy through client review. Haug suggested that ,although organisational accountability and evaluation were difficult because, a) professionals' actions were not easily observable, b) there were unclear goals and techniques, and, c) unclear connections between methods and outcomes [c.f. Daniels (1972)], the effective power of clients to criticise the professional and to hold him accountable had increased. Haug explained this change in terms of the bureaucratic content of work and large-scale services aggregating clients and providing conditions for client organisation, as well as because of a developing consumer ideology and clients being more ready to challenge expert authority and autonomy.

Oppenheimer (1973), in a similar vein, proposed that the "autonomous professional" was becoming "proletarianized", that is , subject to an increasing division of labour, where many aspects of practice were determined by higher non-professional authorities, where they were remunerated on a salary basis, and were increasingly forming unions to defend working conditions. The study noted that the increasing bureaucratisation and rationalisation of work, methods for measuring professional output and quantitative criteria to replace qualitative (professional) criteria, high unemployment, and relative reduction in income, all created "proletarian" conditions. As a result professionals tended to join trade unions or influence their professional associations to assume trade-union-type activities.

In considering the proletarianisation thesis it is necessary to distinguish between a process for rationalising work, associated with the ideas of "de-skilling" (Braverman (1974)), work fragmentation, and loss of control over the labour process by the worker, and a process by which previously self-employed professionals become employees and adopt working class strategies such as unions. The latter is consonant with the Marxist thesis of increasing class polarisation; the former describes a process by which "rational" and scientific techniques are applied to professional work as to any other work in order to increase productivity, and, in a capitalist society, profit. This process, as described by Braverman (1974), turns work which was skilled and relatively autonomous into fragments, and removes control from the worker. It involves a separation of the intellectual facets of work, involving creativity and planning, from the worker, leaving him to execute the ideas and plans of others. (hierarchical fragmentation).

There are certainly processes outside of the control of professionals which affect the work which they do and their occupational structures. One of these processes is the use of management techniques to increase productivity (in state welfare services and communist countries) and profit (in capitalist organisations). Managerial rationalisation ,however,does not necessarily lead to work fragmentation and de-skilling for professionals (and consequently union opposition); indeed it may enhance professions' status by encouraging professions to delegate "menial work" to

assistants to "make cost-effective use of their skills and training". Some professions are in fact instigators of "work rationalisation" processes, and the process of professionalisation can in some instances be complementary to and supportive of increasing productivity.

Where de-skilling does occur and professions adopt an oppositional and union-stance, it does not necessarily follow that "proletarianisation-as-polarisation" follows. In many instances private practice is a viable alternative, and the individualist ideology of the professional leads to alternative action. In short, in the case of the professions, managerial rationalisation is a complex phenomenon and does not automatically lead to either "proletarianisation-as-polarisation", or "de-professionalisation".

PART 6: SUMMARY , CONCLUSIONS AND INITIAL THESIS

The chapter considered the main research and theories about professions and professionals in the social science literature, and the theoretical perspectives which had been used to investigate professions. It used the question which all studies implicitly or explicitly addressed,"what is a profession?", to organise a review of the literature.

A discussion of common usage showed a multiplicity of meanings which have changed over time . It is of note that social scientists have tried, perhaps more than with other definitions, to remain faithful to common meanings. When we also note that aspiring occupations capitalise on features which are associated with traditional professions, and that their rise depends on their ability to gain a mandate and trust from the public and clients (Hughes (1963)), we see that the use and change in meaning of terms is not purely a question of philology. In remaining close to common meanings, perhaps early social scientists recognised the significance of the public's understanding of what constituted a profession and a professional for a social scientific understanding of the nature of professions. That the early social scientific definitions proved an important resource for professions advancing their claims perhaps also shows that professions had a clearer understanding of their own nature and place in society : a profession is an occupation which the public are prepared to trust, and the public's conception of "professional" is crucial to acquiring this trust.

An historical review showed that social changes influenced the concerns of social scientists and their approach towards the study of professions. Professions were not a significant force in Marx's day and did not figure in his analysis of society. However the theoretical perspective established by Marx has been used to understand the rise of professions and the economic base

of their power. From this perspective the debates have centred around whether professions constitute a distinct class, and whether social change has or will lead to the "proletarianisation" of professionals.

The Weberian perspective, whilst recognising the significance of the economic concept of class, introduced the concepts of status and power which were to prove important to later understandings of professions. Durkheim's analysis of the division of labour highlighted interdependence in complex societies and the possible basis for social cohesion centering on occupational organisations. His perspective was developed by later functionalist writers. A number of writers drew on his ideas to advance the notion of professions as a liberal, progressive and scientific social force which upheld the value of the individual, in opposition to communism and fascism

The social scientists of the first half of the century generally accepted professions' claims about the degree and significance of their differences to other occupations: more than with any other conception the "ideal type" of "profession" became a moral rather than an analytic category.

Many post-second-world-war social scientists also were in broad agreement that a profession was defined ("trait" theories) or characterised ("continuum" theories) by skill based on theoretical knowledge, required education and training, adherence to a code of conduct, and loyalty to an occupational organisation and an ideal of altruistic service. The disagreement was over which traits were more fundamental and which derivative, and whether professions were qualitatively different from other occupations in these respects, or whether the difference was one of degree. With an increase in the number of "professionalising" occupations, the traits turned into continuums and social scientists considered the "process of professionalisation", the limits to this process, and the meaning of "professionalism".

The nineteen-fifties and sixties saw the development of specifically social scientific categories for research into professionalisation, and an attempt to develop theories which were capable of explaining the power and significance of professions in modern society.

The first of the more critical studies arose out of the interactionist perspective as applied to the world of work. These studies highlighted the differences between professional claims and practice, and the similarities between professionals and other workers in the dilemmas each faced and the strategies each adopted. These "naturalistic" and sometimes "debunking" studies were limited, however, in focusing on individual interaction and ignoring social change ,stable social institutions,and political power.

Another development was to focus on certain types of professions such as "semi-professions", "para-professions" or "people-professions", noting common features of the work content and context of these professions. With the increasing employment of professionals in bureaucracies, another field of work addressed the question of whether professionalism was antithetical or compatible with bureaucratisation.

Along with consumer and managerial challenges to professions in the late sixties, social scientists reassessed the concepts of professions, professional and professionalism. Probably the most important development was the "power perspective" ,which is adopted by this thesis and which is examined in more detail in the next chapter. This approach considers the political and social process through which professions maintained and advanced their interests. This perspective views a profession as a particular way of organising certain work and workers, and shows how professions manipulated public belief to achieve positions of power and to maintain their occupational advantages by organising and controlling markets and practitioners. This view holds that the particular attributes of the occupation or the worker are less relevant than the way in which these attributes are used, and the social structures and processes which create and sustain the special position of the profession and professional: a profession is first and foremost a social creation. The general historical review closed by considering the deprofessionalisation/ proletarianisation debate.

Conclusions

One conclusion of the above review is that typologies of the client practitioner relationship more often described the relationships practitioners wished to achieve to minimise "problems" and maintain autonomy, than the realities of modern practice in large organisations, and the institutional arrangements regulating the relationship.The notion of independent professional and individual client is a professional ideal with an ideological function, rather than an accurate representation of modern professional practice. As Freidson (1975) noted in his study of doctors in a health insurance funded group medical practice,

> "Living in a period when private practice was the taken-for-granted normal mode ..... their conception of solo, entrepreneurial practice established many of the parameters of what was normal and acceptable about their work." (p 41). It was this conception which led them to see themselves and their patients, "locked into an "unnatural" situation in which neither had any freedom of choice, in which both were in some sense trapped."

The author's research [especially Øvretveit (1986a) and (1986b)] found that the client-practitioner relationship in many instances in UK welfare services is not an isolated relationship but is part of a relationship between two groups or networks: on the one hand the practitioner as part of a multidisciplinary team, taking into account other professions' contributions and referring to them constantly; on the other, the individual client is part of a system or network of family group or community, or the client is another professional or the client's carers . Professions are increasingly concerned with changing the client's social, psychological or physical environment to support or maintain whatever changes they may have effected in their direct relationship with the client. There are primary and secondary clients (the client's main carers), and sometimes "a system" is the client (e.g. family therapy). The social sciences,and the professions,have yet to recognise the multiplicity of interdependencies and relationships in these situations.

The review revealed that there are certain core questions addressed by social scientists studying professions: do "the professions" constitute a new class?, What is the significance of professions in the social division of labour - are they particular kinds of monopolies for pursuing self interest, or do they restrain trends towards the competitive pursuit of individual economic self interest?, Is there a hierarchy of dominance of professions in fields such as health and law?, Are professions compatible with, or an opposing force to, bureaucracy?, Will the western "post industrial" or "information" society be ruled by professions with their monopoly over knowledge? (the "professionalisation" thesis), and will professional experts be increasingly integrated into large organisations and, backed by bureaucratic authority, become even more powerful in relation to clients, or will other forces reduce professions to the status of "skilled workers", and the concept of profession become obsolete (the "deprofessionalisation" thesis)?

The author's main conclusions from the review were:

- there is not a qualitative difference between a profession and an occupation or between a professional and other types of worker;

- like any social group, any group of workers will develop ideologies which emphasise their differences from other groups, in part to affirm identity and self-worth within the social group,in part to differentiate their product as a marketing strategy;

- in occupations, differentiation is accentuated by the length and depth of common experience, the commitment to a career, and often by full-time "occupational organisers";

- both for occupations aspiring to be professions, and for established professions, certain attributes are particularly important to emphasise in order to gain the trust of clients and the public, and to acquire the advantages which derive from this trust;

- the nature of such attributes are irrelevant as long as they enable the individual client to extend their trust and submit to the authority of the professional, and, more importantly, convince the public that it is safe and necessary to institutionalise that trust in a mandate for the profession alone to carry out certain social functions;

- trust and the client-practitioner relationship are central to an understanding of professions and their organisation;

- new conceptions of client-practitioner relationships and of service and labour markets are needed to understand professions in state welfare services. "Service recipients" and "users", with entitlement to services, are more appropriate concepts than "consumers" or "customers" who usually have a choice;

- in the current state of development of knowledge, the study of a range of occupations within a particular field is more likely to generate new insights than either a study of occupations in general, a comparison of "professions" with other occupations, or an historical study of one occupation.

The main conclusion, however, was that previous research had not found anything inherent in the work of professions which distinguished them from other occupations, or which enabled clear distinctions to be made between the work of different occupations.

This conclusion is borne out by the existence and severity of the problem experienced by professions and professionals in defining the practitioner's role and work responsibilities. This "problem" and the strategies used by professions and professionals to define their work is central to an understanding of professions and forms one focus for the chapters which follow. The available research suggests that the definitions of work which do exist are the result of a complex social process of negotiation and continual redefinition. Social scientists who have attempted definitional typologies have themselves introduced new elements to this process, which are frequently referenced by aspiring professions. It will be argued that it is the particular way in which the occupation defines its work and regulates workers and clients which distinguishes different occupations, rather than intrinsic features of the work itself. Later chapters show that it is occupational organisation, and increasingly the state, which defines the work and characteristics

of occupations; and that occupational organisation distinguishes occupations and produces many of the differences reported in the research reviewed.

Initial Thesis

Drawing on the above discussion an initial thesis about occupational power, which will be explored in the chapters to follow, can be stated thus:

A. Objective preconditions for achieving a "profession"

Five objective preconditions are necessary before a type of work and workers can achieve the status and power of "a profession":

1. The work is desired and required

The work is considered necessary by individuals and is functionally necessary for the continuation of a social order.

2. Harm by incompetence

There is a likelihood of harm to individuals (and/or the social order) if the work is poorly done. (In most cases clear outcome criteria can be set.)

3. Expert knowledge required

In order for the worker to consistently achieve "successful" outcomes, it must be objectively necessary for the worker to apply "expert knowledge", not available to someone who has not undergone years of education and training.

4. Little possibility of external direction and evaluation

The degree of competence of the worker could not be judged by a client or general manager, either from outcome or during the work process. (Extreme incompetence, and negligence could be judged.) In addition people outside the occupation could not judge the training which would be necessary to carry out the work competently.

Although particular problems must be associated with a need for a particular type of worker, clients or general managers could not judge how the worker's skills and knowledge should be deployed to the best effect, in terms of techniques, types of work processes, and siting of posts. (Marketing and productivity decisions).

5. Common economic interests

The workers must have common short and long term economic interests. This would usually arise because of their immediate market situation, and in order to maintain or increase income in return for their investment in previously gaining "expert knowledge" and in establishing their trade.

In situations where people need certain work done, where workers are available to do the work, and these five objective conditions are met, then people will have to extend a high degree of trust in the worker and allow them to determine aspects of their work and conditions of work. These objection conditions place workers in a position where they can exploit the situation to their own advantage. (In a position of potential power.)

However, in addition to objective preconditions, for a group of workers to achieve the power and status of a profession, they must also, 1) become collectively conscious of their potential power, 2) develop a common occupational ideology, and 3) organise successfully to advance and defend their interests.

B. "Subjective Conditions": occupational consciousness and organisation

Given the above preconditions, workers with common interests are able to organise successfully to advance and defend their interests. This requires that they exercise their power to, a) establish a clear labour and service market, b) defend these markets usually through registration, and c) shape and exploit technological, social and organisational change to advance their interests.

The extent to which workers will develop "an occupation in itself" ,into "an occupation for itself" will depend on:

- the extent to which a common occupational ideology is created and maintained, and values are shared;
- worker's career commitment to the occupation;
- the sexual and class composition of the occupation;
- the organisational context of the work.

This initial thesis was revised as a result of the thesis research . The final chapter presents a modification of this initial thesis in a general model of the process of the authorisation of professional power . The next chapter considers in more detail two of the theories reviewed

above which appear to hold out the greatest promise for exploring and developing this initial thesis.

CHAPTER 3 : OCCUPATIONAL CONTROL AND THE STATE AT THE NATIONAL LEVEL

PART 1: INTRODUCTION

One conclusion from the review of the literature about professions in Chapter 2 was that a paradigm shift had occurred in the study of professions in the 1970's.The attention moved from distinguishing occupations in terms of characteristics of the work, or of the workers, and with establishing trans-historical and trans-cultural definitions of "profession", to an examination of how certain occupations attempted to achieve and maintain professional status.

Although a number of theorists and researchers had abandoned the "definitional" paradigm no clear alternative was available until Friedson's theory of professional dominance established a new theoretical perspective within the field in 1970. This perspective emphasised the social process and structures through which occupations establish and maintain control over markets.

This thesis took Freidson's theory as its point of departure. It chose to concentrate on Freidson's theory and his general perspective on professions for a number of reasons .First his approach avoided the narrowness of the microsociological studies,which,whilst overcoming the sterility of the "definitional" studies, failed to recognise the larger sociological and institutional aspects of professions. Second,the more recent single-profession historical studies eschewed attempts at theorising about professions in general. The review noted a lack of theories of professions which related the variety of phenomena which had been extensively researched into a comprehensive explanatory or predictive schema. It will be suggested below that Freidson's general perspective, rather than his theory itself,provides the basis for a general theory of profession, which the thesis sets out to develop.

Third, Freidson's theory made connections with concepts and theories in government and organisational studies, which could be drawn on to improve understanding of professions in modern state welfare societies. Fourthly, the theory addressed phenomena which the author had studied in the course of his research into the organisation of different U.K. welfare professions. There were findings from this research which cast doubt on some of Freidson's propositions, but did not necessarily disprove the general perspective. The research challenge was to explore whether the theory could be developed to accommodate these findings, and how

Freidson's theory could improve our understanding of the relationship between the state and professions .

The purpose of this chapter is to review the theory, and to assess the validity of the theory in the light of the author's research into occupational control at the national level in the U.K..

The chapter first briefly reviews Johnson's study of professions and power. This study is also relevant to the general perspective which the thesis adopts because, like Freidson's study, it examines ways in which professions seek to control areas of work, conditions of work, and workers themselves. The chapter then reveiws Freidson's theory and presents the author's research into the details of the structures of national regulation of five occupations in the U.K. . These are details of state registration and regulation, and structures for negotiating pay and conditions of service. The descriptions are based on documentary sources such as: Acts of Parliament, reports of relevant state regulatory councils, documents of professional associations, social science research reports and publications, and published reports of individuals involved in creating and administering the structures.

This research is then used to assess the validity and relevance of Freidson's theory to professions in state welfare societies .The findings and discussion of state regulation cast doubts on the simple proposition that some occupations (termed "professions") control work jurisdictions with state support. The details provided evidence that these structures and regulations do not define areas of work, and that they provide for various forms of control <u>of</u> the occupation by the state, as well as for control <u>by</u> the occupation of aspects of practice and training.

PART 2: PROFESSIONAL POWER AND AUTONOMY: THE THEORIES OF JOHNSON AND FREIDSON

Johnson and Freidson studies of professions concentrated on the ways in which professions established and maintained work jurisdictions or work monopolies. Aspects of this approach were foreshadowed in Weber's discussion of the ways in which groups attempted to control and exclude competitors, a strategy common in the case of occupations competing for a valued area of work (e.g. psychotherapy in the USA [Gouldner (1968)]. Weber noted that,

> "When the number of competitors increases in relation to the profit span, the participants become interested in curbing competition. Usually one group of competitors takes some externally identifiable characteristic of another group of

> (actual or potential) competitors - rage, language, religion, local or social origin, descent, residence, etc. - as a pretext for attempting their exclusion. It does not matter which characteristic is chosen in the individual case: whatever suggests itself most easily is seized upon. Such group action may provoke a corresponding reaction on the part of those against whom it is directed."
>
> [Weber (1968) p 342]

Chapter two showed how early studies tended to reflect or support the efforts of professions intent on identifying defining and distinguishing features. A paper by Hughes in 1963 questioned these "trait" approaches, and suggested that knowledge would be advanced by examining the circumstances in which people practising an occupation attempted to create a profession. Two theorists who, between them,established a new paradigm were Freidson (1970a) and Johnson (1972). Both started from the premise that professional power and occupational monopolies served to maintain and promote the interests of members, and were not to be explained in terms of the characteristics or requirements of the work itself.

Professional Power and Control

Johnson's (1972) discussions considered ways in which professions attempted to control their conditions of practice, in particular, market conditions. His analysis was influenced by economic theory and Durkheim's (1933) theory of the social division of labour.

Johnson suggested that, with increasing specialisation, relationships of social and economic dependence were created, as well as relationships of "social distance". These relationships existed between different producers and between producers and clients. Social distance created the potentiality for autonomy as well as uncertainty ("indeterminancy"), and power relationships resolved the uncertainty of the relationship in favour of one party.

Johnson proposed that by increasing the uncertainties of the relationship through "mystification", occupations could extend their autonomy and control over clients.

> "Occupational activities vary in the degree to which they give rise to a structure of uncertainty and in their potentialities for autonomy. It is this factor which provides an explanation of why it is that some occupations rather than others achieve self-regulation." (p 43).

Johnson's argument was that "professionalism" was one form of institutional control, the purpose of which was to change power relations,

> "Professionalism then becomes redefined as a peculiar type of occupational control rather than an expression of the inherent nature of a particular occupation. A profession is not, then, an occupation, but a means of controlling an occupation. Likewise, professionalisation is a historically specific process which some occupations have undergone at a particular time, rather than a process which certain occupations may always be expected to undergo because of their "essential qualities." [Johnson (1972) p 45]

In order to develop a typology of institutionalised orders of occupational control which applied to all occupations, Johnson focused on "the core of uncertainty - the producer-consumer relationship". He proposed three methods for managing tensions of the relationship, which corresponded to historical periods.

The first type was collegiate control where the "producer" (i.e. the professional) defined the needs of the consumer and the manner in which the needs were to be met. In the second, oligarchic, corporate patronage or communal control, the "consumer" defined his own needs and the manner in which they were to be met. In the third type, a third party mediated the relationship between producer and consumer and defined both the needs and the manner in which the needs were to be met. An example was capitalist mediation where, "The capitalist entrepreneur intervenes in the direct relationship between the producer and consumer in order to rationalise production and regulate markets." No less significant, however, was state mediation in which the state intervened in the relationship between producer and consumer, initially to define what the needs were, as with the development of state welfare policies in the UK. [Johnson (1972) p 46].

Rather than explaining professional structures in wholly rational or technological terms, Johnson's analysis highlighted the social processes and power factors which produced certain structures, and the function of the structures in advancing the economic interests of a professional group. The analysis also drew attention to the role of social structures in controlling uncertainty, in particular the uncertainties of the practitioner-client relationship. However, as Parry and Parry (1976) noted, medical associations and institutions (the Colleges, BMA and GMC) have been much more concerned with controlling competitors than clients. This is largely true of most of the established and developing professions, particularly those mainly employed in state welfare agencies where a "ready market" exists. It is only at local levels that structures for "controlling" clients are established in these services. In monopoly state welfare services in the U.K. ,structures usually function as rationing devices.

The concept of "mediation" between consumer and producer is also questionable. Modern capitalist corporations and private professional practices both produce and market goods and

services. In addition, the state as "mediator" has performed a complex role in defining needs, and has largely been influenced by professional definitions.

Johnson's analysis was useful in developing an understanding of occupational control by drawing attention to aspects of the consumer-producer relationship, and to how professions seek to control the uncertainties of "the market". However, no specific examples were given of actual regulatory structures at the national or other levels, and the three-fold typology remains an heuristic guide.

Freidson's Theory of Professional Dominance and Autonomy

Freidson is commonly viewed as the initial proponent of an approach to the study of professions which emphasised ways in which professions attained and extended control and autonomy. His 1970 work developed out of the "traditional" approach which was preoccupied with "definitional" questions, and, it will be argued, his later work still retains a concern with such questions. However, his original thesis was that the previous concerns to define "a profession" had diverted attention from analysing the significance and consequences of aspects of professions common to most definitions. He contended that,

> "From the single condition of self-direction or autonomy I believe we can deduce or derive virtually all the other institutional elements that are included in most definitions of professions. [Freidson (1970a)]

As an example, Freidson suggested that an occupational group was more likely to be self-directing in its work when it had achieved a "legal priviledge" which protected its work from being undertaken by other occupations. He also suggested that self-direction was only possible if an occupation could control the production and the application of knowledge and skill in its work, and that "full autonomy" of this type was not possible if others could reasonably criticise or evaluate the way in which members carried out their work. Freidson also linked codes of ethics to autonomy, regarding them as, "A formal method of declaring to all that the profession can be trusted and of persuading society to grant the special status of autonomy."

Freidson's argument was thus that,

> "most of the commonly cited attributes of professions may be seen either as a consequence of their autonomy or as conditions useful for persuading the public and the body politic to grant such autonomy."
>
> [Freidson (1970a), p 135]

The main subject of Freidson's 1970 study was medical dominance. The central argument was that the only "truly autonomous" occupation in health services was medicine, and that its autonomy was sustained by the dominance of its expertise in the health division of labour. He proposed that a clear distinction must be made between the dominant profession and others, and came close to offering a definition of "a profession", not in terms of "autonomy", but in terms of "dominance".

> "One might call many occupations "professions" if one so chooses, but there is a difference between the dominant professions and the others ..... in essence the difference reflects the existence of a hierarchy of institutionalised expertise."

Much of Freidson's 1970 work was concerned with examining the effects of medical dominance on clients' experiences. He argued that patients' dehumanising experiences in hospitals resulted just as much from professional organisation and professional dominance in the health division of labour as from the faults of "bureaucratic organisation ". He proposed that the source of legitimation of authority for the shaping and control of this division of labour was the imputed expertise of medicine, an alternative form of authority to bureaucratic authority.

Freidson's later works developed his analysis of "organised autonomy", its significance and the process by which occupations maintained or increased their autonomy. In a 1977 paper Freidson again drew attention to the difficulties of defining "profession" and "professionalisation", and showed that certain so-called distinguishing features (e.g. knowledge, skill, and length of formal education), "may reflect institutional processes more than functional necessity", and did not discriminate professions which were fundamentally different. He suggested that professions be regarded as, "Special kinds of status groups - organisations of workers who have gained a monopoly over the right to control their own labour." (p 16). He proposed that knowledge about professions would be advanced by a study of the nature, degree and mechanisms of control over work,

> "To understand better the division of labour and the institutions of production and to understand the crucial differences among occupations, I believe, requires instead an emphasis on the degree to which they have gained the organised power to control themselves, the terms, conditions and contents of their work in the settings where they perform their work."
>
> [Freidson (1977) p 22]

This thesis is in broad agreement with Freidson on this point and aims to develop these insights by reference to the author's empirical research into five UK public welfare service occupations. The thesis focuses on the actual structures and processes which regulate professions at the national and local levels.

Finally, a subject raised in Freidson's 1977 paper which was neglected in his previous work was the question of value orientation, ethics and the idea of "committed labour". Freidson drew attention to the problems of earlier studies which took professions' declarations of ethics and principles at face value. He suggested that value orientations should not be ignored, but viewed these as products of the social organisation of professions which, "constitute circumstances which encourage the development in its members of several kinds of commitments." At another point, however, he states, "commitment to serving others and to doing good work cannot be connected so plausibly with occupational organisation, and remains analytically separate from it except as an ideology that aids its development and maintenance."

In summary, Freidson's main argument was that education, skill or the nature of the work did not explain the existence of, or degree of control over work by the workers themselves. Control required political agitation to, "Negotiate and establish favourable jurisdictions in an organised division of labour and to control the labour market" [Freidson (1977) p 23], and usually involved state support. Variations in control were seen by Freidson as the criterion differentiating occupations, which produced most other characteristics of occupations, and which should form an important subject of study.

Criticisms of Freidson's Theory of Occupational Control and Autonomy

The following presents the author's criticisms of Freidson's theory of medical dominance and of his general analysis of professional autonomy . Most of these criticisms will be substantiated in the next section of the chapter which presents the author's documentary research into professional and state regulatory structures at the national level,and in later chapters which present the author's research into local management structures.

Values and Occupational Structure and Rules

Freidson argued that, a) professionals' value orientations were products of professional organisations, b) values could not be easily related to professional organisation, and c) values might help to develop and maintain organisation. Freidson did not, however, state to which aspect of professional organisation he was referring, but in the context of his 1977 paper it must be assumed that it was professional codes of ethics which, being regulations, were only one

aspect of structure. If it were codes of ethics to which he was referring, then the argument that professional codes should not be accepted without question was justified. The author's field research in social work documented a marked discrepancy between the principles of one profession, as espoused in its code of ethics [BASW (1975)], and the every-day practice of social work [Øvretveit (1986a)].

However, when considering other aspects of professional organisation, such as local management structures, particular values could be shown to be formative of structure as well as derivative. Democratic and individualistic values are central to the organisational structure of at least one clinical psychology department [Bexley Psychology Department (1980)]. Democratic values underlie the organisation of many social work teams [Payne (1978)], and many clinical multidisciplinary teams [Øvretveit (1986b)]. At local levels there is a clear link between professional structures and values.

Freidson's sceptical view of the importance of values and commitment in professional organisation was related to his concern to highlight the self-interested stance of professions, in contrast to earlier work which had unthinkingly reproduced professional ideologies. A second criticism of Freidson's theory is that whilst it was important to reveal the self-serving function of some professional regulations, this should not be taken as the sole explanation for their existence, or that such regulations or strategies were consciously adopted to advance the interest of the profession. For example, professions have traditionally invoked a principle of "client confidentiality" to oppose inspection of their records and evaluation of their performance. They have also opposed clients having full access to their records. In both cases the strategy maintained professional control, but this was not the only reason for the strategy. There were also legitimate concerns to protect clients' and third party's interests. Policies on confidentiality [Data Protection Act (1984), LAC (1983) 14, DHSS Consultation Doc. (Sept 1985)] are good examples of state involvement in "occupational control" which also protected profession's confidentiality "privileges".

The last point relates to a criticism of Freidson's theory of medical dominance and autonomy. Freidson's emphasis suggested that "medicine's control" was an intentional conscious strategy, and that constraining limits to other professions were agreed by the state in a conscious alliance with medicine (c.f. "conspiracy theory"). Larkin (1982), however, has shown that a number of occupations have themselves campaigned for controlling legislation, albeit legislation acceptable to the medical profession. Further, although "protection of the public" is one of the main arguments mounted by medical and other occupations in favour of regulation, it is also a legitimate concern of the state as the representative of clients and of the public. Such "constraining limits" often serve the function of enabling medical control, but this does not explain their existence,

nature or origins. In addition, the mechanisms and structures of control needed to be described to show exactly in which ways the structures and regulations control professions, and the part played by the medical profession in their formation and maintenance.

A fourth criticism concerns the importance attributed by Freidson to professional expertise in his analysis of medical dominance. In tracing the rise to power of the medical profession, Parry and Parry (1976) have shown how expertise was used by medicine to establish and legitimise a position of dominance: expertise per se was not the "cause" or sole explanation for the structure of the health division of labour. In addition, it has been argued that specialisation and rationalisation, rather than increasing scope for autonomy and dominance, could enable others to predict, evaluate and control performance [Parry and Parry (1976), p.258, and Jamous and Peloille (1970), pp.111-153; Armstrong (1976), Alazewski (1977), Baer (1981)].

Further, the continuing dominance of the medical profession in mental health and mental handicap services shows that "professional authority" does not derive solely from expertise, but involves elements of bureaucratic authority sanctioned by the state through its employing authorities. For example, a consultant psychiatrist in a northern psychotherapy department was unable to arrange for members of another profession to become head of the department as both the Regional and District Health Authority insisted that the consultant must remain clinically and managerially accountable for the department and its clients [Øvretveit (MD.01)(1984)]. Employers can institute arrangements to ensure multidisciplinary clinical team accountability through a non-medical head or chairperson [BPS (1985)] and there are examples of health authorities which had done so [Psychology Workshop (1985) Oct 13/14]. "Expertise" is but one of a number of considerations in decisions over organisational structure (e.g. management arrangements for "paramedical" professions in NHS reorganisations, 1974, 1982, and 1985 reported in Ch.6).

A fifth criticism is that the "dominance of medicine" in the health division of labour was, and is not, as absolute or clear-cut as Freidson proposed, certainly in societies such as the UK with large-scale state employment of different occupations in welfare services. Freidson stated, "In present-day health care ..... there is little or no evidence that physicians have been losing significant elements of their monopoly over ordering and supervising the work provided by other occupations in the division of labour."

However, in the UK there has been significant changes in the types of medical control at all levels, as a result of state development of community services and the increase in services for people with chronic or "non-medical" problems such as the mentally handicapped, the mentally ill and the elderly. Later chapters will present evidence to show that managers of non-medical professions have eroded or escaped medical control over the work of members of non-medical professions.

Øvretveit (1985a) documented in detail the development of professional autonomy in physiotherapy over the last 20 years and showed substantial changes in the authority of doctors in relation to physiotherapists in the area of referrals, prescription, management, and influence at the national level.

There is similar evidence in the cases of nursing, clinical phychology and medical social work [Armstrong (1976), Alazewski (1977), Baer (1981)].These studies describe the increasing independence of such occupations from medicine in a number of areas.The concept of autonomy is used differently, in a way which suggests that degrees of autonomy are possible ,and which links the increase in autonomy of developing occupations to a decrease in medical dominance. However without a clear definition of "medical dominance",it is impossible to assess whether it has declined ,and if it has,in what way such a decline might be related to the increasing independence of developing health occupations.

The sixth and most important criticism is that Freidson did not clearly define "autonomy" or "control", making it difficult to confirm or falsify his theory. Further, that the definitions he provides do not distinguish professions. In his 1970 work Freidson used a dictionary definition of "autonomy":

> "The quality or state of being independent, free, and self-directing ..... control over the content and terms of work."
>
> [Freidson (1970a)]

In this work he emphasised the significance of "organised autonomy" of professions rather than de facto autonomy, in particular the state regulations which provided for autonomy and control,

> "The autonomy of the individual practitioner exists within social and political space cleared and maintained for his benefit by political and formal occupational mechanisms."
>
> [Freidson (1970b) p 24]

However, Freidson did not describe different <u>types</u> of institutionalised autonomy, nor show through empirical evidence exactly how different institutional structures provided for autonomy and control. This was a shortcoming in a work which attempted to establish autonomy as the criteria by which professions could be distinguished.

The most specific statement offered by Freidson referred to only one mechanism of "control" at the national level which were state registration arrangements. He showed that, unlike many

occupations, "Most of medicine's conntrol has not been exercised directly in negotiation with clients or employers, but rather indirectly, through licensing, registering and certifying legislation that establishes constraining limits about what can be negotiated among workers and with managers in concrete settings." However, Freidson's analysis should have considered the situation in countries where the state is also a monopoly employer. In these cases "managers in concrete settings" are often civil servants and agents of the state. In many countries the state as primary employer has separate and sometimes conflicting interests. The state will not sanction legislation which is against its interests, and on occasion introduces legislation which furthers its interests as an employer. State monopoly employment is one factor which weakens Freidson's thesis about medical dominance.

In addition, "managers in concrete settings" are increasingly members of the same profession (termed "profession-managers" in this study), and management in welfare services cannot be so simply compared to management in manufacturing and commerce. Managers often pursue strategies and establish local structures in order to increase their own autonomy and that of their professional practitioners (e.g. challenge national constraints, and develop new types of services). Indeed it has been argued that the main challenge to medical dominance in the NHS had come from the increasing numbers and powers of "profession-managers" in developing health occupations [Armstrong (1976), Alazewski (1977)].

It will be shown below that state registration arrangements place few "constraints about what may be negotiated", and that, in the UK, other structures and rules at the national and local levels establish constraints which have had far greater effects on occupational autonomy and control (e.g. Whitley Council regulations, employing authority policies).

A final criticism is that rather than pursuing his argument that knowledge about professions would be advanced by a study of the nature, degree and mechanisms of control which they exercised over their work and future, Freidson returned to earlier preoccupations to define "profession". As with his 1970 analysis, cognisant that the criteria of control per se did not define professions, Freidson proposed a restrictive definition of profession,

> "It is possible to reserve the term profession for that form of occupational organisation which has at once gained for its members a labour monopoly and a place in the division of labour that is free of the authority of others over their work."
>
> [Freidson (1977) p 23)]

This proposal detracts from the thrust of Freidson's argument, which was to turn away from unproductive attempts at definition to an examination of degrees and mechanisms of control and

social processes. As argued above, the "authority of others over their work" was not specified. No profession was or is entirely "free of the authority of other over their work". The interesting and relevant questions which emerged from Freidson's approach were not pursued in detail: what exactly are the differences in degree and mechanisms of control, and why do such differences exist? It is these questions which this thesis pursues.

Freidson later states clearly that his definition of profession relied not only on the notions of "autonomy",or "control", as suggested above (not distinctive), but also on the concept of "dominance" :

> "Given this definition of profession as an occupational monopoly with a position of dominance in a division of labour, what is the likelihood of more occupations professionalising in the future?"

For the purposes of his 1977 essay it was necessary for Freidson to forward a certain definition of "profession" to examine questions of "professionalisation". However, this essay revealed the weakness of the definition and the limitations to Freidson's analysis of professional dominance.

The thesis returns to a discussion of the theoretical issues raised above after presenting the empirical research in the next chapters.

PART 3: THE AUTHOR'S RESEARCH INTO OCCUPATIONAL CONTROL AT THE NATIONAL LEVEL

In order to substantiate the above criticisms of Freidson's theory and to develop his perspective in the context of UK public welfare services, the following presents the author's documentary research into the details of professional structures and regulations established at the national level. The findings show that, in the UK, institutional mechanisms for regulating professions do provide occupations with certain forms of control and autonomy, but also provide for state control of the occupations.

Three main forms of "professional organisation" exist at the national level: associations of members of the profession, structures for regulating training and the practice of a profession (e.g. state registration councils), and structures for negotiating the pay and conditions of service to be offered by state employers . Professional associations are involved in different ways in creating and operating structures established by the state for the last two purposes.

The following describes the exact nature and extent of control of each profession ,firstly over pay and conditions of work, and secondly over practice and training by reference to the details of the structures which exist. Unfortunately little primary or secondary evidence is available as to how the structures are operated in practice, but a description of the formal arrangements is sufficient for the limited purpose of the chapter, which is to consider the evidence for Freidson's theory in the context of the UK.This evidence also lays the basis for the theoretical argument advanced later, which proposes that the concept of authority is a more useful concept than autonomy for understanding and analysing the nature of professions.

The Nature of Occupational Control over Pay and Conditions of Work

The development of state welfare services has increased the union role of many professional associations and resulted in national structures for negotiating the pay and conditions of work of professionals who are employed in these services. As Dimmock (1979) noted,

> "It was the government's desire to establish an ordered machinery for collective bargaining, as a corollary to the introduction of the NHS, that emphasised the ambiguities of the role of the British Medical Association. The continuous rule-making processes which constitute collective bargaining are different in kind from the spasmodic ad hoc negotiations that tended to characterise the BMA's previous relations with the state."
>
> [Bosanquet, N. (1979) p 208]

The pay and conditions of work which state employing authorities offer to members of professions which they employ are negotiated and decided at a national level through a variety of different structures. These structures have an indirect influence over both the division of labour (often by setting minimum qualifications for employment), and over career and management structures of the profession (by establishing grade definitions which specify specialist experience or management responsibilities).

The institutional structures and the development of professional union activities have sometimes produced competition between professional associations and multiple- occupation trade unions. In national negotiations over pay and conditions of work, some professions are represented solely by their association(s), which have recognised trade union status and have established local steward systems (e.g. medicine and physiotherapy). Some professions are represented both by one or more professional associations, and by one or more unions (e.g. nursing, social work).

Some professions are represented solely by a multiple-occupation trade union, and the profession may not be a recognised trade union (e.g. clinical psychology).

None of the occupations of the study "controls" their pay and conditions of work. Each influences decisions about pay made by the state at the national level in different ways and through different mechanisms.

Medicine and Nursing

When the NHS was created in 1948, medical and nursing professional associations represented their members in negotiations with employers (Regional Hospital Boards) and the state (Ministry of Health) on Whitley Councils established for each of these occupations [Levitt (1976), Dyson and Spary (1979), Parry and Parry (1976)]. The medical profession felt that this structure and the decisions which were reached were unsatisfactory. Stevens described the profession, in1951, as viewing itself as being,

> "tied to a politically dependent service" , and that, "The Ministry of Health as the employer and source of income could not by itself commit government funds in addition to those already granted for the NHS by the Treasury."
>
> [Stevens (1966) p. 130]

After a long and complex series of political manoeuvres [Parry and Parry (1976) pp 218-222, and Stevens (1966)] involving a Royal Commission, doctors were removed from the system of direct negotiation between their representatives and health departments on their Whitley Council. A permanent independent review body was set up for doctors and dentists in 1963 to, "advise the Prime Minister on the remuneration of doctors and dentists taking any part in the NHS." This review body based its recommendations on evidence from doctors' representatives, from the DHSS, and on changes in cost of living, state of recruitment and comparisons with other professions.

It is therefore too simple to suggest that either the state or the occupation "controls" the pay and conditions of service of members of the medical profession. An independent review body is a particular type of structure, which arrives at recommendations through a complex process. As Stevens (1966) remarked, "The creation of review machinery could be seen as a successful attempt by the medical profession to overcome some of the penalties of being state servants ..... the Review Body removed from the Ministry's jurisdiction the vital but unpleasant decisions regarding the level of professional remuneration for the most powerful and important group in the health service." (p 137).

The profession does, however, entirely control a merit award system which awards payments additional to the basic salary for contributions to medical knowledge and practice. ("national statistics" reported by the Guardian newspaper (17/2/88) showed that in 1987 one consultant in three (total numbers 6,500) held an award worth between £5,790 to £29,550 ,and that two-thirds of consultants retired with such an award.)

Nurses were represented by their professional associations in direct negotiations with employers and the state in the Nurses and Midwives Whitley Council. In response to widespread dissatisfaction and the threat of strike action, an independent review body was created on 1982, but members of the occupation are suspicious about state influence in the body, and the status of its "recommendations". In the cases of both the doctors' and nurses' review bodies the government ultimately determines the finance available for pay settlements, which in turn is influenced by public expenditure policies. In 1987 District Health Authorities were not provided with additional funds to meet the pay awards which were finally decided. Review bodies making "unrealistic" recommendations risk losing credibility and popularity with both sides.

Physiotherapists

The way in which pay and conditions for physiotherapists in the NHS are decided is different, and the professional association plays a different role in the process. Physiotherapists are represented by their professional association, together with other professions, on a "Professional and Technical" Whitley Council. The influence of the professional association over its members' pay, grade definitions and conditions of work is thus limited by the requirement that this Council reaches settlements agreeable to a number of occupations.

Clinical Psychology

In the case of clinical psychology the profession's influence is weaker, not only because of the structure of a multi-occupational Whitley Council, but also because it is represented by a multi-occupational union: The Association of Scientific, Technical and Managerial Staff (ASTMS). The professional association of clinical psychologists (The British Psychological Society (BPS)) is not a recognised trade union, and the occupation, together with other occupations, is represented on the Council by ASTMS representatives. The profession effectively has little influence over pay, grade definitions and conditions of work. This has caused a number of problems and concerns in the profession. As with physiotherapists, union representatives have aimed to negotiate the best short-term settlements, and have used grade definitions as bargaining counters in their strategies. The result is that employing authorities are constrained in the descriptions of the posts they can

offer by the wording of grade definitions, and the "career structure" of the profession is built on a series of definitions negotiated for short-term expediencies (DCP Newsletter correspondence (1981-1983)). It is of note that clinical psychology is one of the few professions ,apart from the medical profession, which has arrangements for awarding pay on purely professional criteria in its top grade award and assessment procedure.

Social Work

The professional association of social workers (The British Association of Social Workers (BASW)) similarly has little influence over pay and conditions because of representation on multi-occupational bodies by more than one multi-occupational union (mainly NUPE,and NALGO). A council for negotiating pay and conditions for local government workers exists which is similar to the Whitley Council arrangements.

In summary, the occupations of the study exercise different forms and degrees of influence, rather than "control", over pay and conditions of work. Medical and nursing professional associations are registered trade unions and they represent their members' interests in hearings undertaken by independent review bodies. Such professional structures and mechanisms enable these associations to exercise some influence over the pay and conditions of their members. Physiotherapists' professional association is also a trade union, and is the main representative of the occupation in direct negotiations with employers in the Whitley Council system. The association is only able to exert a minor influence over decisions about pay and conditions which also have to apply to a number of occupations covered by the Council. Psychologists exert even less influence over pay and conditions because they are represented in a multi-occupation Whitley Council by a multi-occupation trade union. Social workers are represented by more than one multi-occupation trade union in a multi-occupational negotiating mechanism.

Thus in the UK none of the occupations examined "controls pay and conditions of work" (Freidson (1970)), and each exerts different degrees and forms of influence through structures and mechanisms at a national level. Decisions made at this level, however, constrain the types of employment and levels of pay which employing authorities can offer, and determine career structures within the occupation. The decisions are also affected by government public expenditure policies. In short, the state exerts a profound influence over pay and, in the longer term, over a variety of aspects of the occupation through its role as employer (e.g. in Regional manpower planning). In this instance the institutions and structures at the national level clearly provide for control <u>of</u> the occupation by the state, rather than for control and autonomy <u>by</u> the occupation of pay and conditions of work.

Central control over pay is not only of significance in setting general levels of pay and differentials, but also in deciding grade definitions. Grade definitions affect the career structure of the profession and can have a profound long-term influence. Of particular significance are high- level clinical practitioner posts which provide opportunities for career progression within clinical practice. A general concern of professions is that organisations frequently reward management roles more highly and experienced practitioners are drawn into management roles to increase their pay, and are "lost to the profession" (Ovretveit et al (1982)). For a number of reasons each of the professions of this study has been concerned to establish practitioner grades to provide a clinical career structure, with varying success. Central determination of these grade definitions and pay levels is a slow process, and in effect provides central government with control over the long-term shape and nature of the profession.

The Nature of Occupational Control over Practice and Training

Different structures exist at the national level, and different rules apply for regulating the practice of a profession and its training. Some occupations (e.g. clinical psychology) are not supported by the state in their regulatory activities. Many occupations, however, have a complex involvement with the state in establishing and administering state regulatory structures and rules [Larkin (1982)]. Often state regulation is exercised through the rules and structures of occupational associations, or by involving members in state structures.

The following describes the exact details and mechanisms of these structures and their regulation to show that the simple view that the state provides occupations with control over the content of their work is also inaccurate. Rather, state registration provides for particular forms of "occupational control". The strongest type of regulation is that of making the practice of certain activities by the unregistered a criminal offence ("functional prohibition"). For this to happen, which produces a form of state-authorised monopoly, an unambiguous definition of the activity is necessary. To prohibit certain activities,however,is not to prohibit others from carrying out other activities commonly undertaken by the profession, so even the strongest form of regulation does not establish a pure monopoly. The second main type of regulation is to make it an offence for the unregistered to represent themselves as a registered practitioner, usually through a "protected title". The following describes the type of state regulation of the five professions of the study by providing details of the Act of Parliament providing for a state registration authority (Council), and of the forms of regulation imposed by the Act.

Doctors

The Medical Act of 1958 established the current General Medical Council (GMC) to set up a register. (This Act has been amended by subsequent Medical Acts). The GMC has the usual functions of a statutory registration authority: (a) keeping and admitting to the register; (b) disciplining for "unprofessional conduct" by removal, and (c) setting qualifications for admission. The GMC assesses training institutions directly and does not rely on a professional association for this function.

The exact form of regulation was established in a section of the Act (almost unchanged since 1858) which makes it an offence for an unregistered person to "wilfully and falsely" represent themselves as registered. The offence is not that of practising medicine without being registered, but of assuming a name or a title which implies registration. There is no "functional closure" of the profession, but the regulation is stronger than "protected title" because of the following restrictions on the non-registered: non-registered practitioners may not charge for "medical or surgical advice" but may do so for treatment which does not constitute "an operation"; non-registered practitioners may not hold a "public medical appointment"; only registered doctors may prescribe "restricted drugs"; only registered doctors may sign various "certificates".

Nurses

The General Nursing Council for England and Wales was originally established for the state registration of nurses by the 1919 Nursing Act. At present it is an offence for an unregistered person to represent themselves as a state registered nurse. "Functional prohibition" is difficult because of the problem of defining nursing practice. Various Acts since 1919 have enlarged the functions of the Council, and the Council administered both the state roll for State Enrolled Nurses and the state register for more advanced nurses (SRN) and approved training establishments. The Council dealt with training centres directly via inspectors. The new English Nursing Board (ENB) performs similar functions.

Midwives

The Midwives Act of 1902 established the Central Midwives Board to administer the state register, prohibited the use of the title "Midwife" by the non-registered, and specified that the midwife could only practice "under the direction of a qualified medical practitioner". As in the case of other nurses, the Council (now the(ENB))dealt with training schools directly.

Professions Supplementary to Medicine (including Physiotherapy)

The "Professions Supplementary to Medicine Act of 1960"(PSM Act) established the Council for Professions Supplementary to Medicine, which provided the legal, financial and administrative framework for the following eight Statutory Registration Boards: Chiropodists, Dietitians, Medical Laboratory Technicians, Occupational Therapists, Orthoptists, Physiotherapists, Radiographers, and Remedial Gymnasts Board.The composition of the Council is 7 medical members on a Council of 21, and 6 medical members on the Physiotherapists Board of 17 members.

The Boards have the usual functions of (a) keeping and admitting to the register, (b) setting qualifications, and (c) disciplining. In the case of (b), the Board decides the qualification for registration, and it is the professional association whose qualification is assessed and which undertakes the work of monitoring standards and quality of training. (The majority of members of the Boards are also members of the main professional association).

The Act regulates the practice of the professions by making it an offence for those not registered to use the title "State-registered Physiotherapist", but there is no prohibition of practice by unregistered practitioners.

Regulation of registered physiotherapists also existed through codes of conduct. These codes were originally laid down by the BMA when it set up a Board of Registration of Medical Auxilliaries in 1936. The codes were carried over into the state registration scheme of 1960 on the insistence of the medical profession and, surprisingly, still exist. The codes state that:

(a) A patient's illness should be diagnosed or treated solely on referral from, or while having direct access to, a doctor (except in emergencies);

(b) Diagnosis and treatment should be limited to what the practitioner has been trained to do;

(c) The practitioner should be prohibited from holding themselves out to be someone who is able by experience or training to treat disease.

Presumably infringement of this code (which is additional to "professional misconduct") is likely to bring a registered practitioner to the attention of the disciplinary committee of the Board.

For further regulation of the professions covered by the PSM Act, it would be necessary to amend the Act. This has been attempted by chiropodists who hoped to attain "functional

closure", but the attempt faltered because of the difficulty of providing an unambiguous definition of a chiropodist or of chiropody treatment.

Speech therapists were to be included under the Act, but opted out on the grounds that they were a free standing profession in their own right ,as much related to education as to medicine - complementary, rather than supplementary, to medicine. This also explains why clinical psychology was not registered under the Act.

Social Work

In the UK there is no state registration of social workers, but the state and members of the occupation exercise regulatory control through The Central Council for Education and Training of Social Workers (CCETSW) which regulates training and qualifications. This is one of the weaker forms of regulation, its aim being to ensure that practitioners holding the qualification have undertaken a certain training and have attained a certain level of knowledge. It is then up to the client and/or employer (usually the state employing authority) to make a further assessment of ability, and to decide whether or not to employ a qualified or unqualified person. With no state registration the autonomy of members and of the profession is less than it would otherwise be. For example, a worker could not ignore an employing authority's policy, or manager's instruction which infringes the association's code of practice on the grounds that to do so could lead to their losing their registration.

Clinical Psychology

Clinical psychologists, also, do not have state registration. However, a condition of employment in the NHS, stipulated by Whitley Council regulations, is the possession of a qualification set by the professional association, which also regulates training. Unqualified persons can and do undertake private practice. Recently there has been considerable debate about state registration and an increasing political awareness within the profession about the advantages and disadvantages of state involvement [BPS correspondence and members' polling (1984/85)]. A decision was made in 1987 to establish the title of "Chartered Psychologist" and a chartering council.

Implications for Occupational Control and Autonomy in the UK

The above described the institutional arrangements which exist to regulate the practise of an occupation, as outlined in various Acts and documents. The aim was to show (a) the limited nature of the regulation, (b) the variety of types of control which exist, and ,(c) differences

between professions. Before presenting a general discussion of the nature of this type of "occupational control", the following shows how the description extends and qualifies Freidson's theory of occupational control when applied to the U.K..

Firstly, state registration is the only form of institutionalised control which approaches "regulating" content of work, but none of the regulations and structures described actually defines content of work. Full "Functional Closure" is difficult because of the problems of unambiguously defining content, and none of the professions has state registration which could be said to provide for a monopoly over an area of work. Thus an examination of the details of regulatory structures shows that, in the UK, Freidson's statement that professions establish monopolies over work jurisdictions with state support is inaccurate: the state only regulates who may undertake certain activities by prohibiting untrained persons from performing certain activities.

Secondly, state regulation provides for a variety of forms of occupational control. "Functional closure" is where an Act of Parliament makes it illegal for an unqualified person to carry out certain activities or a strategic aspect of work. None of the professions considered was or is governed by this form of regulation, although medicine has acquired sole rights to perform operations, prescribe drugs and to sign various certificates. Acts usually only provided for "Protected title", which make it illegal for an unqualified person to represent themselves as registered. Thus, in the case of medicine, nursing and physiotherapy, an Act of Parliament "regulates" the practise of the profession by non-members only in the sense that it specifies the circumstances under which unregistered practitioners may be liable to prosecution in a court of law. The other forms of "occupational control" provided by state registration involve members of the occupation in the regulation of registered practitioners' professional conduct (disciplining for "unprofessional conduct"), setting qualifications for registration, and approving training establishments.

Social workers or clinical psychologists in state or private practice whose conduct is "unprofessional" or "negligent" may be subject to sanctions by their professional association. However, the sanctions of these associations do not have the force of those associations or councils empowered by regulatory Acts to discipline practitioners, and consequently the control of the occupation over its own members and of certain standards is less than that of medicine, nursing and physiotherapy.

Physicians did at one time establish a monopoly of practice through the licensure of practitioners in a Royal Charter in 1518. Power was given to the Physicians' Guild (chartered as the Royal College of Physicians) to try, imprison, and/or fine those who infringed the rights granted in the Charter [Malherbe (1979)]. However, these powers were limited after the Bonham case in 1610, where Bonham claimed damages against the College for false imprisonment. This established

the principle that the association itself did not have the power to infringe the rights of individuals in law, and laid the basis for, and revealed the need for, public control of licensure. Subsequently the powers of occupational associations were limited, although, as was shown, members of the occupation were usually the majority in the special councils, which were set up by the state to regulate the occupation.

State regulation of qualifications and training establishments also takes different forms. In medicine, nursing and physiotherapy the state registration councils undertake this work, in social work a training council exists solely for this function with a different form of state control, and in psychology the professional association is the only body to regulate training, with no state powers.

Finally, it could not be said that occupations themselves exerted the forms of "control" described. In the regulatory councils described each profession had different representation, and thus the degree to which "the profession" exercises control through each form of control varies. The forms of state regulation described are not operated exclusively by each profession, but involve representatives of the state and usually members of other occupations.

PART 4: STATE REGULATION AND OCCUPATIONAL CONTROL

The above drew on research into national regulatory arrangements to provide evidence for the proposition that the simple view that state registration empowers an occupation to exclude others and to regulate its members is inaccurate. However, a number of occupations have sought state registration and this form of regulation has provided occupations with certain forms of control, as well as imposing controls on the occupation.

The following presents a general discussion of the arguments for and against this form of regulation. Such arguments provide further insights into the nature of professions, their relationship with the state,and their work and organisation, and are relevant to the theory of occupational control. The discussion also returns to the question of the exact significance of national structures and regulations in predetermining the work of a practitioner .

The Purpose and Limitations of State Regulation

It has been said that the primary purpose of state regulation of a profession is to "protect the public" [Carr-Saunders and Wilson (1933)]. In addition, that state regulation is "negative" insofar

as it put limits on certain aspects of the practice of the profession, rather than promoting good practice or defining the work of the profession.

The two main aspects of protection are from the misuse of professional position for selfish ends, and protection of the public from technical incompetence. The way the state "decides" when a person is competent is through specifying the training and qualification necessary to register. (The question of "monitoring" technical competence once qualified is another matter which has to be dealt with separately through the management arrangements for the practitioner).

The Sieghart report on "Statutory Registration of Psychotherapists" (1978) made the following comments on these points, which also supports the argument presented in the earlier discussion of the centrality of trust to professions (Ch.2),

> "Lawyers, doctors, architects and nurses, for example, all put at their client's service, for reward, intricate skills of which their clients are ignorant and which they must largely take on trust. All of them are conscious of the dependence which their professional relationships tend to create, and of the harm which they could do if they failed to use their skill or exploited the dependence in a selfish fashion."

On the general issue of the state taking upon itself the duty of protecting the public, Foster (1971) noted that,

> "The policy on which Parliament appears to have acted in the past is to control only those dangers which are not immediately obvious."
>
> ["Enquiry into the Practice and Effects of Scientology" (1971) para. 245]

Carr-Saunders and Wilson (1933) held that,

> "It would seem therefore that the State is only justified in assuming the responsibility in those cases where the public are unable, or have not the opportunity, to distinguish for themselves those who are qualified to perform certain work, or where the consequences of consulting an unqualified man are very serious; that is to say, in those professions where the service is vital or fiduciary in a marked degree, and demands a prolonged intellectual training of specialised kind."

These points support the initial thesis presented at the end of the last chapter that the danger of harm by incompetence and difficulty of evaluation are important objective preconditions for both achieving "profession",and state regulation.

State Regulation of Conduct rather than Competence

Once registered, the way in which practitioners are "regulated" by the statutory registration authority is through the sanction of removing the practitioner from the register ("striking off"), or suspension ,but only for negligence or unprofessional conduct. The disciplinary committee of the authority decides on each case put before it, but acts of "professional misconduct" are almost certain to result in removal from the register.

The disciplinary committee of each profession is responsible for drawing up a code of conduct which provides guidelines to registered professionals about the kind of conduct likely to bring them to the attention of the committee. These guidelines are usually prohibitive in form and concerned with the moral conduct of the professional; they rarely mention matters of technical conduct. The only statement in a code of conduct in any way approaching technical conduct is in the Code of Professions Supplementary to Medicine, where it is stated that a patient's illness should be diagnosed or treated solely on referral from, or while having direct access to, a doctor. The various disciplinary committees do not consider charges of technical incompetence apart from cases of gross negligence. One reason is that professionals can rarely agree about what constitutes technical incompetence.

Carr-Saunders and Wilson (1933) gave the following explanation for the fact that disciplinary committees (and often professional associations) do not deal with matters of technical conduct or competence,

> "The real explanation must be sought in the nature of the professional function ..... If, however, the exercise of judgment is as fundamental as is suggested in the work of a barrister or doctor, it would be disastrous if the fear of being called upon to answer for the consequences were never absent from his mind. He would be tempted always to play for safety, and never to depart from rule-of-thumb methods whose antiquity would be their chief recommendation ..... It would be possible, no doubt, were power to be given to strike a doctor off the register for technical incompetence, to entrust that power to a tribunal composed preponderantly of doctors; but this would be open to another objection. The danger would not perhaps be in too great an insistence on the observance of a routine, but in the facilities it would offer to heresy-hunting. The rival theories of medicine current among doctors are notorious. Equally notorious is the hostility shown by the upholders of one theory or orthodoxy towards the upholders of another, and the anxiety of each to impose his own pet beliefs on the rest of the profession. The fear

> that the GMC might be tempted to use its authority for the institution of heresy-hunts was clearly present in the minds of those who framed the Medical Acts and the Dentists Acts, even though it was not proposed to give the Council power to strike off for technical incompetence. In each case, they took the precaution of adding a proviso prohibiting the exclusion of any registered person, "on account of his adopting or refraining from adopting the practice of any particular theory of medicine, surgery, or dentistry as the case might be." "
>
> Carr-Saunders and Wilson (1933[pp 399-400])

The argument advanced by Carr-Saunders and Wilson is that the internal conflict common in most professions about the proper role of the profession and about appropriate methods [Bucher and Strauss (1961)] prevents evaluation of competence by the profession itself. This point has a bearing on self-management by a profession. Assessment, or even monitoring, of technical competence by other professionals could be liable to theoretical bias. The key issue appears to lie in the nature of professional work, which is characterised by uncertainty, and experience may be the only guide in many circumstances.

Advantages and Disadvantages of State Registrations for Professions

In their attempts to gain state support for regulation schemes in order to exclude competitors, professions argue that regulation would enable public protection. However, most commentators suggest that there is little evidence that the usual forms of regulation do so [Malherbe (1979]]. Different structures and mechanisms are needed for effective public accountability : the role of management structures in ensuring quality of practice is considered in later Chapters.

There is also little evidence that state regulation improves or guarantees basic standards. State regulation only shows that the state has judged a practitioner once to have met certain educational and training requirements which the profession believed to be necessary for doing the work which they believed the occupation should undertake. Thus it may be said that state registration only indirectly stabilises a social division of labour.

The debate in recent years within social work as to whether state registration should be adopted highlights a variety of issues concerning occupational and state control. Hardcastle's (1977) article reported that, in the USA, fourteen states adopted "protected title" legislation ("Certification") but none adopted "protected function" legislation.(In the USA state regulation takes three forms: "State registration" simply refers to a list or registry of persons who carry out the occupation, although sometimes there may be educational requirements for registration.

"Certification" involves the state making a judgment about the competence of the practitioner and is similar to "protected title" state registration in the UK. "Licensure" is similar to "protected function" state registration in the UK.)

Hardcastle described a licensing act promoted by the professonal association (NASW) and concluded that it had, "little potential for the protection of the public and the development of the profession", and that legal regulation through state involvement would have had little impact on the profession.

Hardcastle noted that, "the basic difficulty seems to be in the uncertainty and lack of preciseness in the definitions of knowledge and skills, and the inability or unwillingness of those formulating the legal regulations to include and develop meaningful standards." That is, that ensuring quality of service was made difficult by the absence of clear standards. He suggested that the inability to define knowledge and skill meant that it was unlikely that the profession could test and differentiate either. His conclusion was that, "Social work, as a liberal profession, has the implicit obligation to resist arbitrary and meaningless public regulation as a bogus status-accruing device."

In addition to the problem of assessing competence there is thus a related problem in defining the nature and purpose of the work, a "problem" occurring with most occupations, but perhaps more acutely in social work. There is the technical difficulty of defining work, and the political difficulties of reaching agreement either within the occupation, or between the occupation and the state as employer and clients' representative, as well as between the occupation and other occupations (e.g. community nurses).

Malherbe (1979) noted that accreditation was essentially a process where a person or group was invested with authority and trusted to do certain things. In the case of statutory accreditation, the state not only identified persons as "capable" of practising, but also conferred rights and responsibilities not accorded to others, for example the power to prescribe drugs. Malherbe suggested that accreditation in social work raised fundamental issues which went beyond the definition of the social work task, "Why should some be given a special position of trust and responsibility - on what basis and to what ends? Are there aims and ends in social work fully agreed to, not just by social workers but by our society?"

Malherbe suggested that the problem of accreditation in social work was that social workers were ,"committed to considering if not effecting change", and that they were bound to challenge "the public values embodied in the society which gave them mandate to act." For social work perhaps more than other occupations the fact that state regulation confers authority as well as controls, means that the state also must believe that the work is of "benefit to society", and does not

undermine the interests of those in power. Chapter 8 returns to the question of the legitimation of professional power and the basis of various forms of professional authority.

PART 5: SUMMARY AND CONCLUSION

Both Johnson's and Freidson's work established an approach to the study of professions which emphasised the strategies and structures of professional control and organisation. Rather than accounting for differences between professions and occupations in terms of characteristics of the work or of the workers, or in terms of the statements and policies of professions, they considered the way in which professions exercised power over both the practise of certain activities and the conditions of practice.

The approach proposed that professions, like any occupations, seek to control aspects of work, but that professions differ from occupations in the way in which their control over work is organised. Particularly important is state support and the institutionalisation of aspects of control. The approach directed attention to the ways in which individual professionals and their associations sought to control:

(a) other occupations: to prevent encroachment on valued work activities and to ensure that others carried out work which was necessary for members of the occupation to carry out their work;

(b) others who practise the occupation: to protect the reputation of the occupation, and to regulate manpower suppply to maximise job security, income and status;

(c) clients: to ensure a stable market and demand for services, to make work easier by ensuring compliance, and to "protect" members from unwanted client demands , criticisms and complaints;

(d) employers: to maximise income and gain the best terms and conditions of work, and to protect members from employers' demands.

The chapter presented the following criticisms of Freidson's theory. Firstly, few empirical details of the mechanisms or structures of "control" were presented to substantiate the theory.

Secondly, ambiguous definitions of "control" and "autonomy" made it difficult to confirm or refute the theory. Thirdly, the one example given of state support for "occupational control" was that of state registration and this only provides for one limited form of "occupational control". Fourthly, state involvement enhances the "control" of the occupation over certain matters, but also provides for control by the state over aspects of the occupation. The conclusion is that professional "control" and "autonomy" are not as absolute, or as strongly promoted or supported by the state as Freidson suggested.

However, the chapter set out to apply and develop Freidson's theory because his analysis suggested a more fruitful approach to the study of professions and their organisation than trait, functionalist, micro-level and other approaches. The theory provided a counterbalance to earlier studies, was compatible with the earlier conclusion of the thesis that a distinctive feature of professions was not their work but the social process for defining work, and also provided opportunities to enrich the sociology of professions with insights and knowledge from organisational theory, government studies, and economic theory.

To substantiate the criticisms, the chapter presented documentary evidence of details of the national structures and regulations of the five professions of the study. These details were also presented to develop and apply Freidson's analysis of professions in the context of the UK. His suggestion that differences between professions could best be understood by considering the institutional structures for organising work was pursued by describing the different structures and regulations applying to each profession. The chapter did not assess Freidson's contention that different characteristics of professions could be explained by reference to these structures, or that economic interests and power alone led to their creation - this is the subject of the final chapter.

The details of these structures and regulations showed that no professions in the UK "controlled" the content, pay or conditions of their work, or were "truly autonomous". Further, that the division of labour between occupations in welfare services was not defined by state registration. In certain cases these regulations prevented non-qualified practitioners from undertaking certain activities, but they did not define work, and only indirectly structured a division of labour.

A description of the structures showed that "occupational control" in the UK at the national level was a subtle and complex phenomenon exercised in a variety of ways through different structures and regulations. Occupational associations alone do not have powers to prevent the practice of certain activities nor the use of particular titles. Their powers of "control" are through convincing clients and employers that membership is an assurance of quality and standards, and through setting qualifications and accrediting training programmes. The requirement of membership

produces larger associations, which in turn are able to exercise greater influence over employers, members and non-members. "Medical Dominance" at the national level is mainly through the profession influencing the manner in which state regulations of other professions were established [Larkin (1982)].

State regulation of an occupation usually provides the occupation with control over the use of a title (state registration "protected title"); over disciplining for unprofessional conduct or negligence (loss of title); over defining and assessing qualifications for the title, and over training schools. Direct control (i.e. "protected function") is hampered by the politicial and technical difficulties of defining the work of the occupation. Control is thus of initial entry and of misconduct only.

The type and extent of control exercised by an occupation through its involvement in state regulation mechanisms varies. State registration bodies and regulations are different, the involvement of the state in regulating social work is through education, and there is no state involvement in regulating psychology.

Occupations exercise only indirect institutionalised control of the practice of the occupation through regulating training and education. Over a longer term, this defines the work of the profession and its place in the division of labour by equipping practitioners with skills and knowledge which were thought to be necessary to practise the occupation. Employers are thus indirectly limited in this way by the judgments of the profession as to the work which its members should undertake.

There are also variations in the relative influence of the state and of occupations in the different mechanisms and structures for deciding pay and conditions. The state, as virtual monopoly employer, exerts a substantial influence over the employment opportunities and future of many "welfare" occupations.

By examining the structures and mechanisms by which both the state and occupations influence content, pay and conditions of work, the chapter showed the way in which occupational control and autonomy varied between occupations, and the need for a detailed analysis of the specific mechanisms involved. It showed that institutionalised autonomy and control by the occupation, also provided for control of the occupation by the state. The chapter showed that state regulation did not define work content or specify a division of labour, but laid broad parameters within which employers and managers defined the work of occupations.

The main conclusions of the chapter are thus,

1) State regulation through licensing does not assure professional autonomy and a protected market in the absolute way in which Freidson suggested.

2) The state only acts to regulate in this way when parliament is persuaded that practice by unqualified or incompetent practitioners is a danger to the public.

3) Professional influence at the national level is complex and indirect - mostly through the professional association influencing training and qualification requirements. (Only clear negligence, not incompetence, would result in removal from the register.)

Evidence of the actual structures and processes of state regulation of five professions in the UK does not support Freidson's theory that autonomy is upheld by state licensing arrangements,or that these structures institutionalise medical dominance.

If these structures do not provide professions with the control which Freidson suggested,how then is it possible to account for the division of labour which undoubtably exists,in for example ,a hospital? How is it possible to account for differences in the autonomy of practitioners in each profession?

The next chapter of the thesis presents the author's research into professional autonomy at local levels.It proposes that it is local profession-managers and practitioners who decide the content of work and a division of labour, and that it is the management structures and processes established by employing authorities which institutionalise professional autonomy and control in the UK, and which have a profound influence over future characteristics of the profession.Later chapters will pursue the implications of this proposition for a theory of professions in state welfare societies,after first presenting evidence of the differences which exist.

CHAPTER 4: RESEARCH METHOD AND CONCEPTS

PART 1: INTRODUCTION

This chapter describes the research method and conceptual framework used to investigate professional organisation and autonomy at the local level. It describes the types of evidence which was gathered , which is reported in the next chapter.

The purpose of this chapter and the next is ,

- to show how accurate information about professional autonomy can be gained from research into management structure,

- to show that different forms of autonomy are institutionalised by local state employing authorities in their management structures,

- to contribute to descriptive knowledge about differences between the five professions in terms of the autonomy and management structures of each, and about how the structures are established and changed,

- to show how central government influences the type of structure and autonomy established by local employing authorities, and hence to contribute to knowledge about the details of the relationship between the state and welfare professions in societies with state welfare systems.

- to show that the type of local management structure adopted by an employing authority has an important, but previously unrecognised, influence over the work and the immediate and future conditions of work of members of welfare occupations.

- to find evidence which either supports or disproves Freidson's thesis that occupational characteristics derive from their autonomy.

PART 2: RESEARCH METHOD AND ASSUMPTIONS ABOUT SOCIAL STRUCTURE

General Assumptions about Structure

The operational concepts used in the research and the research method are related to certain assumptions about the nature of social structure (described in Øvretveit (1984) M.Phil]. The perspective taken in the thesis is that social institutions have both a subjective and an objective nature. On the one hand, social structure exists only as it is produced and reproduced through human interaction. Social institutions are made up of people who creatively interpret their environment and actively attribute meaning to their own and to others' acts. Social structure exists only in, and through, the interactions of individuals who choose to recognise and perpetuate aspects of structure.

However, social structure also has an "objective" nature in at least three senses. Firstly, past or future patterns of action and aspects of structure (e.g. management divisions) may be described, and examined without reference to individuals or to observed actions (e.g. the constitution of a governing body). Secondly, these descriptions may be adopted by an employing authority as regulations and directives which it wishes its employees to observe. Although it is individuals who interpret these descriptions, descriptions of this type may be said to constrain and direct individuals, supposedly towards common objectives. In this sense therefore social institutions and social structures have an objective quality and a "determining" influence over employees. Thirdly, individual actions and interactions are influenced by, or can be understood in relation to structures and conditions about which individuals are not consciously aware. Descriptions of these structures and influences have to be produced by research and theoretical abstraction, and if they can be shown to "exist" then they may be said to determine individuals' actions without them being aware, or being able to choose whether or not to be influenced by them.

This thesis is interested in the structures which have been established by state employing authorities, especially where agreement was reached between professional employees and employing authorities, and in the process through which these structures are established, for the following reasons. Firstly, structures which have been discussed and worked through by professional employees, and then adopted and sanctioned by employing authorities, are more likely to correspond to employees' every-day behaviour than structures imposed without consultation. Descriptions of structures arising from such a process are likely to be more valid than official statements which have not originated from, or involved employees.

Secondly, the subject of the research is autonomy, and in the case of work organisation, one element of this autonomy is the authority delegated by employing organisations to professionals to decide aspects of their own work. The study therefore considers management structures where professionals manage other professionals, and are themselves managed by senior managers or management teams. The thesis is interested in the process through which professionals agree to accept the power of other professionals and managers, and in the power of different parties in the process which leads to the legitimation of power in authority structures.

The thesis is also interested in instances where employing authorities impose regulations and positions of power over professional employees without the agreement of professionals.

In the above situations power is legitimated in different ways: the first is a situation where those to be governed agree to the power which will regulate their activities, and the employing authority in turn sanctions this use of power because it is compatible with its aims and interests. The second is where an employing authority sanctions the use of power over employees, without their consent, power in this case only being authorised by the state and the public.(An example is where a District Head of Profession is replaced by a General Manager). Where the latter occurs professional employees were not able to invoke their own power to resist the imposition of employing authority requirements.

The thesis notes that frequently the authority of posts or of particular regulations is rarely specified in detail in advance, and that it is usually only specified when disputes, conflict or "problems" arise. For example, the authority of a head profession-manager in relation to a practitioner may only be defined when higher management are called upon to arbitrate, and then only in relation to a particular matter.

Links between Assumptions and the Research Method

The main field research method used to investigate structure (described in more detail in Appendix 2) involved procedures to help individuals reflect on and become more aware of processes and conditions which influenced their actions. By describing and making explicit the organisation which they will adopt, this process also helps individuals subsequently to review and evaluate the explicit structures which they establish. The procedures of the method lead to detailed specification of aspects of structure, and are founded on the above assumptions about the objective and subjective nature of social structure.

Features of the research method made it particularly suited to investigating authority structures and institutionalised autonomy. Firstly the overall process involved helping staff, as individuals and then in a group, to make explicit the aspects of structure and considerations which were preventing cooperative working. This involved constructing precise and shared conceptions of aspects of existing and future structure, such as the authority of roles, the type of management divisions, and the scope of discretion available to practitioners. Where future structures were agreed and instituted by employing authorities, the researcher was therefore able to gather precise descriptions of structure, aspects of which were relevant to the subject of the thesis.

Secondly, this process of explicating,agreeing and sanctioning structure is in effect a process through which new structure is produced and legitimated, usually by those who are to be governed by it. For example, individuals in a professional division may agree that a head of division is necessary and argue about, and finally decide, the details of the authority needed by a person to carry out the role. The employing authority then agrees to the proposal and establishes the role as part of its structure. In this situation both the group authorise the role, and authority is delegated to the head of a professional division to carry out certain functions and, as a consequence, the profession as a group acquires a particular form of institutionalised autonomy. The process, and the outcome in terms of the structural role, is accepted as legitimate by both employees and employers and authorised by both.

A third feature of the method was that it provided the researcher with access to the process of discussion and negotiation through which structure was changed or created. This required that the researcher understood the perspectives and interests of different individuals and groups, and that he recognised the overt and covert power which was exercised to attain structures advantageous to certain interests. The researcher was able to draw on this experience to develop hypotheses to explain structures in chapter 8.

Further details of the method and of the theoretical basis for the method are provided in Appendix 2. Part 4 of this chapter describes the different types of data which were gathered using the method.

The chapter now considers the aspects of structure which are relevant to the subject of the thesis, and describes the operational concepts used in the author's research by managers and practitioners to specify these aspects of structure.

PART 3 : ASPECTS OF STRUCTURE AND OPERATIONAL CONCEPTS

The research method was driven by the concerns and practical problems of managers and professional practitioners, which motivated them to specify and refine their descriptions of their organisation. This made it possible for the researcher to gain access to the organisation and relevant discussions,but involved the disadvantage that not all of the discussions and descriptions were relevant to the researcher's subject of interest - professional autonomy.

The researcher selected relevant data from this research according to three criteria. First ,where practitioners and their managers specifically raised issues as matters of "professional independence",or of "clinical freedom" , or "autonomy". Second, where the researcher identified and confirmed with staff that a particular aspect of structure affected autonomy, on the basis of the researcher's knowledge of Freidson's and other theories.Third, where other research into work organisation (reviewed in Appendix 3) identified particular aspects of organisational structure as sites of conflict and as relevant to the question of professional autonomy and control.

Drawing on these three sources the research concentrated on certain aspects of structure to investigate the delegation of authority to professionals and the exact nature of institutionalised autonomy. These were,

1) Bureaucratic Regulations

Explicit policies, rules and procedures to be observed. (These are mostly those established by the employing organisation, but can include those of the professional association). The number and precision of these regulations are relevant to the degree of institutionalised autonomy. The likelihood of these rules impinging on autonomy is increased by the requirement for and frequency of supervision .

2) Supervision and Evaluation by a Superior with Bureaucratic Authority

The nature (direct face-to-face, monitoring information, etc.) and frequency of supervision, and the nature of the authority of, and sanctions available to superiors.

3) Profession-Management Division

The size and nature of the management division within an organisation which groups together members of the same profession. The authority delegated to the professional head of the division by the employing authority to undertake certain management functions.

The research presents findings about these aspects of structure, although the author's research also investigated a variety of other aspects of professional organisation. The particular "operational concepts" used by the researcher and staff to specify these aspects of structure are described below.

Prescribed and Discretionary Elements of Work

The concepts of the prescribed and discretionary elements of work (Brown(1960))were used to define the degree of freedom of an institutional role and hence of certain aspects of professional autonomy. The degree of freedom of an individual in an employment role is governed by a variety of employing authority and professional association rules, regulations, procedures and codes of practice, which rule out certain activities, and require certain behaviours in different situations.

The two other operational concepts which were used to investigate details of professional management structures and autonomy are authority and accountability.

Authority

General Principles

A general definition of authority for the purposes of specifying profession management structures is, "the socially-established right to act at discretion, to use resources (cash, material or human), to initiate tasks and allocate work, and to exercise sanctions over others". This definition specifies the different areas over which managers in certain structures are authorised to act.

The authority of roles and the management structures reported below were specified, agreed and institutionalised using the social-analytic method,and it was this method which made possible the accurate descriptions,and the documentation of the reasons for the structures.The more common process is that the authority of a post in a number of matters is established through precedent and through testing in a process analogous to case law. In effect a higher authority gradually clarifies the authority of the post as disputed cases arise, by deciding whether or not to uphold the authority of the post holder, rather than thinking ahead and clearly defining the role in advance.

Types of Authority

Concepts of different types of authority were used to make explicit and specify authority relationships between roles in management structures. The weakest degree of authority is the right to be informed before action is taken. A stronger authority is the right to be consulted, then the right to persuade or request, then veto an action, and the strongest is the right to decide and to instruct or direct others.

Different degrees of authority may be exercised over different matters (e.g. over organisation, people, programmes, and techniques).

An important role relation in this conceptual framework is the managerial relation which specifies types of authority over different matters which are thought to be necessary for the manager to be held accountable for the work of their subordinates.

Accountability

General Principles

The general definition of accountability adopted is the socially-established requirement that an individual explain why they did, or did not, carry out a particular action. It involves a recognition that the individual may be judged and subjected to sanctions exercised by higher authority in relation to the matters for which they are accountable. In this framework accountability is distinguished from responsibility, the latter viewed as referring to an individual's feelings about their past or future actions . As with authority and work definitions, the framework is concerned with the institutionalised and socially-agreed definitions.

Types of Accountability

Using the concepts of the prescribed and discretionary elements of work,a distinction was made between accountability for observing or adhering to prescribed limits (e.g. answerable for actions outside policy or contract), and accountability for quality of performance within limits, or for justifying actions.

Subordinates in managerial hierarchies are typically answerable to their superiors for all their actions or inactions within their area of work . They may be called upon to explain what they did and why, the discretion they exercised over any work matter may be scrutinised and assessed,

and rewards or punishments applied accordingly. Usually they are not accountable to superiors for most of their activities outside the workplace. Accountability in this instance is for adherence to various prescribed limits and for the quality of performance and discretion exercised within limits on all work matters.

Another type of accountability is the expectation that an individual will answer for their actions which lie outside of prescribed limits, (i.e. not following policy, negligence), but is not accountable for the quality of their performance and discretion exercised as long as it is within the limits of acceptable standards. This idea informs the concepts of "case" and "practice autonomy" which were developed in the author's research. For example, an administrator or manager of professionals may hold a professional accountable for not keeping to contract, request an explanation, make a judgment and apply sanctions accordingly. However, the administrator may not hold the professional accountable for actions and decisions which do not infringe policies, contracts and other explicit or implicit limits to discretion.

Professionals' accountability to bodies outside their employing organisations is to their professional associations for adhering to codes of conduct, and to state regulatory bodies for observing regulation requirements. These codes and requirements are sets of prescribed limits which partially define the autonomy of a practitioner role.

The above concepts were used to guide the author's investigation of the exact details of authority and autonomy which were institutionalised by state employing authorities in management structures for five professions. The next part of the chapter considers the different types of data which were gathered on the above aspects of structure.

PART 4: SOURCES OF EVIDENCE ABOUT PROFESSIONAL MANAGEMENT STRUCTURES

Three types of data were gathered by the author in investigating professional management structures and institutionalised autonomy. These are, in descending order of generality:

Category "A": General statements issued by governmental and professional bodies about how professionals and their work should be organised;

Category "B": Descriptions of existing and future organisation at one site;

Category "C": Detailed examples of critical incidents or instances which demonstrate the authority and autonomy exercised by managers and practitioners in certain situations.

Category "A": Government Recommendations and Reports

The main source of these statements was government circulars instructing or recommending that employing authorities adopt certain arrangements, and government or professional-sponsored reports and inquiries recommending forms of organisation. The statements were authoritative prescriptions of how work should be organised, and often represented the outcome of a social process of negotiation between members of the profession and employing authority and government representatives.

Such statements are relevant to the subject of institutionalised autonomy because, regardless of whether, or to what extent, they are followed, they give an indication of the ability of different professions to influence both employers and the state to issue authoritative statements which advance or defend their autonomy. They provide evidence of state legitimation and promotion of certain forms of autonomy and organisation by issuing guidance or instructions which employing authorities are expected to observe. Such statements are often acted on, and provide a first general description of the organisation which may exist at one site. Where no such governmental statements exist, the profession is not able to call upon an authoritative statement to justify its preferred form of organisation.

The method used to gather such statements was to note and gather copies of the documents, reports and statements commonly referred to by managers and others in justifying certain forms of organisation. The limitation of these statements was that they did not provide direct evidence of the structures and autonomy which existed at one site, and empirical research was necessary to investigate the details of the local management structures, the variations which existed, and their distribution. In addition, field research was also necessary to gain an understanding of the political, historical, personal and other factors which could account for the particular form of organisation which existed. The author's research did not systematically investigate the latter, but the main research method did make it possible to gather some insights into these factors which form one basis for the explanation outlined in later chapters.

Category "B": Descriptions of Existing and Future Organisations

The second category of data was descriptions of existing and future organisation at one site. The review of previous research in Appendix 3 showed that work organisation could be described in different ways and from a number of perspectives. The discussion above proposed that, for the purposes of investigating institutionalised autonomy, three aspects of structure were particularly relevant: the rules and regulations which limit the discretion which individuals may exercise, the nature of the authority of superiors, and the nature of the management division for professionals.

Descriptions of these and other aspects of structure were gained using the social-analytic method outlined in detail in Appendix 2. This method produces different types of research data about autonomy and organisation, each with different validity. The following distinguishes the different types of data ,in terms of the reliability and validity of each type.

B1: Official Public Descriptions

The first type of data which was gained was public written statements issued by the organisation or a manager describing the organisation as it was supposed to exist (referred to by Brown (1960) and Rowbottom (1977) as the "manifest statement").

B2: Subject Reports

The second type of data was the verbal or written statements of staff reporting their perception of the organisation which existed, or should exist. These were statements by a staff member of items which they chose to report, and described certain features of organisation from a particular perspective. These descriptions used that person's idiosyncratic concepts and often did not cover many features which others viewed to be important.

One limitation of evidence of this type is that it is selective and may not describe what actually happens in practice. For example, a manager reported to the author that he was "responsible" for a group of staff who were "under his control", but omitted to mention both the authority of another manager in relation to "his" staff, or the nature of the "control" which he exercised. The description provided by the other manager was entirely different. The reliability and validity of this type of evidence was increased in the author's research by cross-checking and comparing individual's descriptions, using a procedure which formed part of the social-analytic process (Appendix 2).

Such descriptions are also limited for the purposes of cross-site comparisons. The individual uses their own concepts to represent features of organisation which are important to them. They may say nothing about constraints and authority, or, if they do, they may describe these features of organisation in a way which makes it difficult to compare their reports with reports from other sites.

Reports of organisation produced by, or checked by, a group of people who work together have a higher reliability and validity than one individual's report (collective subject reports). However, such reports still use concepts of organisation which have a particular meaning to each individual or the group; do not allow comparison, and may not describe the key features of structure which are the concern of this thesis.

B3: Researcher Subject Constructions

The third type of data was descriptions constructed by the researcher and staff member. These describe aspects of existing and/or future organisation which the researcher and staff member believed was necessary to make explicit. [The descriptions were documented either in reports which were amended, agreed and cleared by the member, or in the researcher's notes. (Listed in Appendix 1)].

The descriptions are of a higher validity than types B1 and B2 (i.e. more "accurate") because the researcher probed and questioned to specify what the staff member meant by the use of certain concepts, often using specific examples. The descriptions are more comprehensive because the researcher ensured that aspects of organisation overlooked by the member but viewed as important by others were covered.

Where relevant the researcher drew on concepts and theories of organisation (described above) to help the individual to describe their organisation. The quality of the descriptions that resulted depended on the researcher's ability to use examples to demonstrate the meaning of the concepts, to probe areas which may have been overlooked, and the staff member's belief that specifying organisation could help to understand and resolve some of the problems.

Any field-interview method would produce such descriptions, if the interviewer were drawing on explicit concepts and theories of organisation. However, interviews carried out as part of the social-analytic process were carried out under conditions which are different from those usually involved in conventional field-interviewing.

One condition was that the researcher was invited by one or more members of the organisation to help them to review their organisation. Staff members have an interest in gaining an accurate

description where they believe it to be necessary to do so as part of the process of improving organisation. Their motivation to gain an accurate description is higher than it would have been if they were not involved in a process of change [Jaques (1976)]. However, this argument overlooks the fact that not all staff are interested in change, and may be more wary of jointly analysing organisation with an action researcher involved in this process than with a "detached" conventional researcher.

A second condition which improves the validity of these descriptions of structure is that the social-analytic process involves the researcher in developing a common understanding of concepts of organisation among a group of staff, so that each individual uses the concepts in the same way to examine and define their organisation. In this way a more objective and precise description of organisation can be constructed than by a description provided by an individual on their own, especially if it is a specification of organisation which is to be adopted by all ("B4" below).

Threats to validity are presented by conflicting subjects of interest to the staff member and researcher. The researcher may wish to describe certain aspects of organisation (for research purposes, to compare with other sites, or because the researcher believes that problems will arise if these aspects are not defined), but the staff member may not believe these aspects to be important to define, or of interest. The principle of the method is to hold to the member's concerns to ensure validity, but this may conflict with the research interest .

B4: Descriptions Agreed by Staff Members Governed by the Structure

The fourth type of data was statements by a group which described organisation which a number of involved staff members agreed existed in the past, or would be adopted in the future. These were usually produced by building up from individual statements, but sometimes as a result of a group meeting or workshop in a locality, and in some cases as an agreed statement at a national or regional workshop. The validity of these statements when they are sanctioned by the employing organisation is higher than "B3" statements in two senses Firstly they are more likely to correspond to what happens in practice because all involved agree the organisation which did or will govern their actions.Secondly the employing organisation accepts the statement and instructs staff to adopt the organisation described : it institutionalises the authority and autonomy specified in the statement. However, these statements are still general descriptions and are not built up from instances directly observed by the researcher.

B5: Review Descriptions

The fifth type of data was individual or group statements of existing or future organisation which were produced as a result of a later review of the original organisation which was implemented. Data of this type are of the highest validity of all the descriptions produced using the social-analytic process because members are able to describe how certain aspects of organisation which were previously specified in the process were, or were not, followed in practice, and why subsequent changes were necessary.

Most of the descriptions presented in the next chapter were produced using social-analytic methods. The main limitation of the data produced by this method is that there is no guarantee that what happens in practice accords with the description,unless the researcher also uses participant observation methods. The quality of the description depends on the motivation of individuals and the experience and ability of the researcher to explore a variety of areas and examples and to relate these to concepts of organisation.

Category (C): Critical Instances

The third general type of research data gathered was critical instances or situations which were observed or reported to the researcher and which proved or disproved the existence of a certain form of autonomy and control. They are examples of action taken or prevented in certain situations. These examples were used by the researcher to find out the actual structure of authority which operated, or were presented by staff as an example to illustrate an individual's authority or autonomy. Because organisation is rarely specified in detail, these examples were important to help to specify structure. In "organisational life" it is often such instances which serve as an indication to staff of the structure which operates, and serve to define structure through a process similar to precedent in law.

The next chapter presents the findings of the author's research, which are summarised and analysed in Chapter 6.

CHAPTER 5 : RESEARCH INTO AUTONOMY INSTITUTIONALISED IN MANAGEMENT STRUCTURES

PART 1: INTRODUCTION

This chapter presents the author's documentary and field research into the management structures and autonomy of the five occupations of the study. The chapter presents findings for each occupation in turn, starting with Psychology (Part 2), followed by Physiotherapy (Part 3), Nursing (Part 4), Social Work (Part 5), and Medicine (Part 6). The format for each part is to first present relevant statements from government and other reports which were noted by the author as having influenced discussions and decisions about structure at local levels. (Chapter 4, considered the relevance of this "Category A" data to the subject of the thesis.) These national statements (Section 1) are followed by a section presenting previous field research, mostly undertaken by researchers using the same conceptual framework and research method as the author (described in Appendix 2).

The main section (Section 3) of each part reports the author's field research (This research data was classified in Chapter 4 as Category "B"and "C" data). Research into three areas is reported, 1) the overall management structure of each profession within an employing authority; 2) the role and institutionalised authority of head profession-managers, and 3) the autonomy of practitioners after qualifying, and after 20 years of practice.

The primary focus is institutionalised structures, authority and autonomy (roles, relationships and rules which are explicit, agreed and instituted by employing authorities). However, findings about managers' and practitioners' divergencies from institutional structures and "informal" arrangements are also reported, together with notes on aspects of the process of negotiation and on different interest groups, where these were documented by the author.

Chapter 6 analyses the findings and compares the professions. It summaries and describes the main differences in management and practitioner autonomy, and in management structures.

PART 2: RESEARCH FINDINGS - PSYCHOLOGY

Section 1: Government and other National Reports and Recommendations

No government circulars or detailed recommendations have been issued on psychology organisation, possibly because of the small size of the profession [439 in 1971 (DHSS (1978), 995 in 1980 (BPS (1980); 1105 in 1981 (Watts (1985)) and 1734 in 1985 (Scrivens and Charlton (1985)]. In devising their management arrangements, employing authorities have been guided by references in general circulars to "paramedical" or "scientific and technical" staff, and by the Trethowen Report (1977) on clinical psychology. The Trethowen Report recommended that psychologists be grouped and managed within Area Departments of Psychology, with a Head of Department,

> "administratively responsible to the Area Team of Officers and would need to cooperate with the Area Medical Officer in the coordination of services within the Area" (para. 5.3.6).

The Report also recommended that specialities within the department be headed by Principal Grade Psychologists and that,

> "We would not expect those in the grade of Principal Psychologist to have to account to the head of department on matters of purely professional judgment. Below Principal level, however, we consider that all clinical psychologists should be directly accountable to a professional superior."

In 1981 the professional association issued guidance to its members proposing that,

> "Ideally the head of the district department should be accountable to the authority, reporting to it through one of the management team, who would need to carry some general coordinative and monitoring functions on behalf of the authority in relation to other heads of department." [BPS, May (1981) p 8.1]

Section 2: Previous Field Research

Research evidence of structures which existed before 1974 is scarce, but some psychologists interviewed by the author reported that psychologists in mental illness and mental handicap hospitals were often managed by consultant psychiatrists.The only detailed research on

structures which existed prior to 1974 which the author could find was an interview with one psychologist reported by Rowbottom (1973) who,

> "argued that they are indeed independent therapists, with their own patients, received by referral from consultants or general practitioners, and as such are not eligible to be managed, or instructed on clinical matters by consultants or anyone else." (p 115).

Rowbottom's discussion suggests that psychologists were members of a group of "paramedical" staff, which were different from the group occupied by physiotherapists, and were "not normally subordinate to consultants, though they may or may not be subject (in contrast) to their direction on treatment or services required." However, later discussions in the North West Thames (Staine's Group HMC) Project in 1973 established that the Senior Clinical Psychologist in the group was,"accountable for her work to the Consultant Psychiatrist", and "an immediate subordinate" of the Consultant, as well as being subject to the "monitoring and Coordinating authority" of the hospital secretary (Doc. 1376).

A study of the Ealing Psychology Department in 1976 clarified changes in the authority of consultants in relation to psychologists. The research documentation shows that consultants no longer managed psychologists, and that their prescriptive authority had changed; "The psychologist referred to decides the appropriateness of the referral, the best way to handle the problem and how to report to the referrer." (Doc. 1945).

These findings were found to be representative of other departments in the Region at a workshop held during 1976. Two workshops held by Rowbottom in 1978 and 1979 (documented in Kat,B.(11/5/78), and in Doc. 3044) showed that group management in Area departments existed in a number of Areas and no examples of prescriptive authority relations were reported.

Section 3: The Author's Research

Findings are reported from three main types of research into psychology organisation undertaken by the author between 1982 and 1987. The first type was small-scale short-term field studies of district psychology services involving discussions with heads of services, followed by workshops with the psychologists employed in the service. The second type of research involved thirteen national and two regional workshops each with representatives from 15 - 22 different services, who reported and discussed organisational structures and roles within their services. Other findings, mainly concerning practitioner autonomy, are drawn from a wider range of sources, including workshops for multidisciplinary teams which involved psychologists, and from

conferences on organisation arranged by psychologists, as well as from a variety of governmental and professional documents.

The main findings of each field study and workshop are reported below, in each case prescriptive statements about overall organisation and about the head psychologist practitioner roles are presented, followed by descriptions of aspects of organisation provided by participants in individual or group discussions. Critical incidents providing examples of managers exercising, or being prevented from exercising, forms of authority or autonomy are also presented.

District Field Studies

The field studies which are reported involved an initial analysis of employing authority prescriptions, and descriptions by the head psychologist, followed by discussions with the head psychologist to clarify aspects of structure not described. This was followed by one- or two-day workshops involving all the psychologists within the organisation to identify their areas of concern and their understanding of their organisation.

The studies were undertaken over a four-year period, involving services of size from 8 to 27 psychologists in urban and rural districts in England and Wales with populations from 110,000 to 360,000.

The outcome of the discussions was documented in field notes listed in Appendix 1,Part 1, but no detailed research documents were produced and the notes were not checked or revised by the participants, which was normal practice in longer-term social-analytic field research.

Northumberland Field Study

The only prescriptive statements in health authority documents defined the district psychologist as a "budget manager" and as "responsible for the day-to-day operation of the service and accountable to the budget holder", the latter being the unit administrator (UA).

Unit Management Groups (UMGs) were described as "monitoring budgets", and the district psychologist as having authority ,(a) to carry over annually all planned savings, as long as the UMG was informed in advance, and ,(b) to carry over "fortuitous savings" only to the next year (NP.01).

Preliminary discussions with the district psychologist revealed that he was provided with information on all staff salary, travel and equipment costs, and that Units did not have detailed information on costing. The authority of the district psychologist either to switch staff sessions

between Units, or to change a post if recruitment was difficult, had not been tested. In the past session changes had been carried out "informally", without the District Management Team(DMT) being informed.

The district psychologist was concerned that UMGs might oppose changes if they were told, and that Unit budgeting would both provide information about session changes and "complicate changes" and reduce the district psychologist's and other psychologists' autonomy.

The purpose of the workshop was to clarify existing organisation and future possible options, in order for the district psychologist to present a report to the District Management Team (DMT) about the future of the service and its organisation. The motivation for the workshop was the district psychologist's and the other psychologists' concern that the district psychologist's imminent departure would lead to his not being replaced, and to a "unitised" service being created, which would have reduced psychologists' group autonomy, and their influence at district levels.

Overall Structure

The statements about structure to follow are taken from discussions with the district psychologist, from his report to the health authority (NP.01), and were checked with workshop members(NP.FN) Members of the workshop agreed that the district psychologist as the "administrative and professional head of service" had the "responsibility and authority to ensure that the services are coordinated and are being provided as agreed, and has the power to use the Authority's disciplinary procedure where there is a breach of professional conduct". As well as being the head of the district service, the district psychologist was head of one of the three specialist groupings of psychologists, the other two groupings comprising four and five psychologists respectively. The workshop members agreed that the following provided a simple representation of overall structure:

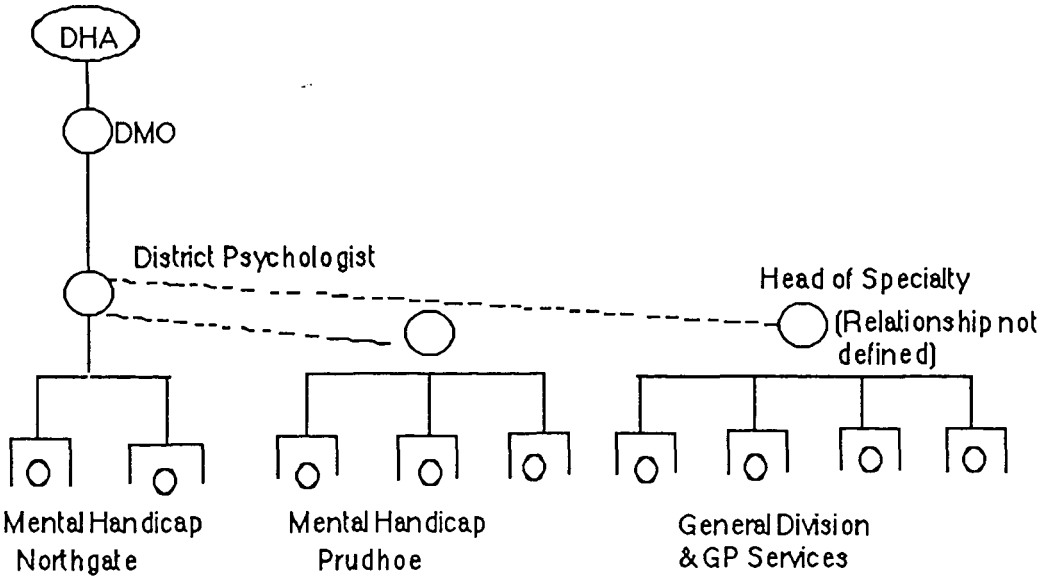


Fig.5.1 Northumberland Psychology Department Divisional Structure(1982)

A "district committee" of all the psychologists met monthly to share information and discuss proposals for new posts and services. Psychologists in the general division each specialised in work for particular client groups,and had developed greater independence in their community and GP work to choose the type of work which they undertook. Workshop members took the view that each psychologist was "independent with respect to his or her clinical practice". When questioned as to the limits to their autonomy the collective view was that the prescribed limits were defined in a job description which ,"specifies main areas of work and sometimes the balance expected between different kinds of work", and in health authority statements on priorities set by planning groups and management teams.

No examples were given of situations where individuals had not observed the general limits which were prescribed. It was felt that in "extreme" situations the head could institute disciplinary procedures.

The head's report stated that ,"psychologists' clinical practice is not"managed" in the way that nursing or social work are. It is essentially a personal service to people. Referrals from doctors and social workers and nurses come on the whole to named psychologists with whom these practitioners have personal contact". (NP.02).

Case Autonomy

In working towards specifying the structure which would,"reconcile the need to preserve the clinical independence of individual psychologists with the need for an identifiable individual to carry out duties on behalf of the Authority" (NP.03), the workshop based its discussions on a paper by a member of the department (Kat (1980)). This described the responsibilities of the previous area coordinator, responsibilities which had been taken over by the district psychologist. The paper noted that," The acceptance of clinical psychologists as independent practitioners by area officers has been tested in several difficult and unpleasant episodes ", and a workshop member cited one critical incident where psychiatrists had objected to psychologists taking direct referrals from GPs, and the health authority had resolved the issue in favour of the psychologists.

The conclusion to the incident was an agreed procedure which described,"What happens if the GP is unhappy about some aspects of the psychologist's work or behaviour ".The paper continued:".. qualified clinical psychologists are accepted as independent clinicians. Whilst in training their clinical judgments are subject to the supervision of a Senior or Principal grade psychologist; having qualified, their clinical judgments are not subject to the direction of any other person. Hence if it is some aspect of the psychologist's judgment in a particular case which is at issue, the first person to take the matter up with is the individual concerned. Clinical psychologists are very conscious of the importance of providing a high standard of service to patients and if the GP suspects gross misjudgment it would be in order to raise the matter with the individual's immediate colleagues. If the GP's concern is with some other aspect of the psychologist's conduct, it may be appropriate for him to contact the Area Coordinator of psychology services who has the power to involve the Area Health Authority's disciplinary procedure if necessary." [Kat (1980 (NP.03)].

Management Autonomy

The workshop agreed with the description of the district psychologist's authority in relation to psychologists as being: "to advise on the appointment and grading of staff; to undertake disciplinary actions in accordance with the authority's agreed procedure, and to monitor the adherence of psychologists to the established policies and procedures of the Area Psychology Committee and AHA. This does not include authority to direct the clinical work of individuals, but does imply the right to enquire into it." The area coordinator and the district psychologist were nominated by the psychologists and ,"designated by the Authority", and received, "copies of the management team agendas and were invited to attend team meetings for relevant items."

In summary, although the details of the service organisation were not fully specified, the short field study provides evidence that psychologists were organised as a group in a "district psychology committee", were monitored and coordinated but not fully managed by the district psychologist, and clarified some of the limits to each practitioner's autonomy. It did not resolve how changes were to be made to psychologists' sessions to enable a district psychologist to ensure a more balanced service (members would not agree to the district psychologist being able to impose changes) or whether the district psychologist had the authority to overrule a committee view about priorities for new posts. The workshop did establish that the district psychologist had disciplinary authority to act in cases of breach of contract and negligence; did not have authority to "direct the clinical work of individuals", and that referrals were to a named psychologist providing a personalised service.

Manchester Field Study

Initial discussions with the district psychologist established that his post had recently been created as a result of pressure from psychiatrists, who felt that,"there was no leadership in psychology and that each psychologist did what they wanted " (MPFN). The new district psychologist wanted to bring together two traditionally separate psychology departments in mental health, and in child and family services, as well as his own speciality in mental handicap, to provide a "district service". The psychologists saw their new head as being able to prevent consultant doctors from "bringing psychologists back into consultant teams" as a result of new Unit organisation, and as being there to maintain their current independence. The district psychologist, on the other hand, saw the purpose of the workshop as being for the psychologists to agree ways of working together to provide a district service, and to agree and define more clearly his role and authority.

The workshop established that the employing authority had delegated authority to the district psychologist to appoint staff once posts were agreed, and to apply disciplinary procedures for breach of contract or unprofessional conduct (MPFN). Units had not been provided with budgets, and the district psychologist had authority to use "up to 50% of savings in his budget for non-recurrent items without DMT approval". His authority to change psychologists' deployment was unclear.

Each of the two separate departments was headed by principal grade psychologists who were described as carrying a ,"strong coordinating role in relation to psychologists in each department". (Seven and four psychologists in each department). Actual examples of these heads exercising authority in relation to psychologists are not documented.

One outcome of the workshop was to define the head of specialties' authority to "ensure psychologists adhered to contract and department policies and to report sustained divergencies to the district psychologist for disciplinary action as necessary" (MPFN), and that the district psychologist would have authority to define the overall policies and type of service to be provided by each specialty, after consultation.

In summary, the workshop provided evidence of the formation of a management structure for all the psychologists in the district, headed by a district psychologist with delegated budgetary and disciplinary authority, as well as agreed policy-making authority to define the overall type and balance of services if agreement could not be reached within the group. It did not provide evidence of incidents or specification of consultants' or unit management group's authority in relation to psychologists: the district psychologist's view was that complaints or requests would come to him to resolve, and that higher management (DMT) would arbitrate if he supported the psychologists' independence.

Eastbourne Field Study

In contrast to services in Northumberland and Manchester, the department in Eastbourne was based and managed within one unit of management and the district psychologist was accountable to the unit administrator for "managing" the psychology budget and service. Discussions with the district psychologist established that the authority's new unit management arrangements (EP.01) made it more difficult for the district psychologist and other psychologists to change or develop the services they provided outside of the base unit, and hence restricted their previous individual and group autonomy.

The district psychologist confirmed the general description of his role as outlined in the health authority document as being, "accountable for the management of all the professional staff within the department, whatever unit they may be based in", and that "day-to-day matters" were to be "sorted out" by the senior person in each unit (EP.01). The unit administrator (UA) was described as ensuring that,"adequate appointment and disciplinary procedures are observed by the district head", and that they may be "involved" in various personnel matters, but the head reported that the UA had never exercised his authority or "interfered" with the head's decisions on personnel matters.

The unit administrator's budgetary authority was a source of concern for the head :changes to sessions across units, or new posts had to be agreed by the relevant UAs. Previously psychologists had met requests to provide services without informing higher management outside of psychology, and new posts had been agreed or turned down by district management.

The new arrangement was that each unit was provided with information about the cost of psychologists' time, and any changes required costing and financial transfers between units and the agreement of UAs: "Where services are provided to other units, then proposed changes must involve the district head plus the relevant UMTs at an early stage." (EP.01).

The district psychologist was concerned that where his views and those of his colleagues about new posts or changes were different from those of a UMG, the DMT would decide in favour of the unit, hence reducing psychologists' ability to decide the future shape and type of service. This possibility was noted (but not decided)in the authority's statement that, "One unit may wish to expand a service and another unit to contract it in complete contradiction to the professional opinion of the district head as to what constitutes a balance." (EP.01). No "test cases" had occurred clarifying the authority of the head.

The main purpose of the workshop, however, was for members of the department to agree a "decision-making process for the department as a whole". In particular the concern was: "Given limited resources, how do we make decisions and cope with competition between different members' needs and areas of interest, allowing for the personal and professional differences?" (EPFN1). Related issues were clarification of the role of department chairman,who was elected by the group, and the role of the district psychologist.

The workshop discussion revealed that new posts in different specialties had been created in a "disorganised" way when funds became available, with each psychologist practising in different fields and "coordinated" by the district psychologist. No incidents were cited where the head had required a psychologist to take on a case or undertake new work against their own judgment. Discussion revealed that the main limits to practitioners' autonomy were vaguely-worded job descriptions, and "informal peer group pressure" at departmental meetings. After a few years in the department each psychologist decided, within the terms of their job descriptions, how many sessions they would spend on which activities and where they would work their sessions. They would report major changes to the department meeting "to keep others informed".

The problems faced by the group, which were not resolved, were how the group could decide amongst themselves what work should be undertaken by new post holders, and how each member couid change their work to provide services to areas in the district which did not receive psychology. The district psychologist was reluctant to require individuals to make changes because he supported the notion of freedom from "interference in clinical matters" which he and the group took to include decisions about the siting and type of work. He was also unsure about his authority to impose changes. Workshop discussions, however, revealed that junior members

of the department were sometimes asked to change their sessional arrangements and did not have freedom to decide changes in the siting and balance of work.

In summary, the Eastbourne field study provided evidence of a psychology organisation based and managed within one unit of management, headed by a district psychologist who was accountable to a unit administrator rather than to a district officer. Psychologists' previous independence to change setting and type of work was not constrained by the head's authority in relation to them, but by his lack of structural authority to ensure that budgetary and administrative changes in other units were made to allow the psychologists to make the changes which they saw to be necessary. The workshop provided further confirmation that within the terms of their employment contract senior psychologists had a certain "practice freedom", whilst junior psychologists were instructed as to setting and time spent on certain types of work, but were not supervised in their clinical work.

Macclesfield Field Study

Further evidence of the degree of practitioner independence and of the authority of the head of service was gained in a workshop involving all psychologists and the three unit general managers (UGMs) of the district. The district psychologist post had been established in 1980 to develop a district service (McPFN), but with the creation of units of management in 1982 and new unit general managers in 1985, there was concern amongst psychologists that units would not fund new posts, and might require or oppose session changes.

For their part the UGMs were concerned about psychologists deciding to stop sessions for or referrals to the Units for which the UGMs were responsible without consulting the UGMs.The UGMs were worried about how they would deal with complaints from consultants if psychology services were reduced. The UGM responsible for the Unit in which the psychology department was based expected to be ,"held accountable by the DGM for the performance and effectiveness of the district psychology service". He wanted to know what this would mean, and how he and psychologists were to undertake the unfamiliar task of accounting for service effectiveness.

Preliminary discussions with the district psychologist established that psychologists' patterns of work had emerged as each had reacted to requests and referrals and had pursued their particular interests. Most had "manipulated demand" by "selling their services" and by "educating" GPs and other consultants to send them referrals which were within their area of interest and expertise. The district psychologist wished to agree a plan for a more "balanced service", and a structure which would ensure that such a service was provided - she felt her task was to respond to the statement in DHA's strategic plan that,

> "It is considered that the District Psychology Department is in need of rationalisation given that staff developments have tended to take place in an ad hoc fashion without reference to the overall structure of the service and the needs of the district."
>
> [Macclesfield DHA (p.1.9)].

The district psychologist also wished to agree how to institute one aspect of the operational policy she had drafted,

> "Each member of the Department will have their performance reviewed by Staff Appraisal from their immediate Head of Service, Heads of Service being appraised by the Head of Department. (District Psychologist)" .

This was viewed by some staff as entering the"grey" area between managerial and professional matters, and as a review of clinical practice.Discussion at the workshop focussed on the degree of freedom of individual practitioners to pursue different types of work at different sites, how psychologists as a group were to agree the specialty divisions of the service and which new posts were required, and how new posts were to be funded and existing posts changed through units of management.

One conclusion was that the district psychologist would consult other psychologists before proposing a specialty division structure and plan to UGMs for agreement. In the presence of the three UGMs the psychologists decided that if they could not agree the future structure, the head would have authority to decide and propose a structure, within the next month.

No psychologists had job descriptions and the discussion clarified the existing boundaries to their practice. The formal institutional limits were reported to be those of professional ethics and standards, and contractual statements concerning holiday entitlement. No formal statements existed which restricted any individual to a particular site or even field of work, and the consensus of the meeting was that the main restriction on practice would result from the district psychologist taking action on a consultant's complaint about a psychologist's refusal to take a referral. No examples were cited.

The picture which emerged, much to the astonishment of the UGMs and to the embarrassment of the psychologists, was of a considerable degree of freedom for each psychologist to pursue their practice as each saw fit, and of no mechanisms or policies which ensured that their work was coordinated or monitored. The main constraint to their independence was the need to reduce sessions or services to some consultants and units which had been built up through "custom and

practice" over the years, in order that each could take on new areas of work which each decided was of greater importance. The district psychologist did not have prescribed structural authority to direct psychologists to work in certain areas, although it was clear from the workshop that UGMs and the DGM would support her in requiring changes and in directing psychologists as to types and fields of work.

The budgetary arrangements which were agreed gave an indication of the district psychologist's management autonomy. She was required to agree new posts in each of the three Units with each UGM, and she or the UGMs could veto the proposal to be arbitrated by the DGM. The UGM who agreed the post was then to propose it as part of their plan to the DGM for final agreement, and funding would be channelled through the "host" Unit. This represented a reduction in the district psychologist's autonomy as previously posts had been agreed and funded direct from district level with no formal check by units. The host UGM confirmed that the arrangement had been instituted at a later Brunel workshop where the service was presented as an example unit-based district service. (BWN.12).

In summary, the workshop provided evidence of few constraints to practitioners' autonomy and a reluctance to move to explicit arrangements where individuals could be formally held to account for the work which they undertook. This was demonstrated by a refusal of three psychologists even to state at which sites they worked. The district psychologist clarified her authority in relation to psychologists and to UGMs, and the group agreed that she had "policy-making authority" in relation to sites and broad fields of work. These and other aspects of structure examined at the workshop were adopted as health authority policy for the department two months later.

Dudley Field Study

This field study involved preparations and a workshop for the nine psychologists of the Dudley district service and the six psychologists of the Bromsgrove and Reddich district.

Discussions with the Dudley district psychologist revealed that the district service was to be managed within one unit of management and cross-charging arrangements were to be established with other Unit General Managers receiving services. Here concern was that the 'host' UGM, to whom she was "managerially accountable', would question or oppose the level and type of service which psychologists provided to other Units, and that recipient UGMs may also wish to influence the level and type of services they received. (i.e. the authority of the head in relation to UGMs was unclear and the head was concerned that new budgetary arrangements could limit her managerial autonomy). The general health authority prescription was that UGMs had "the right to

decide how to use their resources ..... whilst professional control is vested in the District Officer." It was clear that UGMs could significantly influence a district management decision about whether a new psychology post should be created and could influence the content and type of work to be done.

It was not possible to agree the limits to and extent of the district psychologist's managerial autonomy because no UGMs were present, but the district psychologist concluded that in the future it would be necessary to describe to UGMs in more detail the type and amount of work each psychologist undertook in each Unit for costing purposes, and to explain to each UGM why the work was undertaken. It was thought that case law would clarify the DP's authority by her taking proposals for changes to services which were not agreed by UGMs to the DGM for arbitration.

Evidence of practitioner autonomy was revealed in the workshop discussions concerning how decisions were made about where and what type of work each psychologist undertook. The department policy stated that,

> "All trained psychologists in the department are autonomous professional practitioners .... who are administratively accountable to the District Psychologist who initiates the disciplining procedure. After due consultation the District Psychologist will set limits on resources and set priorities between specialties. Thus each specialty will have clearly-defined limits within which each Principal (with responsibility for that specialty) will operate. They will be responsible for monitoring and coordinating work within that specialty."

Discussions of management information, staff performance appraisal and clinical responsibility clarified some of the limits to practitioner autonomy. Where a practitioner within a specialty disagreed with the Principal head of specialty about whether the practitioner should change the siting or type of work, the district psychologist would decide, and would use disciplinary procedures to enforce the decision (DPFN). (No actual or likely instances were cited). Each practitioner was expected to provide workload statistics returns and to fill out a detailed two-week time diary. This provided the district psychologist (and UGMs) with information to question the practitioner's use of time and one example was given of where the district psychologist had done so. Finally the district psychologist was proposing to carry out "performance appraisals" where each member would provide a general review of their year's work and discuss their future plans - no case work reviews were to be undertaken.

Oxford Field Study

This field study provided evidence of the constraints to management autonomy in a district with a large number of psychologists (27) practising in different specialist areas, and with eight Units of management. The workshop was undertaken at the instigation of the district psychologist and heads of specialties in order to consider existing and future alternative structures for the department, how specialisms would relate to Units, and head of department roles.

The department documentation and preliminary discussions established the existence of six specialty areas of work with "heads of specialty" with varying responsibilities and authority (confirmed at the workshop). The district psychologist coordinated the heads of specialty, who each decided the type of service to be provided. Psychologists in each specialty provided services to a number of units of management.

Psychologists were concerned that they would be allocated to different Units for management purposes (possibly managed by UGMs) and budgeted for within these Units without regard to their cross-unit working. The district psychologist was concerned to establish a structure and process to ensure a more balanced service and to strengthen his coordinating authority.

Preliminary discussions and the workshop revealed that each practitioner had responded to and generated demand according to their specialist interests. Heads of specialty had made suggestions to the district psychologist about the siting of new posts and had dealt with the various requests of practitioners, but had not actively monitored practitioners' work nor proposed changes in siting or methods of work. It was changes to Unit structures which prompted the district psychologist and heads to examine their structure and their management role, and to begin to define the authority which each reequired in order to be held accountable for providing a district and a specialty service.

The agreement which was reached was that four head of division posts would be established to "monitor" psychologists in each division, and would be coordinated by the district psychologist. The authority of divisional heads in relation to psychologists in the division was not specified further than the "monitoring role" [Øvretveit (1985c)] (i.e. limited to specific field of work), but it was agreed that disagreements between divisional heads about new posts were to be resolved by the district psychologist's decision.

This study revealed limits to the district psychologist's management autonomy in large departments with long-established specialties, each of which had separate power bases within institutions. Each head of specialty's concern about what they perceived as "the threat of Unit

management" led them to join forces to establish a coordinated district service for "protection". (OPFN).

Other Research Findings

The above field studies provided evidence of forms of organisation which balanced (a) the views of each practitioner about the type of work they should be doing and how best to spend their time, with (b), an overall view of the psychology service as a whole and how each person's skills could best be used. Other national and regional workshops conducted by the author and conferences organised by psychologists focused on this issue and provide further evidence of group and practitioner autonomy, of the roles of heads of service, and of the functioning of departmental meetings or committees.

Bexley Department

One of the longest-running and best documented examples of ,"committee group management" is the Bexley Department. The author discussed the structure with the head of department in two informal meetings in April 1983 (NETCN) and in 1984 (SETCN), at the Brunel Workshop attended by the head (BWN.03), and with groups of psychologists at two conferences. The description of the department by the head (Field, May 1980) was used as a basis for these discussions.

Group management in this instance involved all the psychologists who worked in a hospital department. With the creation of a district service and the appointment of psychologists to posts based outside the hospital, the hospital group model of organisation was extended to manage the district service. The critical issues concerned the role and authority of the district psychologist with respect to the group meeting and to individual practitioners,in particular his ability to decide changes to use of time and sessions where there was no consensus, or where he disagreed with the group or with individuals.

In discussion the head confirmed the description of the case autonomy of practitioners,

> "Clinical decisions are the direct responsibility of each psychologist and he or she cannot, in clinical matters, be overruled by any office holder or by any meeting of the department."
>
> [Field, May (1980)].

He knew of no situations where practitioners' case decisions had been overruled by himself or others. When questioned about the exact meaning of "clinical matters", it emerged that a

practitioner's decision to provide teaching or consultancy to a new area, or to accept referrals from a new source, was: "more a service matter than a clinical matter, for discussion at the meeting". [Field, May (1980)].

In situations where practitioners were likely to make "major changes" to their use of time, a departmental discussion was required, with the possibility of a vote. The rules were: "major policy decisions affecting the long-term running of the department require two-thirds majority and three-quarters of department members as a quorum". Documentation is not available of "critical incidents" where a practitioner's proposed change was opposed by the meeting.

The district psychologist reported that practitioners did in fact make changes which did not breach contract, which sometimes later came to light in departmental discussions, and the fact that the group had not known about or agreed the changes was ignored. His concern was that the group was not grappling with the task of ensuring an overall balanced service because each member wished to maintain their own independence. His authority extended only to monitoring adherence to contract and to implementing department policy, and he had not sought the group's sanction to discipline a practitioner for not reporting and discussing session or referral changes. In fact the organisation made such actions unlikely - each department meeting was chaired by each member in succession and the district head was originally elected and only later appointed by the authority as a "district officer".

The district psychologist reported that there had been no conflict in the previous single-specialty department, but with new posts outside the specialty and different views about developments and service priorities, as well as requests for psychology input from across the district, the district psychologist experienced pressure on him to overrule meeting decisions to ensure a balanced district service. (NETCN).

In summary, the Bexley Department organisation provides evidence of psychologists organised as a group with a committee structure, headed by a district psychologist who was accountable to the group for implementing its policies, and to the district administrator for monitoring and coordinating practitioners. Individuals were reported to have autonomy over case decisions.They were also formally required to gain committee agreement to changes in their practice, but their practice did not follow the written policy.

South Birmingham

The author conducted a two-day workshop for 18 psychologists from 12 districts in the West Midlands, and took the South Birmingham service as a typical example for defining and discussing

problems of organisation of concern to the participants. Previous discussions with the district psychologist and one head of specialty, as well as analysis of the service description(BP.01), provided a description of the organisation and details of psychologists' management and practitioner autonomy in this district.

The health authority was divided into eight Units of management with five psychology specialties, each staffed by two psychologists with sessions spread across most Units. The psychologists were organised as a "district service", headed by the district psychologist who chaired service meetings of all the psychologists and put forward proposals for new or changed services to the DMT. (BPFN). With "unitisation" in 1982 the district psychologist reported having to take proposals for changes in referrals, sessional arrangements, and new posts to each relevant unit administrator for agreement. She described this as "reducing flexibility" for herself and the psychologists concerned, and as making it more difficult to get new posts established because it required "support from unit administration". (BPFN).

Evidence of practitioner autonomy was provided by discussions of statements in the service description (BP.01, p.3),

> "Qualified psychologists are independent professionals and as such are not accountable to each other for their clinical work. They are responsible for the management of their own time. Psychologists only have management authority over other psychologists if that is part of their job description."

The district psychologist and others at the workshop reported that head psychologists did not examine psychologists' case decisions, unless there was a complaint. Two occasions were described where psychiatrists had complained to head psychologists about a psychologist's conduct of case-work, and on each occasion the head had not overturned the psychologists' decisions because they had satisfied themselves that the individual was within professional standards.

Other aspects of autonomy were examined by the researcher suggesting situations where a psychologist might decide to spend half of their time on, for example, research. Discussion showed that research proposals were "discussed at department meetings". (BPFN). In addition, the view was that most heads did in fact have disciplinary authority to ensure that psychologists kept to their employment contract, and if a psychologist's decision about their use of time led to a breach of contract, a head would be responsible for noting the fact and acting on it. Again, no incidents were reported where heads had exercised formal disciplinary authority over such matters.

This brief study and the workshop discussions provided evidence of psychologists in one district organised as a group, headed by a district psychologist who was having increasing difficulties in arranging changes to sessions and new posts on behalf of her colleagues in the department because of the number of new units of management. It provided another example of a situation where once psychologists were appointed, the main limits to their autonomy were those of their job description (if they had one) and subsequent psychology service policies which were agreed by group. No examples of heads imposing policies without group agreement were provided, nor of heads overriding case decisions.

Hampstead Psychology Service

Psychology organisation in this district was described by the Chairperson of the Heads of Department Committee at a conference on organisation [23.6.82) (noted in BPS, June (1982)], at a workshop conducted by the author (13-14.2.85, BWN.07).

The twenty-eight psychologists in the district were managed in three separate departments, each with a head of department. The elected chairperson of the committee reported that psychologists in each separate unit refused to change sessions to provide services which the committee decided were needed, and the committee itself did not always agree priorities for new posts (NETCN),

> "It was felt to be impractical to appoint a District Psychologist because no single person could effectively participate in the management of these complex and separate units."
>
> [BPS, June (1982)]

The chairperson reported requests to her from the district administrator to arrange for psychology services from one of the units to be provided for people with a mental handicap. As elected chairperson she had no authority to require one of the heads to provide a service when agreement was not reached. As a result the district administrator considered appointing a district psychologist with clearly defined authority to change sessions, but chose the cheaper option of funding a new post in mental handicap instead.

This example and the form of organisation adopted show an arrangement where there was no single group management or clear head of service. As a result the autonomy of psychologists as a group and their ability to plan and act to pursue the interests of the profession was less than in other districts. However, the sub-groupings and individual practitioners maintained their

autonomy. No details of the limits to practitioner autonomy were available.

Brunel Workshops

Twelve national workshops were conducted by the author at Brunel University which were attended by over 200 psychologists from most districts in the UK. The workshops provided further evidence of a separation of ,(a) the managerial monitoring functions of district psychologists who were accountable to DMOs i.e. DAs, from,(b) roles of chairpersons of district committees of psychologists appointed by them to represent psychologists' views. These workshops also provided further evidence of the limits to practitioner autonomy and of two types of autonomy - case and practice autonomy. The following situations and "critical incidents" were described at the workshops.

23/24 Nov 1983 (BWN.01)

A district psychologist with a district budget and management responsibility for 24 psychologists reported difficulties in getting heads of department to agree and implement changes to their services (BWN.01). Another district psychologist (11 staff) reported "difficulty in ensuring that psychologists came to department meetings", and was unaware of her authority to ensure that they did so even though it was a requirement of departmental policy. Another reported that once the department had agreed priorities and the need to change psychologists' use of time, the base Unit management group had opposed losing the sessions, and district management had not ruled on the matter. Most reported the requirement to inform and agree with Unit management any proposals for redeploying sessions. This proved to be one widespread constraint to profession-management autonomy which was noted in the field studies reported earlier.

Discussion of a problem raised by one district psychologist regarding, "what to do if a psychologist makes a bad clinical decision", showed general agreement that the district psychologist had authority to check both adherence to contract and that professional standards were met, but not to override the decision if these requirements were met, and that the district psychologist would not be legally liable if procedures had been followed.

9/10 Feb 1984 (BWN.02)

Many of the district psychologists and heads of department attending were concerned about how to change psychologists' use of time to meet what they and higher management saw to be service priorities. This focused their attention on their authority in relation to other psychologists and to unit management (UMGs or UAs). One district psychologist described wishing to direct a

psychologist to provide sessions to a small local mental handicap hospital, but was opposed by the unit administrator and consultants in the psychologist's unit because they were losing the psychologist's sessions. The district psychologist had not tested his authority in the situation by taking the matter higher to the district administrator for a ruling, because he felt it would undermine the cooperation which existed amongst the psychologists in the department. Another described having to present their case for new posts to the Unit Management Group instead of, as previously, to the DMT. They felt this reduced their chances of gaining new posts. Another district psychologist described a situation where previously he had been able to decide to increase the sessions of a part-time practitioner to make up for not being able to recruit into a new post. With the new unit budgets he had wished to continue the arrangement, but the UMG had opposed the arrangement in order to make use of the psychology savings in other areas. These and other instances provided evidence of the head's authority and the limits to management autonomy in the profession.

One district psychologist raised a problem common to most concerning what influence he could bring to bear on practitioners whom he thought were not making the best use of their time, even if they were complying with contract. The example he gave was of a practitioner undertaking mostly long-term individual psychotherapy, where he felt the practitioner should undertake more group and service development work. Other workshop members took the view that they and the district psychologist could not and should not require the practitioner to change but could exert "informal peer-group pressure". If the department agreed a policy about limiting individual case-work [e.g. Victoria DHA (12 sessions before departmental agreement)] then it was felt that the district psychologist could act, but no examples were given where this had occurred.

23/24 Feb 1984 (BWN.03)

Participants described two types of management arrangements: where the district psychologist was accountable to a district level officer (South Birmingham, Bolton, South Lincolnshire, Southend, Bexley, and Winchester), and where there was no district psychologist and heads of specialties were accountable to Unit management (Waltham Forest, Borders Health Board, Islington, and Barnsley) (BWN.03). One district administrator at the workshop reported a structure of planning where Unit management put forward proposals as to where new psychology posts should be provided, on advice from psychologists. The two separate psychology departments had not developed joint management arrangements and the "district psychology coordinator" was required to settle all routine matters with each Unit management team.

This latter example provides evidence of a situation where all psychologists in the district were not grouped together, and separate departments were accountable to, and managed by, unit

management. As a result psychologists' power to influence the siting and creation of new posts was less than where the whole group represented their views direct to district management, and psychologists' practice autonomy was constrained by unit management control. The two psychologists from each department who attended the workshop were in favour of creating a single department headed by a district psychologist, but the district administrator wanted "his Units"to be the main focus for management and planning in the district.

The district psychologist from the Bexley department described the department organisation and the particular problems he faced in attempting to move posts and sessions between units. These were, firstly, opposition from units losing services, and difficulties in transferring funding brought about by new unit budgetary arrangements, and, secondly, opposition from individual psychologists who were required to change sessions, and a lack of structural authority to overrule them. These factors defined some of the limits to the district psychologist's actual management autonomy.

13/14 Sept 1984 (BWN.04)

Five district psychologists at this workshop reported difficulties which they experienced in undertaking their different roles, and uncertainty about their authority in relation to unit management and to other psychologists. One had been appointed to "advise the DHA on service developments and to manage staff in the department"; another had been "designated" district psychologist pending a decision to appoint to a fully-funded post, and a third had been termed a "district coordinator" by the district psychology advisory committee, although the DHA had not "recognised" the position. The other two were appointed to develop a district service, but reported difficulties in gaining new posts and in transferring staff. The differences in district psychology roles and the absence of the role in the other nine districts represented at the conference showed a reluctance on the part of some DHAs to provide district psychologists with authority to manage and extend the service, especially if it might conflict with unit management. District Psychology Advisory Committees in North-West Surrey and Hillingdon were described as "pressure groups" for representing psychology views and plans to district management.

Most psychologists felt that a district psychologist and a district service was the best way for the profession to increase its staffing and develop its service, and considered to whom and how they might put their case to sceptical management teams who wished to strengthen unit management. A head of department in mental handicap (N W Surrey) described trying to provide psychology time to GPs and primary health care teams, and reported an inability to gain funds from unit management to do so, and medical consultants vetoing her proposals to change the sessions of a psychologist on the community mental handicap team. Most heads' managerial authority was

either unclear, untested, or limited by unit management. There is no documentation from the workshop on details of practitioner autonomy.

27/28 Sept 1984 (BWN.05)

District psychologists and heads of department reported a variety of Unit arrangements and different links with district management. One district psychologist (Essex) described himself as being "managed" by the district administrator and as being instructed to introduce annual staff appraisals. He described arrangements he was introducing to discuss with each staff member their work and future plans, but reported that he was not going to review case-work, and had not, and would not, override case-decisions. There was agreement at the workshop over the latter point, but disagreement over whether staff appraisal should be implemented and, if so, how detailed the appraisals should be. There were no examples of systems in operation.

A second example relevant to practitioner autonomy was a head of department's description of his authority to ,"check that psychologists follow the policies and procedures laid down by the district psychologist". He described requiring psychologists to follow administrative procedures for record keeping and travel claims and being prepared to apply disciplinary procedures for their failing to do so. There were no policies requiring psychologists to undertake teaching or research, or which specified other details of "clinical practice'. Discussion examined whether policies should do so and how district psychologists should respond to expected pressures from new general managers to "manage psychologists more closely". Workshop members, as usual, were ambivalent about their management role, and usually had not and did not wish to exercise their structural authority (where it was specified) to impose changes. They felt this would make it more difficult to exercise their "informal powers" and could lose them the respect and support of their colleagues.

Evidence of the management practices of existing heads showed little monitoring of staff activities. Two were able to report where staff sessions were sited, but most did not know how many sessions were spent in which units or specialties. The evidence suggested that most psychologists who were "managed" by these heads decided where and how to spend their time, and were not questioned about their activities unless complaints were made.

By February 1985 the pressure to develop management information systems in the NHS had increased. Workshop members examined how to introduce such systems and the implications for practitioner autonomy and heads' management authority. A workshop in February 1985 (BWN.08) provided evidence of two departments which had required their members to record details of their work activities as an experiment for management information systems (e.g. time

spent on "direct" and "indirect" patient contact, administration, research, teaching, etc). All departments represented at the workshop intended to complete similar statistical returns as part of the new Korner minimum data sets.

This evidence of moves to provide detailed information on each individual's activities is relevant to the issue of practitioner autonomy. Previously little detail was known about where and how each practitioner worked, but with details on these matters, questions could be, and were, asked by heads and administrators about whether certain activities were the best use of psychologists' time. (Indeed, the purpose of the systems was to make this possible). The availability of this information placed subtle and "informal" constraints on practitioner autonomy. As one psychologist put it - "If I spend too much of my time on individual therapy and not enough on group work, it looks bad on my returns and the head starts asking questions." (BWN.08). In such situations there are implicit limits or assumptions held by heads about psychologists' use of time, and informal rather than explicit structural authority is brought to bear on practitioners to account for their use of time, or to make adjustments. For their part, the problem raised by heads in this and other workshops was, "What do we do if psychologists refuse to change?" This suggested that they had not enforced their views, were uncertain of their structural authority to do so, and reluctant to exercise such authority even when it was clear that higher management wished them to do so.

Documentation from other workshops provides further descriptions of organisation and critical incidents which are evidence of the extent of management authority and the limits to practitioner autonomy. (30/31 Oct, 1984 (BWN.06); 31 Jan/1 Feb, 1985 (BWN.07); 13/14 Feb, 1985 (BWN/08); 4/5 Oct, 1985 (BWN.09); 30/31 Oct, 1985 (BWN.10); 4/5 March, 1986 (BWN.11); 22/23 April, 1986 (BWN.12); 30/31 July, 1986 (BWN.13).

A district psychologist (Brent (BWN.06)) reported that his DMO had instructed him to hold monthly, rather than weekly, department meetings because the DMO viewed it as a "poor use of psychologists' time". The district psychologist had refused to change and the DMO had not taken the matter to a higher authority.

A district psychologist (Gwent (BWN.08)) reported saving funds as a result of being unable to recruit a psychologist, but being prevented from using the "fortuitous savings" by a unit management group. The UMG had received budget statements on costings of all staff in the unit and on realising that the staff member was not appointed, applied to the DMT to use the savings for a ward upgrading. (The district psychologist thus did not have authority over a staff budget).

A workshop conducted with members of a psychotherapy unit which included psychologists (Derby, June 1984 (DPFN)), established that the consultant doctor, "regularly reviewed the overall

management of cases" to satisfy himself that therapists were "taking proper steps to ensure client safety". No trained members reported the consultant directing them to take different actions from those they would otherwise have done, or of removing them from the case. No long-term field work or observation was undertaken to confirm these reports.

Northern Region Workshop (1986)

The structure of the Sunderland psychology service, as reported by the district psychologist (and drawing on previous team field research), was examined in the workshop. Evidence of management and practitioner autonomy was provided by the incidents, negotiations and problems reported by the district psychologist. The psychology service was sited in the Mental Health Unit of Management, which was the base for six of the eight psychologists in the district, the two other psychologists working in two other Units of Management. The district psychologist described his negotiations with district management to ensure that the budget for all psychologists was channelled through the Mental Health Unit, rather than splitting budgets between Units and reducing management autonomy.

It had been agreed that the district psychologist would agree levels of service for the coming year with UGMs in the annual planning cycle and cross-charge the costs to the host unit budget. This agreement had formalised and increased UGMs' influence over the provision of psychology within their units and decreased the district psychologist's management autonomy.

The district psychologist raised two problems which demonstrated some of the limits to practitioner autonomy and the nature of management authority in relation to psychologists. The district psychologist was concerned that one member of the department who had for some years undertaken a specialist "technician" role would be opposed to more flexible working in the community. The district psychologist was reluctant to change the siting of work but described the strategies of persuasion he was to use before instructing the member of the department.

The second issue was the conflict of views between one member who spent a large amount of time practising long-term individual psychoanalytic therapy with a small number of patients, and the district psychologist who viewed this as an inefficient use of time on a treatment where there was no evidence of effectiveness. The district psychologist and workshop members concluded that the district psychologist would be unwise, and possibly unable, to exercise his formal authority to change the member's practice, but could require the member to provide evidence of effectiveness. Again, the workshop members drew a distinction between the siting of work and the use of time in therapies within the sessions allocated.

Conclusions from the Author's Field Research into Psychology Organisation

The limitations of the evidence from the field studies and workshops above are that the evidence is a combination of reports, subject-researcher constructions, and group reports by senior managers of critical incidents and management structures. Although the researcher probed and questioned to clarify and check how the organisation operated, and whether there were examples which revealed key elements of authority, there are no directly observed instances which are cited, and often only one respondent's report was available. However, given these limitations, there is a substantial amount of evidence for certain conclusions about management and practitioner autonomy in clinical psychology.

Management Autonomy

The main problem raised and examined by district psychologists and heads of departments at all workshops was how to change psychologists' sessions and use of time in different types of work to provide a more balanced overall service, i.e. one where psychologists were meeting requests and needs from parts of the district where they did not already work. They reported three factors which limited their ability to provide a more comprehensive service and which provide evidence of the extent of psychologists' "management autonomy" and control.

First, heads were uncertain about who had authority to decide new posts and how they should "present the case" for new posts. Because they were rarely permanent members of Unit and District Management Groups, their awareness of available funds, and ability to put and argue their case, were limited. It was common that heads were required to put proposals to unit management groups to incorporate in their plans, rather than direct to district management. Thus heads' ability to gain new posts for the profession was limited by their not being included in the main management bodies. The autonomy and influence gained from being a full member of such bodies was of significance.

Second, the heads' ability to transfer psychologists' sessions or use of time between units was constrained by the requirement that significant changes could be vetoed by the units concerned, and that funding arrangements had to be agreed. Previously the influence of unit management had not been as formalised or extreme and staff or session transfers were carried out without notifying units and psychologists had moved between units without difficulties.

A third factor was the wish to get the agreement of individual psychologists to the change, and often ,in addition ,the agreement of a committee or department meeting. No instances were cited

of a district psychologist enforcing disciplinary procedures to carry through a change, although in principle district psychologists had this authority and would have been supported by higher management. Thus both the head psychologist and other psychologists' understanding of practice autonomy limited head's management autonomy. Heads did not exercise structural and institutionalised authority, but relied on group pressures in departmental meetings to persuade psychologists to change their practices.

Where group pressure could not be brought to bear, heads did not pursue the matter and psychologists were not prevented from following their own individual interests and priorities. In situations where the main structure was departmental group meetings (e.g. Bexley), meetings often failed to agree the specialty designation or siting of new posts, and usually failed to agree readjustments and changes to sessions within the group. The research revealed only three departments (Birmingham, Essex, Macclesfield) with a clear policy for renegotiating significant changes in working practices within the group. Self-management failed to limit practitioner autonomy which almost always resulted in an imbalanced overall service.

However, towards the end of the research there were indications that three developments were indirectly limiting practitioner autonomy. The first was the costing of psychologists' sessions provided to Units and the availability of this information to heads and UGMs. This provided explicit information on practitioners' use of time, made it possible for UGMs and heads to question use of time, and made it necessary to negotiate changes with UGMs, the latter representing one limit to management and practitioner autonomy - most UGMs could veto such changes. The second development was the requirement routinely to collect management information on each psychologist's activities, which also made it possible to question individual psychologist's use of time. The third was the move to institute regular performance appraisals of individuals and services, although no details of such systems are available. These three developments are systems for increasing practitioner accountability and impinge on their autonomy. Should heads or UGMs wish to exercise structural authority to limit or direct practitioners, the systems provide information which makes it easier for them to do so.

A summary of findings about management autonomy is that psychologists in NHS Districts were either grouped together in one department, or in a number of specialty departments, each headed by a psychologist. Many were titled "district psychology services" but the meaning of the term and the authority of the district psychologist varied. Some districts did not have a district service, but instead, a number of psychology departments which may be coordinated by a district psychology committee (e.g. Hampstead). In all cases heads were accountable to UGMs, and UGMs could veto heads' proposals for new posts or changes to sessions. This placed clear limits

to psychologists' management autonomy because proposals had to be agreed at Unit level before agreement at district levels.

Practitioner Autonomy

There was conclusive evidence that senior grade psychologists had case autonomy, "The right to make assessment and treatment decisions in casework without those decisions being scrutinised or overridden, unless negligence is suspected." (Øvretveit(1985c)). It was less clear whether just-qualified psychologists had this autonomy, although most psychologists argued that they did. No examples were found in the research of instances where psychology managers overturned case decisions, although there were three examples of instances where psychiatrists did so. Staff performance appraisals did not examine individual case decisions.

The limits to practitioner autonomy were less clear and varied between departments. It was always stated that psychologists were ,"not accountable to managers for matters of purely professional judgment", but distinctions were made between judgments in casework and judgments about the type of service to be provided and about the balance between areas and fields of work. Management information systems on work activity were providing information which was increasingly being used to question types and areas of work, and to set targets.

It was clear that most employment contract limits prevented psychologists from practising in other districts, and, where there were job descriptions, some specified specialties or sites of work. Some psychology department policies had administrative procedures for travel or study leave, but none defined the type of work to be undertaken, sources of work and balance of activities between individual case, group work, teaching, consultancy, research, planning, etc.

The field studies and workshop examples show that psychologists' practitioner autonomy is defined by their head's authority to impose changes to their sessions and use of time. There are no "critical incidents" documented where higher management was required to support the head's authority, and the few times where heads have carried changes through they did so by gaining practitioners' agreement and without threatening or invoking disciplinary procedures.

There is considerable evidence that many senior and all principal grade psychologists have practice autonomy to, "decide the balance of activities and details of practice within a particular field, without those decisions being questioned or overridden unless policies or contract is infringed". Future developments in budgeting and information systems may further limit practice autonomy, as may staff appraisal and performance reviews, and posts tied to certain community multidisciplinary teams.

There is also evidence of a "personalised service" and client/practitioner choice, where clients are dealt with by one member of the department, who may choose not to take on a case, and each party may choose to terminate involvement if no progress is being made. Finally, all psychologists in community mental handicap teams and in most multidisciplinary teams can carry case-coordinating authority to coordinate the work of other professions in the care of a client.

PART 3: RESEARCH FINDINGS - PHYSIOTHERAPY

Section 1: Government Reports and Recommendations

Management Structures

The recommendations to the new Area Health Authorities in the early stages of the 1974 NHS reorganisation were that physiotherapists be "accountable to a consultant in physical medicine or may be a direct appointee of the AHA" [Grey Book (1972) p.84)] ,and also proposed that staff (of any profession) with related skills could be grouped in departments under a head of department, e.g. a therapy department. These recommendations did not constitute government support for a district profession-management structure headed by a profession-manager, but suggested a number of possibilities. Previously, however, a DHSS working party in 1973 had recommended that,

> "Members of remedial professions should coordinate, organise and administer their own services."
>
> [McMillan Report (1973)].

Interim official guidance from the DHSS in 1974 proposed that AHAs should make arrangements for, "The remedial services to be organised on a district basis" (DHSS (1974) HSC (IS) 101), and that AHAs should "designate" a senior physiotherapist to advise DMTs and to ensure that professional standards were maintained.

A later DHSS report (the Winterton/Perry Report (1977)) recommended the extension of the designated district physiotherapy role to include responsibility for the management of all NHS services of physiotherapy in the district. Most of the recommendations of the report were issued

as official guidance by the DHSS in 1979 (HC (79) 19), and, by 1981, 115 out of 222 health districts had appointed a full-managerial District Physiotherapist ["Physiotherapy Journal" (1981)].

However, as noted earlier, the Griffiths' reorganisation circular (HC (84) 13) called for a review of all "functional" district heads of service posts, and a number of official DHA statements of structure (e.g. Northern Region Documents 1985) either abolished the role, or reduced its authority by changing the role from a full-manager of all physiotherapists in the district to an advisory role, typically "accountable to a Unit General Manager (UGM) for "service provision", and to a DGM for "professional advice".

Thus, since 1974 government recommendations changed from proposing consultant management of physiotherapists (with the option of direct appointment of a physiotherapist-manager) (1972), to proposing arrangements for district organisation of physiotherapists with an advisory profession leader (1974), to proposing a full-manager head of profession with a separate physiotherapy management structure (1979). Recent recommendations (1984), although not referring specifically to physiotherapy, have reduced the number of district posts and district functional organisation. Over the years government recommendations supported an increase and then a decrease in institutionalised management autonomy and control.

Practitioner Autonomy

There were also government recommendations which affected practitioner autonomy. In 1962, following concern about the standard of physiotherapy treatments, the then Ministry of Health issued guidance for doctors who prescribed physiotherapy treatment for patients,

> "Doctors should prescribe physiotherapy with the same precise therapeutic indications in mind as they have when prescribing drugs .....
>
> All too often therapy is prescribed in general terms and the important details such as frequency and progression of treatment, as well as arranging for attendance at medical review clinics, are left to the discretion of the physiotherapists." [HM (62) 18]

This statement effectively institutionalised medical control over physiotherapist practitioner autonomy. However, in 1977, in response to various changes, the DHSS issued guidelines which limited medical prescription and institutionalised physiotherapist practitioners' autonomy to make assessment and treatment decisions,

> "In referring patients to therapists, doctors should give the diagnosis, where possible, and set out the aims of treatment with a note of limitations and contra-indications to a particular form of treatment."
>
> [HC (77) 33]

Of all the specialist professions, government recommendations about the organisation of physiotherapists by employing authorities have been the most numerous, the most specific, and have been widely used by members of the profession to advance their claims to autonomy within districts. There is a variety of explanations for "central intervention" in this way which will be considered in chapter 8.

Section 2: Previous Field Research

Two programmes of social-analytic field research into physiotherapy organisation were undertaken between 1968 and 1980 by Rowbottom et al (1974), and then by Jaques and Tolliday (1978). The research provided evidence of significant changes and variations in management and practitioner autonomy over this period, which were described in Øvretveit (1985 a).

Rowbottom (1973) reported that,

> "Work in a number of field projects, confirmed in conference discussions, has suggested that the following large groups of paramedical staff are in most situations organised hierarchically under the management of medical consultants." He listed a Superintendent Physiotherapist and Head Occupational Therapist as the "Intermediate" management level "below Consultants in Physical-Medicine".

The main field work reported by Rowbottom was a study of a physical medicine department in a teaching hospital. The full social-analytic process was followed in this study which involved discussions with the director of physical medicine, the group superintendent physiotherapist, three superintendent physiotherapists, and the group head occupational therapist, leading to an agreed and specified structure which was accepted and institutionalised by the employing authority.

Rowbottom (1973) represented the structure thus:-

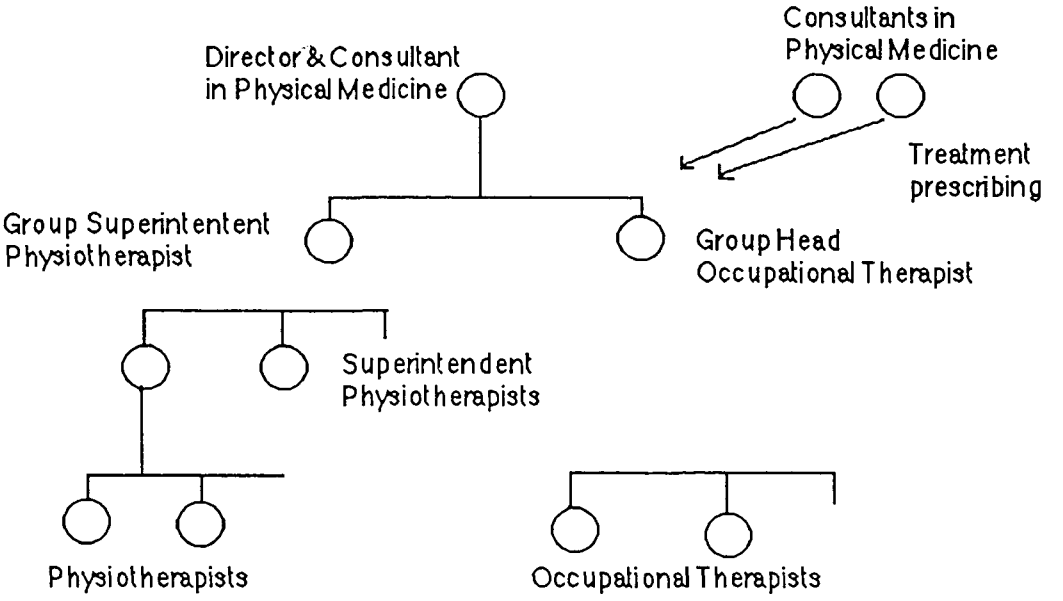


Fig. 5.2: Organisation of Paramedical Staff [From Rowbottom (1973].

It was reported that one of the three consultants in physical medicine (the Director) was accountable for, "the provision of all physiotherapy and occupational physiotherapy services to meet the prescribed requirements of medical staff of the hospitals of the group", and all the physiotherapists (about 46) and occupational therapists (about 15) were seen as accountable to him.

> "All three consultants would have the right to prescribe treatment in respect of their own patients to be carried out by physiotherapists and occupational therapists, as indeed would other consultants in respect of theirs."
>
> (pp. 108-109). (Field research documents available).

This is the only detailed documented study of physiotherapy organisation at that time. The only evidence provided to verify the above statement that this structure existed at other sites in the country is the "confirmation" in unspecified conference discussions. As with most social-analysis research, the main concern was not so much to describe the structure which existed, but to specify a structure which could be (and was) institutionalised at the site, and to report possible alternative structures which could be chosen or adapted by staff elsewhere. Thus for the researchers' purposes at the time it was not necessary to provide evidence of the representativeness of the structure described, or of the following alternative which was also reported,

> "Where for example there is no appointed Director of physical medicine, then the physiotherapists and occupational therapists seem extantly not to gravitate to another consultant, but to stand on their own, or be regarded as subordinate to another administrator."

Actual examples would have provided more reliable evidence for tracing the development of profession-management autonomy in the profession, but these are not available.

The key features of this structure which are relevant to the propositions of the thesis about management and practice autonomy are:

1. Physiotherapists were grouped together with occupational therapists for management purposes;

2. The management structure was headed by a member of another profession - the medical profession;

3. The overall structure was an hierarchical managerial structure;

4. Individual practitioners were managerially accountable to a Superintendent, and ultimately the consultant, and subject to the treatment-prescribing authority of consultants, who were authorised to override their treatment decisions if necessary.

The second set of findings were reported by Jaques and Tolliday (1978). They presented the results of research,

> "carried out during the past ten years by members of HSORU in field-work projects and in research conferences. Some hundreds of individuals have been seen, many of them on repeated occasions over many years, as new organisational patterns were tested." (p 157).

No further methodological details were given, but models of organisation for different departments were described, some of which were successfully implemented in two London health districts [Doc. 1642 (revised)].

One model described a department of ten qualified physiotherapists managed by one Superintendent, with full-managerial authority, and who was a direct appointee of the health

authority. This "profession-manager" was described as being subject to the "monitoring and coordinating" authority of both the medical top-level District Community Physician over matters of "service provision", and the District Administrator over "administrative standards". A variation of this model was described of two or more department heads in a District, one acting as a District Therapist with "coordinating" authority in relation to other heads.

A second model was described as, "suitable for some few situations in very large districts, with a large complement of therapists in many departments (for example, one district with some 80 qualified therapists in twelve departments and a training school with nearly 200 staff)." In this model a District Therapist would have managerial authority over heads of departments.

In each model medical consultants were not described as having managerial authority in relation to practitioners, but their authority was unspecified, "The research unit has not yet succeeded in defining clearly the differences between prescribing and referral. It is recognised that to use the term "prescribing" for all referrals for treatment from a doctor to a physiotherapist has too narrow a feel."

No evidence is provided of the number of departments which were organised according to each model, but available research documentation shows that the first model was formulated and implemented as a result of a full social-analytic study. Accurate details of the number of sites organised according to each model would have been useful for this thesis, but the fact that such models were widely discussed as being viable structures at that time provides some evidence of representativeness.

Jaques and Tolliday's report clearly shows marked changes in managerial and practitioner autonomy compared with the structures reported earlier by Rowbottom (1973). Although there is no documented evidence, it is likely that changes were made in response to the recommendations made by central government for self-management by the profession. The models described physiotherapists as being grouped together in departments separate from occupational therapists, and without medical consultants with full-managerial authority over staff. In terms of practitioner autonomy, Jaques and Tolliday's (1978) model suggests general acceptance that physiotherapy managers had managerial authority in relation to practitioners, but that consultants no longer carried "treatment-prescribing authority" with rights to override treatment decisions of practitioners.

The only other detailed research evidence available at that time is from a study by Alaszewski (1977) of management arrangements for the remedial professions in two health districts, based on interviews with one District Administrator and three heads of department, and "internal

memorandum on an experimental management structure". The report describes a "DHSS-encouraged" attempt to create an integrated therapy management structure, and reports the failure of the experiment and a structure with a Superintendent Physiotherapist as managerial head of department.

Section 3: The Author's Research

Between 1980 and 1987 the author carried out four different programmes of research into physiotherapy organisation. The first was research for the Chartered Society of Physiotherapists (CSP) between 1980 and 1982. The project investigated the organisational problems of senior practitioners and newly-established District Physiotherapists and clarified the different management structures which existed at that time. The research is documented in fourteen revised and cleared field reports, which drew together field interviews with approximately thirty-six physiotherapists at different levels in different parts of the country. These formulations were discussion-tested and other structures were clarified in eight regional workshops attended by senior physiotherapists from throughout the country. The workshops were held between June 1981 and June 1982, involving approximately 130 senior physiotherapists from districts in each region (research documents on each workshop were summarised in Doc. 3300). The research was summarised and reported in a series of publications in the professional journal "Physiotherapy" (Øvretveit et al (1980) Nos. 1 - 6), and in a detailed report to the CSP (Doc. 3119).

The second programme of research was investigations into physiotherapy organisation forming part of wider field projects in four districts on the development of Unit management between 1980 and 1984. The third was a series of National Workshops at Brunel for District Physiotherapists, held between 1983 and 1987. Finally, between 1980-85 the author traced the development of professional autonomy in the profession by drawing on previous field research and reports, and published the findings in Øvretveit (1985 a).

The following first presents findings about the role and authority of district physiotherapists, and the overall management structure of physiotherapy within different districts between 1980 and 1987. Research into practitioner autonomy is then presented, drawn mostly from the 1980 - 1982 study.

District Physiotherapist Role and Authority

Initial interviews in the 1980-1982 CSP research revealed that District Physiotherapist posts had been established in the twelve districts where the interviews were undertaken. In addition, district physiotherapy management structures existed, made up of a number of physiotherapy

departments managed by the District Physiotherapist and headed by Superintendent and Senior I Physiotherapists (Doc. 3119 and Doc. 3097).

The interviews revealed variations between districts in terms of the role and authority of the District Physiotherapist. All interviewed combined their district role with the day-to-day management of one department (Notes, 10 March 1980), and all but one had full-management authority in relation to "their" Superintendents (Doc. 3097, Doc. 3090). One District Physiotherapist described her authority, "to move physiotherapists between hospitals and alter staffing arrangements" (Notes, 10 March 1980), but her budget for staffing was set by the DMT and she had no formal authority to negotiate budget levels with the DMT or district officers.

The exception was an Area Physiotherapist (single District, "designated" post) who did not have full-managerial authority in relation to the three other Superintendents in the Area (Doc. 3099 (Rev.)). Physiotherapy was organised as a district service through the Area Committee of Superintendents, and ,"all claims for funding and staff from the Superintendents are made through the Area Superintendent", who had "formal access to the Area Team". However, the Area Superintendent did not have, "authority to move staff ..... it appears a joint decision between superintendents would have to be made". (Such a committee structure is similar to those reported earlier amongst heads of physhology departments in a district). The Area Superintendent also had less than full-managerial authority in relation to senior staff within her own department. Although ,"basic grades were contracted with the Area, and could in principle be moved" (Notes, 11 March 1980), the Superintendent and consultants had agreed to develop physiotherapy sub-specialities, and senior staff had established their practices on the understanding that they would not be moved.

One District Physiotherapist role was discovered with "direct accountability to the DHA" (Doc. 3090, p 6), and "direct access to the DMT", rather than accountability to the District Community Physician or District Administrator, who then presented physiotherapy reports or proposals to the DMT (as proposed in the DHSS circular HC (79) 19).

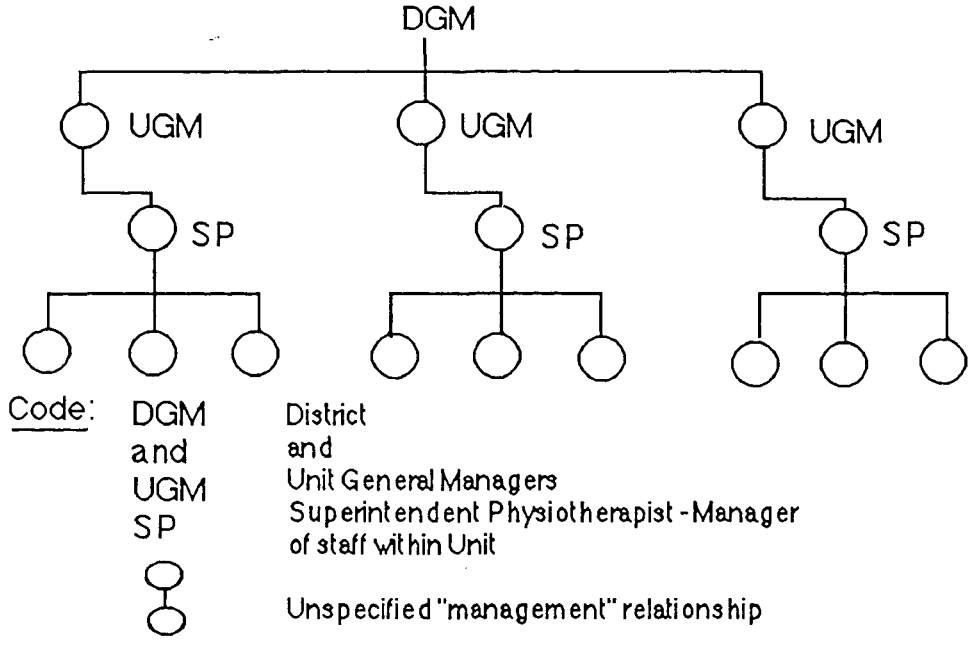
At the same time the author was involved in research into preparations for Unit Management in four districts. In one district a District Physiotherapist post had not been established, and the reasons for the post were closely questioned (Doc. 3096 and 3215). In the other districts management links were being developed between physiotherapy district structure, and the newly-emerging Unit structures. Although the research did not specify existing structure but outlined possible future arrangements, it is of relevance because it shows non-physiotherapy managers moving the balance of control from a District Physiotherapist to Unit management.

Thus in one field project the future possible District Physiotherapist role (DP) was described as "Manager of Superintendents within Units", and as "Controlling the District physiotherapy budget in the sense that the budget would be agreed with the DMT after consultations between the DP and the Units". (Doc. 3270). It was viewed as important that Unit management had some influence over staffing, whereas previously District management had decided - this represented a counterbalance to physiotherapy management autonomy and control. (The District Physiotherapist subsequently reported that this arrangement was established).

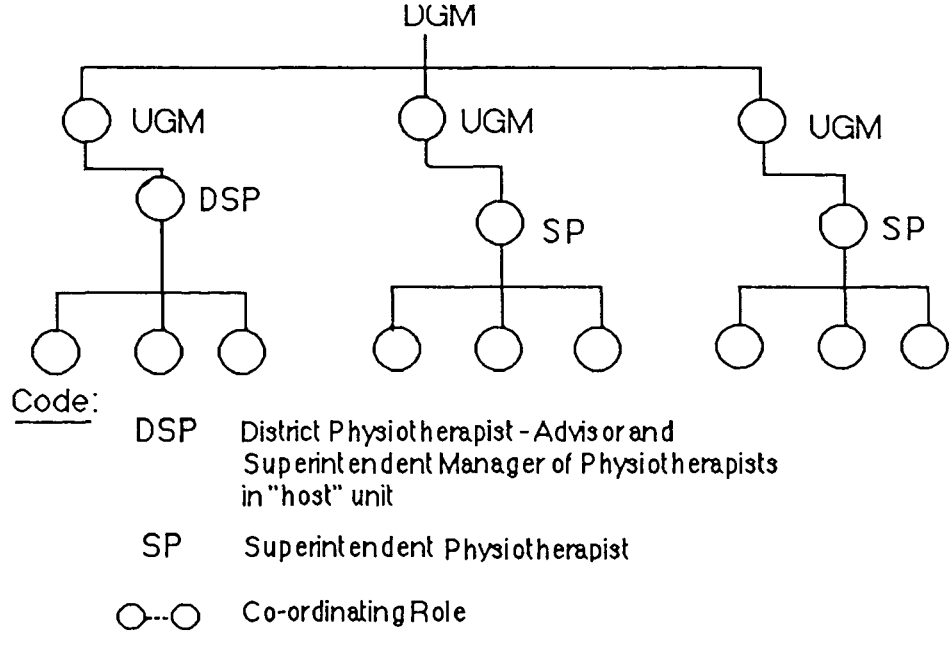
The same issue was addressed from a different perspective in another study, where it was recognised that both Unit administrators and District Physiotherapists would have personnel authority in relation to physiotherapists within Units. (Doc. 3262 p 3). The details of the authority of each were not specified in these studies, but it was recognised that a head physiotherapist in each Unit would manage all physiotherapists within the Unit, and be accountable to both the District Physiotherapist and the Unit Administrator for different matters (Doc. 3262).

Evidence of structures which were established after the NHS reorganisation in 1982 was gained from national workshops for District Physiotherapists between 1984 and 1987. District Physiotherapists reported no longer being supplied with plans and information about future developments and not knowing how and where to propose plans for extra staff; not being involved in District and Unit planning teams, and being referred by district managers to Unit teams for decisions. (Workshop Notes ,BWN.17(20/8/84)). Most reported having to get agreement from Unit management to transfer staff or finance between Units (BWN.18). The conclusions were that District Physiotherapists' authority in relation to staff had been reduced by the new Unit management arrangements. These workshops established that the management structures for most physiotherapy services in the country could be represented in general terms by one of the three models represented in Fig. 6.3 below.

Model A: Unit Services (No district role or organisation)



Model B: Unit-based Coordinated District Service



Model C: Unit-based District Managed Service

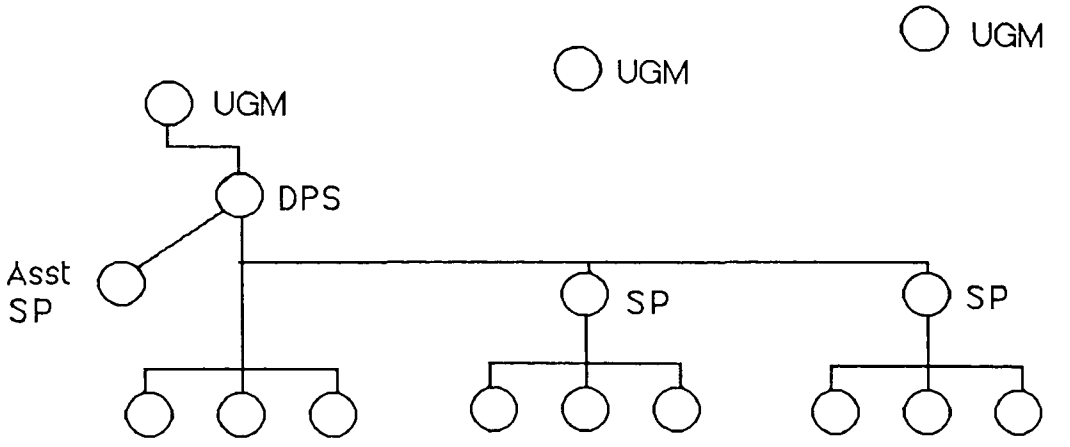


Fig. 5.3: Three Types of Physiotherapy Management Structure

Practitioner Autonomy

One of the findings of the 1980 field research was that, in comparison with their roles in the early 1970s, experienced Senior graded practitioners had considerably more autonomy, and shared the management of newly-qualified basic grade staff with Superintendents. This was partially as a result of the creation of the Senior grade in the later 1970s [Halsbury Report (1975)].

Field interviews and the later workshops established that Superintendents distinguished between Basic Grade staff, who were supervised and could be moved between specialities or were on "rotation schemes", and Senior graded staff, who usually worked whole-time in one speciality and who could not be moved. In addition, rather than all staff being directly managed by Superintendents, it was found that Senior grade staff "supervised" groups of basic grade staff within specialities and were becoming an intervening management level in the structures (C 3300).

In practice, although not formally recognised, Superintendents exercised less than full-managerial authority in relation to Senior staff in specialities (Doc. 3093). Senior staff autonomy was not only independence to practice within a particular area or group of wards, but also involved independence from case-work review by superintendents and doctors (e.g. "It would be improper to interfere with the clinical judgments of a senior practitioner" (Doc. 3093 p 3); "A Senior practitioner will not tolerate interference with the exercise of his clinical judgment. A senior regards himself as an "expert" and, as long as he acts within legal, ethical and policy bounds,

cannot be instructed by another physiotherapist, and certainly not by an outsider, as to how to treat any particular case." (Doc. 3090, p 3).

However, two Senior Physiotherapists interviewed were not clear about "the exact authority to make decisions over type and duration of treatment. There can be conflict within the profession and between members of the profession and doctors over treatment decisions and over who holds full authority for physiotherapy treatment." (Doc. 3112 p 1). They reported that in some cases "treatment decisions depend on the personal confidence and forcefulness of the individual physiotherapist", rather than on agreed and institutionalised authority. (Doc. 3112 p 4). Some seniors were also unclear about their responsibility for treatment decisions made by newly-qualified basic grade staff whom they supervised (Doc. 3100b p 3).

These issues were examined further in workshops for Senior practitioners in eight Regions between 1981 and 1982 and in 1984. (Documented in C.3300, C.3284, C.3290, C.3296, C.3297, C.3304, C.3312, Doc. 3435, and workshop notes).

The workshops revealed that physiotherapy managers usually did not fully-manage Seniors in the sense of deciding case allocation aand reviewing cases. However, this did not mean that Seniors had autonomy to decide where and how they worked. Referrals and requests, mainly from consultants, were high and Seniors were prevented from starting waiting lists and managing their own practices. "Some Seniors struggle at breaking-point under excessive workloads because they are not aware that it is Superintendents' responsibility to regulate workload. Some Superintendents abdicate their responsibility for this work, often burdening Seniors with extra demands." (Doc. C.3300, p 2). The finding was that a failure of physiotherapy managers to exercise their authority to regulate referrals resulted in practitioners' autonomy being decreased rather than increased. The large amount of work which they were required to undertake resulted in a reduction in the discretion practitioners were able to exercise over treatment decisions and location and type of work.

There were exceptions. In one workshop three practitioners reported Superintendents' exercising authority over what they viewed to be clinical decisions: "monitoring number of patients treated, organising patient lists, deciding treatment policies, and changing allocation of work". (Doc. 3296 p 3). This is the only documented evidence showing that Seniors in some districts had less autonomy than was generally reported (Doc. 3093).

The workshops revealed widespread conflict between Superintendent managers and Seniors; not so much about case-work decisions but more about management decisions which Seniors

made regarding how they ran their individual practices or their departments, where Senior staff "supervised" basic grade staff (Doc. 3304 p 2).

Summary of Physiotherapy Research Findings

The CSP field research between 1980 and 1982 established that managerial structures had existed in the past, usually with consultants in physical medicine as managers of therapy departments. In most sites managerial autonomy had developed as a result of Superintendent Physiotherapists taking over managerial duties with the agreement of consultants. The one exception was at a site where a consultant was the main user of the department, where the consultant was involved in appointments, and full managerial authority was not exercised by the Superintendent.

In all field research sites and in all the sites represented at workshops all physiotherapists employed by health authorities were grouped together for management purposes in one or more departments headed by Superintendent Physiotherapists. In most districts there was more than one physiotherapy department, each headed by a Superintendent. Where District Physiotherapist roles existed (in 115 out of 222 districts in 1981) the authority of the role over other Superintendents varied from fully-managerial (e.g. Nottingham, Mansfield) to coordinating, or "advisory".

The research established that the responsibilities and authority of District Physiotherapists varied, largely depending on the number of physiotherapists in the district (the range covered Bassetlaw DHA which employed 11 physiotherapists, to Nottingham DHA which employed approximately 110 staff). Most District Physiotherapists were accountable to District Medical Officers (DMOs) and some to District Administrators.

These findings were corroborated by a questionnaire survey of all head physiotherapists in the country undertaken by Henly and Harrison (1981). The survey showed that most heads were accountable to DMOs (who were members of the DMT); could present papers at DMT meetings, and had right of access to employing authority meetings, and some received DMT agendas and minutes.

The last phase of the author's research into management structures involved four workshops with District and Superintendent Physiotherapists between 1983 and 1984, and drew on other workshops and research into the 1982 reorganisation and 1984 Griffiths' reorganisation. The general conclusion from this work was that where District Physiotherapist roles had been created, Unit management had reduced their authority to switch staff between Units. District

Physiotherapists at more recent workshops have reported structures changing their accountability from district-level officers to Unit General Managers (UGMs), and requiring the agreement of UGMs to changes in staff allocation and to the funding of new posts. Workshop members described their structures as one of the three models represented earlier.

Practitioner Autonomy

In early 1980 practitioners were managed by Superintendent Physiotherapists, but the authority of Superintendents varied. The examples discussed in the field project workshops established that managers commonly refused to question or override experienced practitioners' case decisions, or to instruct them on how to provide a particular treatment. However, managers did commonly assign and review administrative and non-case-work duties and tasks, which caused serious and widespread problems of high workload because practitioners were unable to negotiate case-work reductions with consultants, and managers were also reluctant to do so, refusing to allow practitioners to start waiting lists (C.3300). Practitioners in the eight Regional workshops mentioned agreed that their autonomy could be characterised by the concept of "case autonomy", which is to be described in the next chapter, and subsequent workshops (1983, 28 practitioners; 1984, 36 senior managers) did not refute this description.

However, the research established that experienced practitioners had not acquired the degree of autonomy which the author had characterised as "practice autonomy" in the case of experienced psychologists.

The author's field research did not involve specifying doctors' referral authority in particular field sites, and no other evidence is available of their institutionalised authority in different settings. However, field research provided a number of examples of common practice. Thus members of workshops reported that hospital doctors usually referred patients with a "physiotherapy please" note, or left it to the physiotherapist assigned to the ward to decide which patients to treat. No examples were reported of detailed prescriptions, or of doctors requiring physiotherapists to stop treatments against therapists' own judgments.

PART 4: RESEARCH FINDINGS - NURSING

The following reports research into the nature of nursing management structures, the authority of top-level nurse managers ("profession-heads"), and the autonomy of nurse practitioners. First the main recommendations issued at the national level are presented, followed by relevant

evidence from previous research into nursing structure, and then by evidence from the author's own research into nursing organisation.

Section 1: Governmental and Professional Association Recommendations

The first comprehensive government report on nursing organisation in the NHS [The Salmon Report (1966)] proposed a management and grading structure for nurses in hospital groups. It proposed a head Chief Nursing Officer to be responsible for all nursing services and education in a hospital group, and with a place on Hospital Management Committees (HMCs) or on Boards of Governors.

The recommendations were implemented following the National Board for Prices and Incomes Report No. 60 (1968), and this led to nurses achieving institutionalised management autonomy at hospital group levels in the pre-1974 NHS. The report also proposed that various community nursing services (staffed mostly by Health Visitors, Midwives and District Nurses) provided by local authorities should be brought together under a head nursing officer. The Mayston Report (1969) considered community nursing services and its proposals were "commended" to local authorities by the Secretary of State. These were that every local authority should appoint a chief nursing officer and three levels of managers (top, middle and first-line).

The 1974 NHS reorganisation (HRC (74) 35) brought hospital groups together with local authority health services under the management of Area Health Authorities (AHA). These authorities became the state employers of most nurses in the country. The "Grey Book" (1972) management arrangements issued by central government required each of the one or more districts in an Area to appoint a District Nursing Officer (DNO) to manage all nurses in a district, and an Area Nursing Officer to provide direct "advice" to the authority. It required the DNO to be a full member of the six-member top level District Management Team (DMT).

These prescriptions are evidence of institutionalised profession-management autonomy, which was also perpetuated in the 1982 NHS reorganisation [HC(80)8]. The latter reorganisation abolished the area tier of management and created District Health Authorities (DHAs) managed by DMTs which included managerial District Nursing Officers. Notably later guidance in the Griffiths restructuring (1984) did not recommend district-level nurse managers [HC(84)13].

The importance of government "guidelines" in ensuring that certain structures are established, and the significance of these structures and of management autonomy to the interests of professions was demonstrated in the Royal College of Nursing (RCN) national campaign against

the Griffiths Report (1984) and the subsequent restructuring. The report proposed the replacement of consensus management teams, such as the DMT and RMT, by General Managers. It proposed that Regional, District, and Unit General Managers should review the need for profession-managers at their level, and that where, for example, a District Nursing Officer was appointed, they would be accountable to the District General Manager, rather than an equal colleague with direct accountability to the DHA.

The RCN mounted a public campaign to try to ensure that top level district and unit nurse managers were retained. The findings below show that their campaign failed to persuade many DHAs and DGMs, who referred to the Griffiths Report and the DHSS implementation circular to justify either the abolition of Regional and District nursing roles, or their subordination to Regional, District, or even Unit General Managers.

Section 2: Previous Field Research

Social-analytic research between 1968 and 1971 in two teaching hospital groups and five other hospital groups provided evidence of the actual structures which existed at that time in the North-West Thames Region. Rowbottom (1973 pp 119-147) reported the results of discussions with sixty nurses at ward level, eighty nurses in higher administrative posts, forty nurses in teaching posts, and the results of workshops with senior nurses from eighteen other groups in the Region,

> "Our main finding as far as nurses are concerned, is that they are almost universally (if not universally) organised in hierarchies, under the management of one senior nurse, but subject to the treatment-prescribing authority of doctors." [p.145]

The authority of the head nurse of the grouping varied according to the number of nurses managed (e.g. all nurses in a hospital group as a whole, or a single hospital or school of nursing).

> "We have found little doubt in the area covered by this research that the nurses in charge of such units are regarded as carrying full managerial roles, whatever their grade - and the grades encountered here include examples of all from Nursing Officer upward." (p 132).

The research does not report details of the exact authority of the head nurse, such as the number of nurses for whom he was managerially accountable, or the body or roles to whom he was accountable.

A literature search did not reveal any other empirical research into nursing organisation which gives evidence of management and practitioner autonomy in other areas at this time. However, the relevant published literature on nursing organisation (in particular, Carpenter (1977) and (1978), and Davis (1983)) assumes managerial hierarchies were established in most health and local authorities in the early seventies.

Research by HSORU between 1972 and 1978 [reported in Jaques, ed.. (1978) (esp. pp 80, 89, 100, 109 and 157-8] was undertaken at a number of sites across the country (unreported) and in national workshops. The conclusion of this research is that, following the 1974 reorganisation, managerial hierarchies were established by AHAs, headed by a District and Area Nursing Officer. No detailed evidence is reported, but a number of field research documents which were drawn on in the report are available.

Section 3: The Author's Research

Findings are reported from three types of research into nursing organisation undertaken by the author between 1980 and 1987. The first type was social analytic field projects into nursing organisation. The second type was national workshops for nurse managers held at Brunel, each involving representatives from 15-22 different districts, who reported and discussed organisational structures and roles within their services. Other findings are drawn from a wider range of sources, including workshops for multidisciplinary teams, and research into nursing organisation which formed part of wider research for individual districts on aspects of district and unit structures (Appendix 1, Part 3).

The social analytic field research reported is the North-West Thames Nursing Project (Hospital Nursing), the Nottingham Nursing Project (Hospital Nursing), the St Ebba's Nursing Project (Mental Handicap Hospital Nursing), and the Rhondda Vanguard Project (Community Mental Handicap Nursing Project).

North-West Thames Nursing Project

Detailed field research was undertaken by the author and other members of HSORU into the role of ward sister and other aspects of nursing structure between 1980 and 1984 at Northwick Park Hospital, Barnet General Hospital, and at St Mary's and St Charles Hospitals in Paddington, as part of a project into nursing organisation for the North-West Thames Region. The research provided evidence of the extent of practitioner and first-line manager autonomy, and of the overall nursing management structure. The research involved interviews with ward sisters, their managers and

registered and student nurses at each site, and six, one-day workshops with ward sisters and their managers within the Region.

Repeated interviews and revisions of reports were undertaken by the author with eight ward sisters, four staff nurses and two student nurses, on Orthopaedic, General Medicine and Surgery wards, at Northwick Park Hospital during 1980. (Docs. 3122, 3120, 3125, 3127, 3121, 3132, 3134, 3131, summarised in Doc. 3144).

A key finding was that ward sisters had, and exercised, authority to allocate tasks in detail and review the work of junior nurses. Although in principle they had authority to turn down unacceptable nurses assigned to the ward, or to ask that they were removed, no instances were found where this had happened, mainly because sisters were always understaffed and they took the view that, "a bad pair of hands are usually better than none at all".

All interviewed held the view that the ward sister, "had direct authority to arrange for the nursing work of the ward to be completed by, (a) arranging staffing through off-duty rotas and on the day, (b) allocating work, and (c) checking completion of work." (Doc. 3144 p 7). Differences were found in the degree of autonomy of State Registered Nurse (SRN) practitioners and State Enrolled Nurses (SEN) and student nurses. This difference was described in terms of a distinction between allocating and delegating work, and was apparent in the way sisters were observed to check completion and standards of work. Ward Sisters were found to divide the work of the ward into,

"- tasks she always or usually carried out herself,
- tasks she gave to a sufficiently able nurse, but checked for completion,
- tasks she could safely give to most nurses, and would not go out of her way to check completion because it was clear if the task was not done."

Evidence of practitioner autonomy and ward sister authority was gained from observation of daily meetings of nurses on the ward (Ward Reports or Shift Handovers). Here all ward sisters were observed to, "allocate work to nurses ..... check that certain tasks had been completed, question nurses on actions they took", as well as to question nurses on patient states, etc. (Doc. 3144 p 11). In three observations of ward routines (each 10 hours) at Northwick Park in 1980, the author observed ward sisters regularly assign tasks in detail to all nurses on the ward. (At St Ebba's mental handicap hospital in 1985 the author also observed charge nurses and ward sisters issuing detailed instructions to all grades of nurses on the ward and reviewing nurses' patient programmes in weekly ward meetings).

In terms of the institutionalised authority of managers which constrains practitioners' autonomy, the authority of ward sisters at the three sites of the project was agreed and specified to be to,

"- veto the selection of a nurse,
- assign work in as much detail as she judged to be necessary,
- make and record formal appraisals of nurses' performance,
- decide what training was required and recommend,
- initiate transfer or carry out defined disciplinary actions."

Although ward sisters had formal authority to assign tasks to all nurses on the ward, to check completion, and to question in detail, they only regularly did so with student, assistant, some enrolled nurses, and newly registered nurses,

> "Work is usually undertaken by nurses in the absence of explicit communication between the ward sister and nurses. They take up the work because they "know" it is required to be done. If they did not perform this work, even without direction by the ward sister, the ward sister would think that they had failed to perceive and act on need." (Doc. 3144 p 72).

Ward sisters reported not having to check or assign tasks to experienced registered nurses (SRNs), who could be left to "get on with the work without supervision". Thus, although the formal authority relationship between ward sisters and all nurses on the ward was the same, authority to assign work in detail, check, and closely question did not need to be exercised with SRNs. It is thus only in a particular sense that SRNs could be said to have greater practitioner autonomy, which was certainly not formally recognised. Their authority relationship to all nurses on the ward was characterised as fully-managerial.

A further finding relevant to the question of nurse practitioner autonomy was that no instances were reported where consultants or other doctors had overridden any sister's task-assigning authority and required nurses to ignore a sister's instructions.

> "The ward sister instructs staff to carry out work, and problems in allocating or completing work will be contained within the nursing hierarchy ..... even when a consultant requires specific actions to be carried out, he will leave it to the ward sister to judge who does it."

One of the main problems reported by ward sisters was, "lack of direct formal authority to ensure services are provided from pharmacy, catering, linen, central sterile supplies, domestics,

maintenance, and other hospital service departments", and examples of a network of informal contacts, bargaining, and borrowing arrangements were found to operate. Thus ward sisters were found to have and to exercise a range of types of formal authority in relation to day-shift nurses on the ward whom they managed, but their ability to run the ward depended on "informal authority" and relationships with other wards and departments. Staff nurses left in charge reported difficulties because they did not have "informal authority" and relationships with other departments.

The main conclusions of the first phase of the project were that, although ward sisters had, and exercised, formal authority to assign tasks and frequently (minimum daily) review the work of nurses on day shift, it was unclear whether they had authority to refuse to accept or transfer unacceptable nurses, and their authority in relation to other departments was largely informal. Reports and observations showed that nurses on the ward were closely supervised by the sister. The only exception was in two wards where nurses were allocated groups of patients and nurse practitioners were able to exercise more autonomy in deciding the order in which they undertook routine tasks.

A combined research report (Doc. 3161B) drew together the findings from each site and outlined a future possible ward sister role and the required explicit and agreed authority relationships. This report was discussed by 83 ward sisters and their managers at workshops at each site, and revised and adopted by senior nurse managers at two two-day workshops at Brunel University. As a result the Regional Nursing Officer and District Nursing Officer arranged to institute the role at St Charles Hospital, Paddington (Doc. 3308).

The subsequent interviews and analysis of nursing policies which were carried out to establish this role at these hospitals provide evidence of the precise authority of ward sisters at one hospital in 1983. The main findings of this research (summarised in Doc. 3424) were that the actual authority of ward sisters was,

"In Appointment of Permanent Ward Staff

- Attendance at interview, to propose, and veto unacceptable nurses."(p 3);

"In Recording Appraisals of Performance

- Appraisals of performances of permanent staff are recorded after discussion with them, at yearly interviews, according to nurse personnel procedures. For new staff the same procedure is operated at 8, 18, 30 and 42 week intervals." ("Nurses have right of appeal to next higher level of management."(pp 6 and 7);

"In Upgrading, changes to pay, or other rewards

- only to recommend an Enrolled Nurse is promoted to Senior Enrolled Nurse after three years' experience:" (p 8);

"In Disciplining, Transfer, Suspension or Dismissal

- to recommend on each to a Senior Nurse, who has authority to issue a verbal warning and the first written warning. After this stage the Senior Nurse has authority to recommend further action to the Unit Director of Nursing Services, who has authority to issue a second and/or final written warning and to dismiss." (pp 9 and 10).

In summary, the research provides evidence of nursing management autonomy in districts in one region between 1980 and 1984, in particular the control of appointment and dismissal of nurses by nurses, and ability to institute changes in the role and authority of first-line managers (Ward Sisters). It shows details of the ward sisters' authority in relation to nurseson day shifts, and evidence of the informal autonomy of top-level practitioners (SRNs) on hospital wards.

Field Research into the 1982 NHS Reorganisation

The author's field research involved group discussions with sixteen senior nurses in Nottingham DHA over the period October 1980 to July 1982 which helped to specify a new nursing management structure for the 1,330 nurses employed by the Authority (ref: Doc. 3265 described in DHA Doc. N.011).

In this structure the DNO had full managerial authority over senior nurses who, in turn, were full managers of nurses within their Units and Divisions. A specific example of the DNO's authority was his decision to change the structure and reduce the number of nurses in middle management in order to reduce the nursing budget to meet cuts to the DHA's financial allocation. The proposals were put to the DMT for information, and agreed with no opposition by the DHA.

Evidence of the authority of the DNO role in relation to the overall management of the district services was the creation of a separate Maternity Unit of management, on the basis of the DNO's argument that midwifery and child services required separate management. During the period of reorganisation the researcher observed three DHA meetings, which were normally attended by the DNO, where the DNO's proposals for the new nursing structure and comments on other aspects of the DHA's restructuring and services were acted on. Other researchers' field research in Newcastle and Exeter showed that the DNO's authority and role in these districts at that time were similar [Kinston and Rowbottom (1983)].

Mental Handicap Hospital Nursing

Evidence of practitioner autonomy and first-line and middle management authority in another area of hospital nursing is also provided by research into Nursing Officer and Ward Manager roles at St Ebba's Mental Handicap Hospital between 1984 and 1987.

General Nursing Structure

Interviews and workshops revealed that nurses in the hospital were managed as a separate professional hierarchy headed by the Director of Nursing Services for the Unit (himself accountable to the District Nursing Officer until 1986), but managed on "a day-to-day basis" by the Assistant Director of Nursing Services (Asst. DNS). Discussions revealed that this hierarchy was a system of formal "reporting relationships",and that Nursing Officers (NO's) were unclear about their authority in relation to ward managers, and the limits to the discretion they could exercise; "higher management constantly changed the limits or overruled decisions." [Workshop Report St E's FN.01(1986) p 4]. All felt that they had "insufficient disciplinary powers". (Workshop Minutes 16/4/86).

It was clear, however, that the DNS had formal authority to appoint, dismiss, and to assign and review work (i.e. managerial authority in relation to all nurses in the Unit). The new District General Manager who was appointed in 1985 established a new structure without a head District Nursing Officer (Merton and Sutton Management Arrangements (1985)). The Unit General Manager for the hospital decided not to have a Director of Nursing Services for the Unit, thus reducing management autonomy to the level of the wards.

Discussions with staff in the hospital, observations of nursing meetings and analysis of minutes revealed that an informal system of punishments and rewards was operated by nurse managers. Firstly, the Asst. DNS had authority to move staff between wards, mainly for "training purposes". Staff who complained or "made trouble" were either moved more frequently, or to wards which were viewed as low status or hard work.

Secondly, many nursing staff were married to other nursing staff in the hospital, and organised their shift work to coincide. Nursing Officers and the Asst. DNS could make domestic routines more difficult by exercising their authority to arrange shift rotas and holidays according to administrative criteria rather than personal requests. Nurses reported knowing that they had "done something wrong" when their preferred shift patterns were changed without explanation.

Thirdly, overtime payments were an important source of additional income for nurses who did not have other work outside the hospital. Wards were deliberately "short-staffed" by some NOs at peak overtime payment periods as a way of providing direct rewards to certain staff, who were used to "coping with few staff, especially at week-ends and bank holidays".

Fourthly, many staff had jobs outside the hospital, which could be disrupted by nurse managers insisting on certain shift work, or instituting disciplinary procedures for repeated absence. Nurse managers knew of this practice and only exercised their formal authority when staff "made trouble". Following the appointment of the Unit General Manager in 1986, these practices were "uncovered", mainly because of the need to reduce the over-time budget. [Nurse Minutes, Oct 1986].

In the absence of clearly specified formal authority, nurse managers used the limited formal authority which they had to move staff and organise rotas to operate an informal system of punishments and rewards to control staff. Finally, on the question of practitioner autonomy, ward managers reported having and sometimes exercising authority to assign and review tasks. [Ward Managers Workshop (1986)].

Community Mental Handicap Nursing

Evidence of practitioner autonomy in one field of community nursing was gathered in research into the role of community mental handicap nurses in one Welsh district between 1985 and 1987. Research into other multidisciplinary teams for mental health, mental handicap, drugs and alcohol, child and family, and terminal illness services shows similar roles and organisation as for other community nurses. (No research was undertaken into midwifery, or health visiting).

The Community Mental Handicap Team in the Rhondda was established to coordinate community practitioners of different professions employed by social services, health, education and voluntary agencies. Initial interviews and workshops [documented in RVFN.01 (1986)]established that the three community nurses were fully managed by a nursing officer, who was accountable to a community nurse manager in the health authority mental handicap unit. The team coordinator (a social services appointment and social worker) had no explicit and agreed authority in relation to the nurses, and reported problems in getting nurses to undertake team work.

In effect a community nursing service was managed and operated independently of the community multidisciplinary team. Nurses were concerned that, by agreeing to be managed by the team coordinator as well as by a "nurse superior", they would be forced to take on more "non-nursing work" and would lose their "specialist nursing expertise and identity". [RVFN.02 (1986)].

The management arrangements which were finally specified and agreed were accepted by the nurses and the health authority because they provided "protection" and "professional support" for the nurses. These arrangements show the extent of nurse practitioner autonomy in the team:

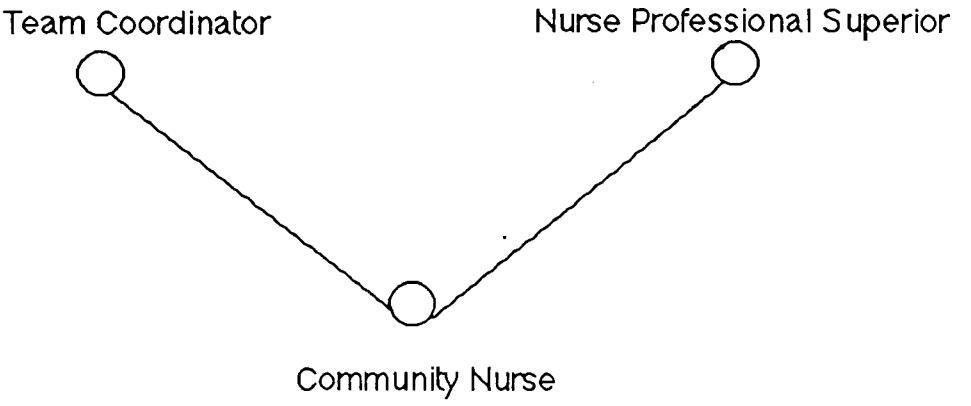


Fig. 5.4 Joint Management of Nurse Practitioner in Multidisciplinary Team

The authority of the Team Coordinator (TC) and Nurse Professional Superior (NPS) was agreed as:

"1. The TC and NPS agree the role description of the nurse practitioner, the type of which is legitimate and general guidelines as to the time allocated to each type of work.
2. The TC then has the authority to allocate tasks within these agreed parameters, and to review work.
3. The techniques and "pathway" are reviewed by the NPS. but he is not authorised to allocate specific tasks." [RVFN.03 (1986)].

In this area, then, community nurses were originally fully-managed by a nurse manager. Work in the community meant that their de facto autonomy was greater than for the hospital nurse practitioners considered earlier, but the formal authority of the nurse manager was the same as for the ward sister. The creation of community multidisciplinary teams led to work being allocated which reduced their autonomy to decide order of visits, duration of case involvement, and type of work. This was resisted, but an arrangement was finally agreed which did reduce practitioner autonomy.

Research into multidisciplinary team organisation (listed in Appendix 1) showed similar arrangements being adopted for community nurses working with other client groups in other areas. However, the research into the one team presented above is the only documented evidence of such arrangements being agreed, instituted and operated.Chapter 6 ,to follow, summarises the above findings in terms of practitioner and management autonomy.

PART 5: RESEARCH FINDINGS - SOCIAL WORK

Most of the evidence presented below is from government recommendations and social-analytic research which was not carried out by the author. The author did not undertake systematic long-term field research into management structures in social work, but did have considerable involvement with managers and practitioners in social services in various projects on other aspects of organisation. Most of the author's findings which are reported were gathered during a two-year research project sponsored by the British Association of Social Workers (BASW) to develop record systems and improve social work practice. This involved field research in five local authorities with eight social work teams and managers, and a series of workshops between 1985 and 1987 in local authorities (Appendix 1, Part 4). In addition a series of one- week workshops on organisation for managers in residential services was carried out (March and November 1983, documented in workshop notes), and research into multidisciplinary team organisation also made it possible to investigate practitioner autonomy in different settings.

Section 1: Government Recommendations

The Seebohm Report (1968) and the Local Government Act of 1970 recommended that qualified social workers and other social services workers in public welfare services be employed by local authorities and managed by Directors of Social Services Departments.
(Directors also managed occupational therapists, home helps and other workers who were not qualified social workers. (In 1976 one large department managed 8,000 home helps, 8,000 residential staff, and 2,400 social work field-workers and managers. [HSSJ (1982)]).

Central government proposed that Directors be qualified social workers, and that the Secretary of State was to be consulted in drawing up short lists for appointments. Both documents recommended that special committees of authority members be created to deal only with social services matters, with the implication that Directors would be accountable to these committees as well as to Chief Executive Officers. Few further details of relevance to the subject of management

and practitioner autonomy were proposed, although the Seebohm Report did advise that, "The career structure of the social services departments should allow a proportion of posts for highly-skilled practitioners to advance in salary and status". (Also proposed by the BASW Career Grade Working Party in 1975).

Section 2: Previous Social-Analytic Research

Evidence of the management structures which were created as a result of the 1970 Act, and of the management autonomy of the profession is provided mainly by reports by researchers using social-analytic research methods.

Rowbottom, Hey and Billis (1974) defined a "managerial" role as one with full accountability for subordinates' performance, and authority to veto selection, assign tasks, appraise performance and initiate transfer. They defined "hierarchy" as "a structure of successive managerial roles", and reported,

> "A striking observation from our own project work is that nearly without exception the members of the staffs of SSDs with whom we have explored this question over the past years have firmly accepted the present structure of SSDs as fundamentally hierarchical in the sense defined above. They recognise, for example in the role of Director, full accountability for all that takes place within the department, and full accompanying rights to determine the selection of staff, appraise their performance and react accordingly. They also recognise his right to prescribe their work as needs be within the bounds of given statute, regulation, and policy." (p 29).

No detailed evidence supporting this conclusion is provided, but the researchers did note that,

> "We have raised this question in conferences and field projects with something of the order of seven hundred staff from some 120 of the 174 authorities in England and Wales. Although the majoriity of these staff held positions equivalent to senior social worker status or above, those of lower status formed a significant group in themselves, and also concurred with the view quoted when this issue was raised with them."

A judgment of the status of these conclusions would be easier if the researchers had provided more details of the field research undertaken, such as numbers of interviews, reports, etc. Social-analytic field research projects involve a far more rigorous series of checks and tests than the

"concurrence" of members attending a conference with a model of organisation which is presented to them(Appendix 2 and Rowbottom(1977)), but no details of the field research were provided. One way of checking the reliability and accuracy of the findings is to refer to other researchers' findings.

These above conclusions were criticised by Whittington and Bellaby (1979) because the way in which the conclusions were formed was not described. ("This method does not lend itself to standard description and by the same token it is difficult to describe"). Related criticisms were that the conclusions arose more out of theoretical concepts about management and hierarchy than from empirical research, and that the conclusions had a normative and prescriptive bias towards managerial hierarchies.

For the purposes of this presentation of research evidence, the criticism of levels of work theory is not relevant. Researchers always use theory and assumptions in empirical research to detect divergencies as well to find confirming instances. It is possible that Rowbottom et al were "blind" to forms of organisation other than a managerial hierarchy, but social workers and social work managers were not.

As Whittington and Bellaby note, the research by Rowbottom et al, "Has been the most extensive so far undertaken in British personal social services", and is one of the few sources of evidence on management and practitioner autonomy. Further, for the purposes of this thesis the criticism of the normative and prescriptive bias of the reports is less relevant if professionals and managers do indeed act on them and institute structures influenced by the concepts as some critics feared. The judgment by critics that "The influence of the Brunel Unit on the re- organisation was rightly claimed" [Draper and Smart (1974) p 454] and that the research is acted on, is, from the point of view of this thesis, an important independent assessment that the models describe structures which exist, regardless of the merits or disadvantages of such structures.

Research since 1974 was referred to by Billis et al (1980) who reported that it provided further evidence that a managerial structure existed in social work. They reported that their previous conclusion that the central employment structure of SSDs was a managerial hierarchy was unchanged:

> "Senior staff and ultimately one person, the Director, carried accountability in principle for everything that went on, and carried the authority, if required, to zoom into all matters resting with more junior staff, however "professional" such matters might appear to be." (p xi)

These conclusions were substantiated by, "field projects in some fourteen local authorities in England and Wales; (five Counties, eight London Boroughs and two Metropolitan Boroughs)" and by workshops involving "some two thousand senior staff, drawn from a wide variety of posts in virtually every one of the hundred and sixteen SSDs in England and Wales." (p. x).

This research, and the author's observations in the course of research into social work records and practice, provide evidence of the general type of management structure in social work. However, no detailed research evidence is available on the authority of Directors of Social Services Departments. There are a number of examples reported in the press of Directors dismissing staff without reference to Social Services Committees of members. There is no research evidence of the authority of Directors over local authority decisions outside their departments, or examples of decisions which have been influenced by Directors, or of the limits to Directors' autonomy imposed by Social Services Committees or Chief Executive Officers.

Section 3: The Author's Research

Social Work Practitioner Autonomy

Evidence of the institutionalised autonomy of social work practitioners is provided by professional association codes and local authority policies and procedures which limit practitioners' autonomy in certain situations, and by social-analytic research reports of the institutionalised authority of social work managers and of other professionals. The author's research involved workshops with social work managers, field research on multidisciplinary team work, and field work on record systems and social work practice, which provided access to and involved investigation of departmental procedures and team leaders' authority.

Limits to Autonomy

In common with other professions, the professional association's code of ethics [BASW (1970), BASW (1985)] gives general guidelines about ideal professional conduct, as well as ruling out certain actions. In practice, however, it does not limit the autonomy of practitioners as there is no state registration which refers to the code. Membership of the professional association is not a requirement of employment and practitioners' autonomy is neither limited by, nor protected by, this code. This is illustrated by the many instances observed by, and reported to, the author, of social workers disclosing to other professionals information given in confidence by clients without clients' permission, which is contrary to the professional code. [Øvretveit (1986a)].

The procedures which are required to be observed by practitioners are more numerous and detailed than for the other occupations. Research into social work recording revealed practitioners' concern to record in detail to show that they had followed the many policies and procedures governing legal, financial and other actions [Øvretveit (1986a)] Most local authorities have detailed procedures to be followed for suspected child abuse, parental access to children in care, court reports, six-monthly reviews of children in care, mental health sectioning, and, as a result of the author's work, procedures for client requests for access to case files and case file recording standards. A variety of other detailed policies was reported at workshops led by the author on client access and recording, such as instructions preventing practitioners from sending assessments to clients or requiring standardised assessments. All such procedures represent institutional limits to practitioner autonomy.

The autonomy of social work practitioners is more restricted as a result of these regulations than the autonomy of practitioners. in the other occupations of this study. In addition, social workers are frequently expected to account for and justify their actions in courts of law, and in recent years have been widely criticised for their actions in suspected child abuse cases. Many regulations arise from statutory Acts of Parliament which require local authorities to carry out certain actions (e.g. child-care Acts). The role of practitioners as direct agents of state policies, therefore, constrains their autonomy in many situations.

Practitioner autonomy is further limited by the institutional authority of managers to review cases and override case decisions, and to assign tasks in detail as required. Examples of this authority regularly being exercised were noted in the author's field research in eight social work teams over two years [Øvretveit,(1985b) and (1986a)], and from seven national workshops during this period. Thus, for example, two team leaders in Hillingdon and one in Kent were observed to carry out monthly supervision meetings with their practitioners, where they would direct work and would close cases where they judged practitioners to be making little progress. Team leaders in the eight project teams signed assessments and three-monthly reviews to indicate that they authorised the actions.

Another example of detailed supervision arrangements was the policy of Dorset Social Services for Team Leaders to review all cases three weeks after referral and to decide whether to close the case or to carry over into a practitioner's long-term case load. Three-monthly reviews were also undertaken by Team Leaders. [Dorset Manpower Review No. 19 (1986)]. Area Managers (7 out of 10) and Team Leaders (7) confirmed that this supervision was carried out, and made arrangements at a workshop led by the author to use case record forms for the purpose of reviews.

Similarly, Islington Social Services Team Leaders reported operating the policy of monthly case supervision which covered case closure, allocation, and instructions on detailed tasks (Workshop Notes 2/3/87),

> "Each piece of work will be discussed in a systematic way in supervision. This includes cases, project developmental and group work." (4.1.a).
> "An essential task in supervision is agreeing and sanctioning the worker's plans in respect of a piece of work, monitoring whether plans are being adhered to and, if not, what new plans need to be developed." (4.1.b).
> "All pieces of work will be reviewed periodically, particularly in relation to the appropriateness of the work remaining allocated. Supervisors will keep records of these discussions and of action to be taken so that these will be available to other managers covering in the absence of the supervisor." (4.1.d).
> "Frequency of supervision will relate to the level of experience of the worker and will be no less frequent than once every three weeks.
> Where there are continuing difficulties in a worker's qualitative and quantitative performance, there may then need to be recourses to the provisions within the Departmental and Council procedures as set out in the staff code." [Disciplinary procedures (4.3)]

Finally, one social work department in Scotland had provision in its client record system for a record by the team leader of their instructions to the worker, as well as the worker's assessment. It was reported that team leaders regularly instructed workers to take actions which differed from those proposed in the workers' assessments. Other research provides evidence that practitioners do not have autonomy over case decisions, should team leaders decide to exercise their authority. [Parsloe (1981), Glastonbury, Ed. (1982)].

With the transfer of health service social workers to local authorities in 1970, doctors and other health service staff in most cases lost direct institutional authority over social work practitioners. However, depending on the situation and agreement between authorities, doctors often continued to assign work, even though their authority was not institutionalised.

PART 6: RESEARCH FINDINGS - MEDICINE

Most of the evidence reported below is from government and health authority documents, and from research documents produced by other researchers. The author did not undertake long-term and systematic field research into medical organisation, but was involved with other researchers in field visits and workshops on the subject. The findings reported are details of the organisation of doctors employed by NHS health authorities and working in hospitals. No research is reported on the organisation and autonomy of General Practitioners contracted by Family Practice Committees.

In view of the subject of the thesis, it is notable that less detailed field research was undertaken by the author and previous researchers into medical organisation. There were and are as many, if not more, problems in medical organisation and issues surrounding professional autonomy,as in any of the other professions investigated. One manifestation of medical autonomy is the ability to avoid outside investigation, and to contain problems within the profession locally and nationally.

Section 1: Government Reports and Recommendations

The first "Cogwheel Report" (1968) and the accompanying circular which "encouraged" its implementation (HM (68) 67) proposed a structure for profession-management within hospitals: "divisions" of specialities in one hospital or a hospital group (e.g. all surgeons), with a chairman (elected in Scotland, appointed in England) to manage and organise services provided by the speciality. Representatives from each division (not necessarily the chairman) formed Medical Executive Committees (MECs). Subsequent "Cogwheel Reports" (1972, 1974) noted variations in arrangements and in the effectiveness of the various committees which were established. It was recognised that individual consultants with their own "firms" of junior doctors had few incentives to group together in divisions and even fewer to operate divisions as management entities.

The principle of "clinical freedom" and the organisational consequences of this freedom was recognised in the government guidelines for the 1974 reorganisation. The principle of "clinical freedom" was viewed as preventing consultants and GPs from being made accountable to one or more "profession-managers" with managerial authority. (Grey Book (1972), para. 1.18: (they)

"work as each others equals and they are their own managers").

However, central government and employing authorities required some form of medical management and organisation, and the wider use of the "Cogwheel" divisions was recommended. The only other specific proposals were for involving medical representatives in District Management Teams. The 1982 reorganisation documents also did not make recommendations about medical management, but did seek to involve doctors more fully in district management structures by proposing that Unit Management Teams involved medical representatives (HC (80) 8).

Section 2: Previous Field Research

Given the lack of formal central government recommendations, and the general nature of the proposals which were made, what structures did various health authorities adopt which institutionalised the autonomy of doctors as a group, and institutionalised their group authority within the organisation?

Field research reported by Rowbottom et al (1973), presumably reflecting the concerns of the time, was more concerned with issues of individual consultant autonomy and authority than with group management. However, forms of organisation were reported, drawn from four three-day conferences, involving "some three dozen consultants from various specialties". One type was where a "self-governing" group of consultants formed a medical staff or advisory committee to, "coordinate their activities, exercise mutual constraint, and resolve how they are to share out what are inevitably limited resources", and to, "form and express a strong and coherent view on any matters of concern so as to influence the decisions of the RHB, Board of Governors, or HMC" (p 93). A chairperson/spokesman elected by colleagues chaired and represented the group. The second type described was where a hospital authority appointed an officer to monitor and coordinate individual consultant practitioners and their services. Rowbottom (1973) reported that these roles were performed by a variety of senior Hospital Management Committee (HMC) officers, such as Group Secretaries, Treasurers, appointed Medical Administrators or elected Chairmen of MECs. (p 82). No examples were given of either type of structure and it is not clear whether these descriptions were of existing structures or proposed models.

One example of group management is documented in a 1972 research report (Doc. 1220, A3). The research was undertaken at the Westminster Hospital Group, and was based on discussions with, "60 consultants in the Group and cleared by them for consideration in the MEC". The report described an organisation of groups of medical consultants in speciality "Cogwheel" committees,

with chairmen who represented members' views about the use of resources to the Board of Governors. A Medical Executive Committee of speciality representatives made additional recommendations to the board about the balance of resources requested across specialities. It described how the sub-committees of the MEC exerted a self-regulating mechanism over the way in which members used resources, and established common policies affecting all their members,

> "Thus, for example, if an anaesthetist cannot agree with his colleagues on the content of anaesthetic trolleys, he has to justify his differences to his colleagues. This will usually lead to accommodations one way or the other, but finally, of course, the individual anaesthetist has the right to have his trolleys set out the way he requires."
>
> (Doc. 1220, B.36).

Details of the second type of structure mentioned earlier for monitoring and coordinating individual consultants are not given. It was noted that, in 1972, in this hospital group,

> "Although the consultants accept that ideally there should be some monitoring of consultants' activities to ensure that they conform to the spirit of their contracts, there is no consensus of which of them should be given the job of doing this, and in general it was felt that no one consultant could be given the job and it must be left to the good sense of the consultant group as a whole to undertake it." (B.39).

Following the 1974 reorganisation, social-analytic field research on medical organisation involved, "field work with consultants in a London Area and seven workshops", in 1975/1976 (Doc. 1956), and three workshops in 1976/1977, and was reported in Jaques Ed. (1978) and Cang (1978) (Doc. 2070 a). Jaques (1978) described District Medical Committees which were made up of consultant representatives from speciality committees (usually based on "Cogwheel" divisions), and GP representatives from Local Medical Committees. District Medical Committees elected one consultant and one GP representative to the District Management Team, which also included a medically-qualified District Community Physician concerned with epidemiology and health service planning. [Jaques, Ed. (1978) p .317]. Such a structure provided medical representation at the top management level in districts, and, combined with Area Medical Advisory Committees which provided direct advice to employing authorities, institutionalised medical influence over a range of health service decisions and plans.

Details of structures which existed were not presented, but it is reported that workshops confirmed that the models described forms of medical organisation in many districts at that time, or influenced the formation of such organisation. The elected representative structure ensured that

influence was largely one way - from the profession to the management bodies. A number of examples confirms that the self-regulatory function of the medical structures failed when difficult decisions about scarce resources had to be made. [Bevan et al (1980), p 270; Brown (1979), p 140]. Research into medical structures in the 1982 reorganisation [Harrow DHA Docs. 3206, 3224, 3260, 3276, 3278; Exeter DHA, Docs. 3212, 3287, 3302; Newcastle DHA, Doc. 3139] provides further confirmation that the structure described was instituted in three districts and mainly worked to channel the "medical view" into Unit and District Management Teams. Representatives from divisional and DMC groups were both expected to help to form and represent the views of the groups to management teams, and, as members of these teams, to communicate management proposals and decisions to doctors in the groups and to try to gain their agreement and commitment.

Practitioner Autonomy

The nature of the group management "collegiates" and the role of the "head-profession manager" (the DMO) can be understood by reference to research into the autonomy of individuals working in different medical practitioner roles.

The first detailed evidence available is from field research reported by Rowbottom et al (1973), involving,

> "Intensive field-discussions with sixty consultants (from five hospital groups), eleven junior hospital doctors of various grades (from three hospital groups) and seven general practitioners (from three hospital groups). In addition, project formulations have received discussion and testing in four three-day research conferences, each involving about a dozen consultants from a number of different hospital groups in the North-West Metropolitan Region, and from a wide range of specialisms." (p 74).

This research established that three main sets of constraints limited the autonomy of hospital consultants

(1) the norms of professional conduct;
(2) civil and criminal law;
(3 the conditions implicit in his contract:
  (a) implicit minima on the quantity and quality of work to be carried out (number of sessions attended, patients seen, etc);
  (b) implicit minimum standards of general behaviour." (p 77).

The precise degree of professional discretion exercised by a number of consultants in the research was agreed to be,

> "(1) Deciding on all matters to do with the treatment of individual patients - priority of examination or treatment or advice, clinical investigations necessary, form of treatment, referral to other consultants, referral to medical social workers, admission to hospital, outpatient examination, discharge, optional post-mortems; also when to decline a request to see a patient because the disease is outside his area of competence or because he has insufficient time to make a true appraisal of it;
> (2) Deciding what clinical information to record in patients' records; to communicate to the patient, to hospital staff or to the referring doctor;
> (3) Deciding what training to give to junior medical staff;
> (4) Deciding what clinical research or development work to undertake;
> (5) Deciding what work to carry out on hospital or professional working parties or committees (as invited);
> (6) Deciding when to accept invitations to lecture to nurses (although specific contracts are sometimes made)." (p 76-77).

This evidence shows that, in the hospitals studied, consultants had a wide degree of discretion over both clinical matters and how they ran their service, as well as authority in relation to a variety of hospital staff. (Other sections of the chapter present findings on the details of consultants' treatment-prescribing and referral authority in relation to practitioners in the other professions.) It was agreed that the discretion was not delegated by a superior manager who could retract or modify it if they wished.

The authority of various roles in relation to consultants was described as "both a monitoring and coordinating relationship and a sustaining relationship", in order to monitor these limits and coordinate consultant services (p 82). For example, in one project an appointed Medical Administrator had authority in relation to consultants to,

> "- discuss and negotiate possible permanent changes to bed allocation with medical staff;
> - authorise temporary transfer of beds from one speciality to another, in emergency situations;
> - participate as a full voting member in the appointment of consultants' junior doctors;

- investigate and report on all complaints concerning medical staff directed to him by the Group Secretary." (p 83).

No roles were reported from field research or workshops as having greater authority than this in relation to consultants.

The research also provided details of the autonomy of junior doctors two years after qualification. As well as contracts with more detailed and constraining limits, "the consultant is accountable for the work of his juniors in all its aspects, he may prescribe that work, and he provides formal assessments of the capability of the junior." (p 87). Rowbottom reports that,"We have found solid confirmation both in Regions and in Teaching Hospitals that the relationship between the two (consultants and junior doctors) are clear and straightforward superior-subordinate ones." (p 87). He describes the authority of Registrars in relation to House Officers as "supervisory authority". (p 88).

Since the above research in the early 1970s no sustained and extensive social-analytic research has been undertaken. However, a variety of projects and workshops since has not disproved the findings, but has provided evidence of more recent constraints on consultant autonomy. (Two national workshops in 1977, four between 1978 and 1980, and others between 1980 and 1985).

Section 3: The Author's Research

The author did not undertake systematic and long-term social-analytic field research into medical practitioner autonomy, but was able to investigate the subject in the course of research into multidisciplinary team organisation.

Field research into mental handicap hospital organisation provided some direct evidence. The researcher worked with three consultants to formuate their different unit policies which were subsequently agreed by the DHA. These policies authorised consultants to decide access to multidisciplinary record systems, the format of the records, the admission and discharge of residents, the frequency and conduct of case conferences, and the use of residents' benefit payments. [St Ebba's Operational Policies (1985)].

Direct evidence of the practice autonomy and collective power of medical consultants is provided by the author's research into community mental health team organisation (Appendix 1, Part 6). In all the teams of the research, apart from mental handicap teams, consultants would not agree to be

bound by team operational policies, and in particular by proposed policies on case referrals to the team.

Traditional arrangements at all the sites before the teams were established were that GPs referred people with mental health problems to the consultant psychiatrist of their choice, who undertook a psychiatric assessment and treatment, or referred the patient to another mental health professional.

DHAs had established Multidisciplinary Community Mental Health Teams to provide a mental health service to a defined community. Consultant psychiatrists and GPs had assumed that referral arrangements would remain the same, and that consultants would "lead" the teams. However, DHA policies and team members' views led in most cases (especially Sunderland (MDT.07), Macclesfield (MDT.12), Bolsover (MDT.10) and Chesterfield (MDT.13), to the non-medical members of the teams agreeing a policy of members receiving referrals directly from GPs and passing them on to team meetings for decisions about allocation (i.e. "team referrals").

At each site consultants would not agree to such proposals, would not pass on referrals to a team meeting but only to individuals, and would not inform team meetings about the cases which they had taken on. In effect consultants would not agree to be full members of the team, felt that the referral arrangements impinged on their Practice Autonomy, and was the first of future possible restrictions, and used their authority to prescribe drugs as a bargaining counter to try to negotiate roles as team leaders.

Other evidence of consultants' institutionalised authority to commit a range of health service resources may be drawn from reports of CASPE clinical budgeting trials [Doc. 2064 (1978); Wickings et al (1983)]. These experiments costed the resources used by medical and surgical teams, isolated items of expenditure over which consultants had direct control, and established agreements between consultants and Unit and District management about the resources required to provide an agreed level of service in the next year. Two planning agreements (Drs. Mills and Rich, East Birmingham DHA, and Drs. Brown, Brazer and Johnson, Southend DHA (1982)) provide a detailed breakdown of items and costs over which consultants had control. These agreements show consultants as being authorised to admit and discharge patients up to their total allocations of beds, theatre time and outpatient sessions, and to make requests and referrals to 17 different clinical support service departments (e.g. X-ray, Cytology, etc).

The next chapter analyses and summarises the findings reported above. It presents a framework for comparing the different types of autonomy exercised by each profession. Appendix 4 provides a summary of the different management structures which were discovered.

CHAPTER 6 : ANALYSIS AND SUMMARY OF RESEARCH FINDINGS

PART 1: INTRODUCTION

The purpose of the chapter is to summarise the research findings and to compare the organisation and autonomy of the five professions of the study. Part 2 summarises and compares the research findings about profession-management autonomy for each profession, and Part 3 compares practitioner autonomy. Part 4 summarises the findings in terms of a typology of "professional autonomy".

Chapter 7 ,to follow ,relates the author's findings to Freidson's theory of professions and to other research reviewed in earlier chapters in an examination of explanations for the findings.

PART 2 : A SUMMARY AND COMPARISON OF PROFESSION-MANAGEMENT AUTONOMY

The following summarises and compares the management autonomy of each profession within employing authorities. Management autonomy is summarised in terms of the size and nature of the practitioner "groupings" (e.g. large or small collegiums or managerial hierarchies), and in terms of the role and authority of the head profession-manager over members of the profession, and in relation to general management decisions made by senior managers and the employing authority .

Psychology Management Autonomy

The main problem raised and examined by District Psychologists and heads was how to change psychologists' sessions and use of time in different types of work to provide a "more balanced" overall service, for example,one where psychologists were meeting requests and needs from parts of the district where they did not already work. Three factors were frequently reported as

limiting their ability to provide a more comprehensive service, and which provided evidence of the extent of psychologists' "management autonomy" and control.

First, heads were uncertain about who had authority to decide new posts and how they should "present the case" for new posts. Because they were rarely permanent members of Unit and District Management Groups, their awareness of available funds, and ability to put and argue their case were limited. It was common that heads were required to put proposals to Unit Management Groups to incorporate in their plans, rather than direct to District Management. Thus heads' ability to gain new posts for the profession was limited by their role not being institutionalised in the main management bodies. The autonomy and influence gained from being a full member of such bodies was of significance.

Second, the heads' ability to transfer psychologists' sessions or use of time between units was constrained by the requirement that significant changes could be vetoed by the Units concerned, and that funding arrangements had to be agreed. Early in the 1980s the influence of Unit management had not been formalised and staff or session transfers were carried out without notifying Units, and psychologists had moved between Units without difficulties.

A third factor was the wish to get the agreement of individual psychologists to the change, and often and in addition, the agreement of a psychology committee or department meeting. No instances were found where a District Psychologist enforced disciplinary procedures to carry through a change, although in principle District Psychologists had this authority and would have been supported by higher management. Thus, both the head psychologist's and other psychologists' understanding of Practice Autonomy limited the head's management autonomy. Heads did not exercise structural and institutionalised authority, but relied on group pressures in departmental meetings to persuade psychologists to change their practices.

Where group pressure could not be brought to bear, heads did not pursue the matter and psychologists were not prevented from following their own individual interests and priorities. In situations where the main structure was departmental group meetings (e.g. Bexley), meetings often failed to agree the speciality designation or siting of new posts, and usually failed to agree readjustments and changes to sessions within the group. The research revealed only three departments (Birmingham, Essex, Macclesfield) with a clear policy for renegotiating significant changes in working practices within the group. Collegiate self-management failed to limit Practitioner Autonomy which almost always resulted in imbalances in the overall service.

However, towards the end of the author's research there were indications that three developments were indirectly limiting both Management and Practitioner Autonomy. The first was

the costing of psychologists' sessions provided to Units, and the availability of this information to heads and UGMs. This provided detailed information about practitioners' use of time, made it possible for UGMs and heads to question their use of time, and made it necessary to negotiate changes with UGMs. The latter represented one limit to management and practitioner autonomy - most UGMs could veto such changes. The second development was the routine requirement to collect management information on each psychologist's activities, which also made it possible to question individual psycholo- gist's use of time. The third was the move to institute regular performance appraisals of individuals and services, although no details of such systems are available. These three developments were systems for increasing practitioner accountability and impinged on their autonomy. Should heads or UGMs wish to exercise structural authority to limit or direct practitioners, the systems provided information which made it easier for them to do so.

A summary of findings about management autonomy is that psychologists in NHS Districts were either grouped together in one department, or in a number of speciality departments, each headed by a psychologist. Many were titled "District Psychology Services" but the meaning of the term and the authority of the District Psychologist varied. Some districts did not have a District Service, but rather a number of psychology departments which were coordinated by a District Psychology Committee (e.g. Hampstead). In all cases, heads were accountable to UGMs, and UGMs could veto heads' proposals for new posts or changes to sessions. This placed clear limits to psychologists' management autonomy because proposals had to be agreed at Unit level before agreement at District levels.

Physiotherapy Management Autonomy

For the purposes of this study the details and variations in authority were less important than the general picture, which was that, up until 1982, approximately half of the health authorities in England had established forms of profession-management with District head profession-managers.

The advent of Unit management in the 1982 reorganisation, and Unit and District General Managers after 1985 reversed the trend. Field research and workshops showed that where District heads were retained, their authority over budgets and staff was reduced. All the evidence suggests that by 1986 there were no single head profession-managers with managerial authority in relation to all physiotherapists employed by a health authority. Sometimes a profession "leader" monitored standards, but the highest level profession-managers were within Units of management and were managerially accountable to General Managers for everything apart from individual case work. A common management structure was one or more profession-managers,

managing practitioners (most with Case Autonomy), and themselves managerially accountable to Unit managers for all work apart from case work.

The institutionalised management control and autonomy of the profession was less than that of nursing and social work. There was no unified management structure for physiotherapy brought together under a single managerial head, but one or more profession-managers, separately accountable to General Managers, with less authority over staff and resources and authority decisions and plans than heads in the other professions. (Health authorities employed anything between 10 and 140 physiotherapists).

Nursing Management Autonomy

The evidence from the author's field research (1980 -1987) and from other social-analytic research (1974 -1984) was that the 1974 reorganisation produced management groupings of nurses, with a single head nurse District Nursing Officer (DNO) managerially accountable for all the nurses in the District. National workshops on nursing organisation and on district organisation showed that the authority of the head nurse varied (as indexed by the number of nurses managed and their total budget) and that the 1982 reorganisation consolidated DNOs' top-level management role on DMTs. However, by late 1985 many Districts had dispensed with DNOs, and made head nurses in each Unit of management accountable to Unit General Managers (UGMs), thus reducing the institutionalised autonomy and control of the occupation.

The evidence provided by official documents and field research can be summarised as follows:

1. From 1974 to 1982 all nurses employed by state employing authorities (AHAs and DHAs) were organised within one hierarchical managerial structure.

2. In 1982 it was a central government requirement that all nurses employed by a health authority were managed by one head nurse, who was directly accountable to, and appointed by, the employing authority for management of nursing services, and was a member of the top management team.

3. Over the period 1969 - 1982 the authority of the head nurse, and consequently the managerial autonomy of the profession, increased as

a result of the increasing numbers of nurses employed, and the creation of DHAs with DNOs on DMTs.

4. Since 1985, with the introduction of General Management, managerial DNO posts were abolished and, although head nurses existed in many Units of management, they were accountable to Unit General Managers who rarely had a nursing background.

5. Nurse practitioner autonomy in hospital settings changed little, but community teams for certain client groups led to the reduction of the previously greater autonomy of community nurses.

An important feature of institutionalised occupational control and autonomy was the creation of a single head nurse role which was managerially responsible for 1,000 or more nurses employed by a Health Authority, and provided with financial and other forms of authority to manage this labour force. Furthermore, the head nurse had a full and equal membership of the Authority's management team with institutionalised authority of veto over team decisions. The head nurse could thus directly influence decisions about other occupations employed by the Authority, and his cooperation in any service plan or policy was essential. The Griffiths' re- organisation (1984 ; 1986) reduced the management autonomy of nursing, but the managerial structure remained within Units in most hospital settings.

Social Work Management Autonomy

Although the author undertook less systematic field research into social services organisation, official statements and the available research provided sufficient data about the main subjects of interest to the thesis. The primary structure in social work was a managerial hierarchy with all social workers ultimately accountable to a Director of Social Services through various intermediate managers.

There was sufficient evidence to conclude that institutionalised profession-management autonomy was less than in nursing: it was neither a requirement nor a fact that the head of the management structure should be a member of the occupation, qualified social workers were a small proportion of the staff managed by Directors, and the Director was accountable to both a Chief Executive Officer and a committee of authority members. The Directors had less structural authority than heads of nursing, the variety of responsibilities put greater constraints on their pursuing the interests of the occupation, and the limits to the autonomy of the role were greater

than those of nursing because of the greater political role of employing authorities and the more restrictive policies and procedures such as those governing finance.

In comparison with the other professions, however, the autonomy and control of head profession-manager roles in social work and nursing in the early 1980s were similar, and the authority of these roles provided both professions with substantial control and autonomy. As Watkin (1975) noted, the proposal for social service departments and director roles, "was given a warm welcome by the social work profession - many were content to describe it as a charter for social workers - and hostile criticism came chiefly from medical officers of health". (p 451).

Medical Profession-Management Structures

Government reports and recommendations for management arrangements for doctors in the NHS usually sought to institute structures to promote the efficient use of resources, consistent with maintaining "clinical freedom". Evidence of formal prescriptions about medical management in recent years showed central government's concern to improve medical organisation, its reluctance to impose structures which could be opposed by the profession, both locally and nationally, and support for the concept of clinical freedom and its organisational consequences.

In nursing and social work formal government directives institutionalised the autonomy and control of these professions through profession-management structures and roles. In medicine, however, the lack of formal directives, and the nature of the proposals that were made, institutionalised the autonomy and control of individual consultant practitioners. The "profession-management" structures were also mainly medical advisory and representative systems for consultation, rather than control structures.

The important feature of the medical "profession-management structures" was that they were created by many DHAs to perform advisory functions as representative structures. Thus the group autonomy and control institutionalised by these structures enabled the profession to influence management decisions, rather than to implement management decisions, as was more clearly the case in nursing and social work. This difference stemmed from the institutionalised individual autonomy of medical practitioners ,which is summarised in Part 3 below.

Head Profession-Manager Role

The extent of the "head profession-managers' " authority , such as there were such roles (District Medical Officer),in relation to consultants was to monitor certain limits to consultants' practice autonomy. The DMO also often had structural authority in relation to "paramedical" heads of

service, and had the same authority of veto on the DMT and direct accountability to the employing authority as the top nurse manager role described earlier. DMOs often exerted considerable influence over Health Authority plans and decisions because they were viewed as representing the weight of medical opinion, or of being capable of influencing it. The structural authority of the role was less than that of similar heads of service in other occupations because the role did not have managerial authority in relation to medical staff. The authority of the role over medical staff and other occupations varied, depending on the authority of Unit General Managers and the authority of the District Heads of Service managed by the DMO.

PART 3: A COMPARISON OF PRACTITIONER AUTONOMY

Psychology Practitioner Autonomy

Starting with the different prescribed limits to the discretion which could be exercised, the research found the following regulations and requirements governed the autonomy of a clinical psychology practitioner in 1985:

The professional association's voluntary code of conduct (BPS (1983)). There was no state registration of psychologists and association membership or adherence to the code was not a condition for employment in the NHS. However, infringement of the code was likely to lead to disciplinary action, and the code did set certain limits to the autonomy of a practitioner. It required a practitioner, for example, to,"obtain the valid consent of participants" to interventions (para. 3), to "refrain from misleading those to whom services are offered about the nature and likely consequences of any interventions" (para. 3.3), to "preserve the confidentiality of information acquired", and to conduct themselves in their practice in a way which "does not damage the interests of the recipients of the services" (para. 5) by, for example, refraining from practice when "abilities or professional judgment are seriously impaired". (para. 5.1).

The second set of requirements which limited an NHS employed psychologist's autonomy were conditions of a practitioner's employment contract,as outlined in a job description and governed by Whitley Council terms and conditions of employment. The job description defined hours of work, leave, etc, and prescribed general limits to the content of work, for example, "provides a clinical psychological service for the population served by the Northern sector." [BPS, Divisional Newsletter (1981)]. The job description may limit the psychologist to working in a particular speciality, or to providing a certain number of sessions at a particular site, and defines the base for

purposes of claiming travel expenses. It also specifies that the practitioner is "accountable" to a head of department, but does not define the head's authority.

Thirdly ,additional DHA and Unit policies, applying to all employees of the authority or site. These required that the psychologist complied with certain health and safety at work regulations, parking regulations, etc.

Fourthly,specific Psychology Department policies. These governed such matters as access to records, methods of record keeping, attendance at department meetings, proportion of time spent on research and teaching, travel and equipment claims procedures, etc. Not all departments had written policies, and some placed more restrictions on practitioners' autonomy than others. The researcher discovered only one example of a policy governing case-decisions, that of Victoria DHA Department requiring departmental review of case progress where more than twelve sessions of individual psychotherapy were undertaken by a practitioner [Brunel Workshop Notes (1984)].

The research evidence presented in Ch. 5 leads to the conclusion that ,in the 1980s ,the autonomy of Senior grade psychologists could be characterised as Case Autonomy ("The right to make assessment and treatment decisions in casework without those decisions being routinely scrutinised or overridden, unless negligence is suspected"). It was less clear whether just-qualified psychologists had this autonomy, although most psychologists argued that they did [Øvretveit (1985c)]. No examples were found in the research of instances where psychology managers overturned case decisions, although there were three examples of instances where psychiatrists did so. Staff performance appraisals were reported not to examine individual case decisions.

The local limits to practitioner autonomy were less clear and varied between departments. It is usually stated that psychologists are ,"not accountable to managers for matters of purely professional judgment", but distinctions are made between judgments about individual cases and judgments about the type of service to be provided and about the balance between areas and fields of work. Management information systems about work activity provide information which is increasingly being used to question types and areas of work, and to set targets.

It is clear that employment contract limits prevent psychologists from practising in other districts, and, where there are job descriptions, some specify specialities or sites for working. Some psychology department policies have administrative procedures for travel or study leave, but none defines the type of work to be undertaken, sources of work and balance of activities between individual case, group work, teaching, consultation, research, planning, etc.

The field studies and workshop examples showed that psychologists' Practitioner Autonomy was defined by their head's authority to impose changes to their sessions and use of time. There were no "critical incidents" documented where higher management was required to support the head's authority against practitioners, and in the few instances where heads had carried changes through, they had done so by gaining practitioners' agreement and without threatening or invoking disciplinary procedures.

There was a large amount of evidence that many Senior and all Principal grade psychologists had "Practice Autonomy" to decide the balance of activities and details of practice within a particular field, without those decisions being questioned or overridden unless policies or contract were infringed. Further developments in budgeting and information systems may further limit Practice Autonomy, as may staff appraisal and performance reviews, and the allocation of posts to community multidisciplinary teams with detailed policies about case referral and management.

There was also evidence of a "personalised service" and of "Client/ Practitioner Choice", where a client is dealt with by one member of the department, who may choose not to take on a case, and where each party may choose to terminate involvement if no progress is being made. Finally, many psychologists in community mental handicap teams and in other multidisciplinary teams exercised "Case-Coordinating Authority" to coordinate the work of other professions in the care of a client, and in some teams this authority was institutionalised in a team operational policy sanctioned by the employing authority.

The conclusion from the research is that, in comparison with other professions, psychologists in the 1980s had a wide degree of autonomy over both individual case assessment and treatment, over what proportion of their time they spent on case work and on other work, and over where they spent their time. Twenty years into their career a psychologist would expect to occupy an employment role with Practice Autonomy. Unlike physiotherapy, social work and nursing, NHS authorities have established high-level practitioner roles mainly involving direct case work [Wallace (1985)] with prescribed limits which allow a wide degree of discretion to run a solo - practice, or one with juniors. Although a Senior psychologist was likely to be accountable both to a manager who is a member of another occupation (e.g. Unit Manager), and to a profession-head with coordinating authority, the managers only had limit-setting authority to define certain limits to the practice (usually budgetary). Neither managers had authority to review or override detailed decisions about the running of the practice (record systems, appointments, work priorities, etc), as long as certain requirements were met.

Practitioner Autonomy in Physiotherapy

Some of the prescribed limits to practitioner autonomy are similar to those for psychology. The autonomy of a just-qualified physiotherapist is bounded and defined by the following limits and requirements:

State registration required that the practitioner adhered to the professional association's code of practice. This code limited practitioners to carrying out only those assessments and treatments for which they had been trained to undertake. If the physiotherapist stepped outside these boundaries, i.e. carried out work for which they were not trained or competent, they could become liable for actions of negligence in a court of law, or subject to the disciplinary action of the Statutory Registration Board for Physiotherapists.

A further limit refers to the context under which the physiotherapist carries out her work: the Code of Practice limits the physiotherapist to treating a patient only on referral from, or with "direct access to" a doctor. Infringement could lead to a physiotherapist being removed from the register. (The Code of Practice was originally laid down in the Board of Registration of Medical Auxiliaries set up in 1936 by the British Medical Association. It was carried over into the State Registration scheme of 1960 on the insistence of the Medical Profession, but physiotherapists could dispense with this requirement, as Australian Physiotherapists have done [Galley (1977)].

At the District level, the Health Authority employing the physiotherapist placed additional context limits on the role in an employment contract. For example, the role was often limited to a particular speciality or hospital, and there was a number of conditions of work limits, such as hours of work, holidays, etc. Doctors' influence in the setting of contract limits at District level had declined, especially since physiotherapists achieved group management in the nineteen seventies (e.g. doctors were no longer involved in drafting job descriptions).

Evidence of physiotherapist practitioner autonomy in the 1970s showed that first doctors, and then physiotherapist managers had authority to assign tasks in detail and to prescribe treatments and treatment methods used by the practitioner. Jaques and Tolliday (1978), however, reported situations where experienced practitioners exhibited de facto autonomy to decide their own work within certain broad limits of contract.

The author's research found that the autonomy of a practitioner in the 1980s, about two years after qualifying, could be characterised by the description of Case Autonomy : Physiotherapy managers did not have structural authority to override or review case decisions and were not

accountable for these decisions, as long as the physiotherapist adhered to policies and procedures and other limits.

For the purposes of this study there is a critical difference between, on the one hand, a social work or nurse manager deciding not to exercise their assigned authority to review cases in detail, and on the other hand, a physiotherapy manager not having authority, or being required, to review cases in detail. The former is institutionalised detailed authority - in social work often arising as a result of statutory functions. Although managers in nursing and social work may hesitate to exercise this authority, they can be instructed by employers, either by policy or by individual case, to override a practitioner's case decision. Physiotherapy managers, however, may, and have, refused to review cases, as long as basic standards and ethics are met.

However, unlike clinical psychology, the employment roles open to a physiotherapy practitioner after about twenty years' experience did not provide for greater institutionalised autonomy, and in this respect the picture is similar to that in nursing and social work,and different to psychology. (There were few high-level practitioner roles, and the autonomy which was achieved was not institutionalised [Ovretveit et al (1982)]. Such roles did have Case Autonomy, but the prescribed limits were essentially the same as for the just-qualified role described above.

As emphasised above,where experienced practitioners exercised autonomy over more than just individual case decisions, this was found to be because physiotherapist managers allowed greater autonomy,and did not exercise the structural authority of their role. Thus the key difference between senior practitioner autonomy in physiotherapy and in clinical psychology is that the latter occupation had roles with Practice Autonomy established to undertake development work as the "career grade" of the occupation.

A second difference distinguishes the autonomy of a physiotherapist practitioner from a nurse: in general a doctor may prescribe certain nursing tasks in detail, whereas the doctor's authority in relation to physiotherapy work is only to set limits [HC (77) 33] and this provided for a wider degree of practitioner autonomy. Chapter 7 to follow considers possible explanations for these differences.

Nurse Practitioner Autonomy

The requirements of state registration limit the autonomy of a just-qualified nurse to undertaking work for which they have been trained, and their training thus effectively limits the content of their work. Post-qualification training, for example, in community psychiatric or mental handicap

nursing enables nurses to undertake a variety of roles not previously available, often in situations with a larger degree of either de facto or institutionalised autonomy than in traditional hospital settings. The author's research with community psychiatric nurses in multidisciplinary teams (1986b) and community mental handicap nurses in the Rhondda (1985) established that they had greater autonomy over case work treatments, priorities and the organisation of their work than the hospital nurses interviewed at Northwick Park (1980 - 82) and St Mary's, Paddington (1982 - 1984). What constituted "adequate training" was negotiated in each community team.

The Nursing Code of Professional Conduct (1984) placed few constraints on practitioner autonomy, apart from general requirements of professional conduct and those of competence already mentioned. Infringement of the code of practice could result in loss of state registration and employment opportunities - it is not a "voluntary code" as it is in social work.

Other structural constraints were set at the local level. Employing authorities supplemented the national terms and conditions of work with certain personnel policies, usually applying to all DHA employees. The key structural constraint at this level was the employment contract, which sometimes limited the role to work in a particular hospital or speciality. Hospital or Unit policies may place further constraints on role autonomy, but usually apply only to conditions of work. They constrain autonomy by prescribing certain actions in specified situations, such as fire procedures, accident procedures, and usually apply to all employees in the Unit.

Structures for deciding the content of the role at local levels are more important for the purposes of this analysis. These structures define the degree of freedom of the nurse in carrying out her everyday tasks. Structures are of two types: the rules and procedures which define outer limits and exclude certain activities, as described above, and institution- alised authority of other roles in the management structure to assign tasks and apply sanctions.

Regulations and requirements set at a national level do not clearly define the work content of the role. The detailed work content of practitioner roles is largely decided by nursing managers who can assign the nurse to different sites (e.g. wards) and delegate tasks in as much detail as necessary. Nurses did not have Client/Practitioner Choice, Case Autonomy or Practice Autonomy.

Medical Authority

The institutional authority of doctors in relation to nurse practitioners further defined nurses' autonomy. No generally-established requirements were specified, as were for physiotherapists,

and the only formal statements discovered by the author on this subject were in multidisciplinary team operational policies, where consultants' authority was specified.

Field research provided a variety of case examples of doctors' authority. No examples of authority in relation to site assignment were discovered in the author's research into nursing. However, doctors' "task-assigning authority" was found to have changed from prescribing authority in all tasks [Jaques, Ed. (1978)], to prescribing authority in relation to certain treatments, and to vetoing certain activities. Doctors' institutionalised task-assigning authority varied considerably, ranging from detailed authority to decide and overrule in acute hospital specialities to "persuasive" authority in all but a few instances in community mental handicap teams. The differences in medical control appeared to be due to ability to assert authority of expertise, the degree of danger and life- threatening nature of the interventions, and the ability of the medical profession within the site to gain backing and support from higher authority for failure of nurses to comply. Chapter 7 considers the available evidence for these possible explanations.

Thus, in summary, a variety of structural limits and requirements set at national and local level constrained the autonomy of recently-qualified state registered nurses by defining behaviours and by ruling out certain activities. These mostly specified terms and conditions of work, although some rules and regulations defined content. The nursing occupation exercised different degrees of influence in setting different limits (see Ch. 3). Within these limits local nurse managers decided the content of the role and had managerial authority to assign tasks in any detail. Doctors' task-assigning authority varied by site and speciality, and the medical profession exercised little control over conditions and terms of work. Developing professions are increasingly influencing the work of nurses: physiotherapists and psychologists delegate tasks with the agreement of nurse managers, but their authority is less than that of doctors.

A typical nurse with twenty years' nursing experience after qualifying would be eligible for a variety of employment roles. The research was concerned with the practitioner roles which would be open to her, and the institutional limits to the autonomy of the roles. The main point is that the institutional limits to the autonomy of the role were not significantly different from an employment role for a recently-qualified nurse.

Also the structural authority of managers in relation to the role was not different. From the occupation's point of view there was no institutionalised career structure which encouraged a clinical career. (Various reports have made proposals for one). This was not solely because there was no clinical nursing work of a higher level of responsibility to be done or to be developed, i.e. work which required less confining nursing policies and procedures to enable the individual to exercise discretion over a wider scope in order to use their abilities and extra experience and

knowledge more effectively. It was not the structure of the managerial hierarchy which prevented the creation of such roles. Rather it was mainly because nurse managers and employing authorities did not require or wish to develop and define high-level clinical nursing. However, nurses with 20 years' clinical experience often had de facto autonomy greater than the institutional role autonomy and there were signs that higher- level practitioner roles (i.e. with time spans between 1 and 2 years) may become institutionalised in managerial structures in certain specialist hospital nursing settings and in community nursing(Øvretveit (1988)). The introduction of the patient-centred nursing process implies greater practitioner autonomy, a development which will be considered in Chapter 7.

Social Work Practitioner Autonomy

The main requirements which limited practitioner autonomy were found to be those of the employment contract, and local authority departmental policies and procedures. Suspension or dismissal could result if the latter were transgressed and these policies and procedures were far more numerous and more specific than for practitioners in the other four occupations considered.

One research finding was that, as with nurse practitioners, the discretion which social workers were able to exercise in general, and in certain situations, was nowhere specified. They could not be said to have institutionalised autonomy in the same sense that doctors or even psychologists or physiotherapists had. The author's field research did not find any areas over which social work practitioners could not be directed by managers, or over which practitioners regularly or routinely exercised autonomy.

Whilst the association's code of ethics [BASW (1970), BASW (1985)] ruled out certain activities, social workers frequently transgressed the code. As there was no state registration which referred to the code, and membership of the professional association was not a requirement of employment, practitioners' autonomy was neither limited by, nor protected by, the code.

More higher level practitioner roles than in nursing were found to exist in local authority social services departments, which were also reported by Hey (1976). These specialist roles were not managerial, and involved some client contact, but were largely consultant roles to other practitioners (e.g. child care principal officers, specialist mental health workers). However, few roles of this type were found in the author's research. Thus a social worker with twenty years' practice experience was unlikely to find a practitioner role with greater institutional autonomy than a role occupied by a recently-qualified worker. The extra autonomy of such practitioners was not a structural phenomenon and did not arise from different prescribed limits to the role or different

structural authority of managers. Rather it arose from managers and others allowing greater degrees of freedom to more experienced practitioners, even though they were still fully accountable for those practitioners' case decisions.

Social work practitioners appeared to have less autonomy than nurses mainly because many statutory functions were delegated to local authorities, and because there was no state regulation of practice which involved the occupation.

Medical Practitioner Autonomy

Two years after state registration a doctor would only be able to practice in the UK in an NHS employment role as a junior doctor (1985). The limits defining the autonomy of the role were those of the state registration requirements, conditions and terms of service of the medical review body, employment contract conditions laid down by the District Health Authority, and additional District Health Authority and Unit medical policies and procedures. The role would be subject to the managerial authority of a consultant.

Twenty years after registration a medical practitioner is likely to be eligible to occupy a practice role as a hospital consultant or GP. Such roles carried Case and Practice Autonomy and institutionalised authority to initiate the work of a range of health professions and to commit NHS resources. The limits to the autonomy of the role were negotiated with senior management, either through the medical representative system or in direct negotiation. In contrast to other professions, a professional association (a Royal College) was involved in checking the conditions and features of such senior practitioner roles. The individual consultant had right of access to the employing authority and could influence authority plans and policies through an institutionalised medical representative and management structure.

The summary now draws together the findings by distinguishing the different types of autonomy which were found and by providing a typology of professional autonomy.

PART 4 : A SUMMARY OF TYPES OF PROFESSIONAL AUTONOMY AND CONTROL

The research found that professionals were authorised in a variety of ways to decide aspects of the content and conditions of their work. The following first summaries the organisational factors which determined the autonomy and control of an occupation. It then distinguishes the different

types of control and autonomy which were institutionalised at the national, local and individual levels. (Summarised in tabular form in Table 6.1, at the end of Part 4).

Summary - Organisational Determinants of Professional Autonomy

The research found that , at the national level, the institutional structures through which a profession exercises influence and control are through a professional association and through structures for state regulation, training, and for negotiating pay and conditions. At the local level the degree of influence and control exercised by a profession depends on the nature of the management structure for the profession and the role of the profession-head.

Profession-management autonomy is determined by three main organisational factors:

(1) Size of Professional "Grouping"

The number of members of the profession within a professional grouping.

(2) Nature of Professional Grouping

Whether the grouping is, at one extreme, (A) a "management division" made up only of members of the profession, each of whom is not subject to the authority of staff who are not members of the profession outside the division (but staff may be subject to the authority of a profession-manager), or, (B) an "intermediate professional grouping", made up only of members of the profession who are subject to both the "managerial" authority of staff who are not members of the profession, and the "professional authority" of a "professional superior", or, at the other extreme, (C) a "professional interest group", made up of members of the profession, but each of whom is managed by staff who are not members of the profession.

(3) Role and Authority of Professional Head

Whether the professional head is, (a) the sole manager of members of the profession within the grouping, (b) their authority in relation to other members of the profession employed by the organisation, and (c) their formal position within the general management structure and their authority in relation to decisions affecting their own and other professions.

The extent of the profession-management autonomy of a profession within one organisation at a particular time may be defined by reference to these three factors, and compared with the autonomy in different organisations, and at different times.

Practitioner Autonomy

Practitioner autonomy is determined by:

(1) The Limits to Discretion. The constraints, directives, and standards set at national, district, unit and division levels, which rule out certain activities, and require certain actions in specified circumstances.

(2) The Authority of Superiors. The authority of one or more superiors (managers and other staff) in relation to siting of work, task or case assignment and review, performance appraisal, and disciplinary authority.

The different types of practitioner autonomy are, Client/Practitioner Choice, Case Autonomy, Practice Autonomy, and Case-Coordinating Authority,each of which is defined below.

Types of Autonomy and Control exercised at National Levels

Chapter 3 presented documentary research into the details of professional autonomy and control at the national level. The findings can be summarised in terms of the following types of control: Occupational Association Control ,State Regulation , and Control over Pay and Conditions of Work.

Occupational Association Control

Members of the occupations of the study formed national associations to advance their professional and economic interests. Occupational associations influence national state bodies and employing authorities, and exercise a form of direct control over members, and indirect control over non-members.

The main instrument of control over members is the association's code of practice. Control is weakest where the code is "voluntary" (usually more a general statement of aspirations and good intentions than basic standards of practice), and stronger where infringement of the code may lead to loss of membership and where the association has an effective "disciplinary" mechanism. Occupational control is strongest where membership is a state requirement to practise, or for employment by a state agency.

The type of autonomy which exists is that members of the occupation can define and exert some control over aspects of the work and the way it is done through the association applying pressure at national and local levels. This is a particular type of "autonomy" which ,it will be argued in Chapter 8,is more properly termed power. This type of autonomy is different to that which members of the profession acquire because of their association membership. Individuals gain autonomy because they can call upon the power of their association ,and are "protected" from demands and instructions from employers or other professions which may infringe their code by support from the association and their colleagues. This form of autonomy is essentially the same as that acquired through union membership, but professional associations are usually more concerned about work content than with conditions of work.

State Regulation

Turning now to the second type of autonomy at the national level,professionals acquire a certain form of autonomy as a result of state regulation. State regulation involves the state in setting a minimum level of education and training for state registration, and de-registration for unprofessional conduct. An occupational association is usually involved in setting the required qualifications and administering the regulations,especially if they are able to sustain the claim that only members of the profession know enough about the work of the profession to undertake this regulatory work. In these cases state regulation strengthens occupational control over requirements to practise and over the regulation of practitioners through professional codes of conduct.

If membership of the association is a requirement to practise, the state indirectly increases the power of the profession by increasing the size of the professional association. Where the state calls upon the occupation to assess training schools and set qualifications as one aspect of state regulation, the state provides the occupation with an indirect control over the future work of the occupation.

It is the effective transfer of responsibility for regulating the occupation by the state to the profession in this way which distinguishes many professional associations from occupational unions. The exact details and mechanisms of state-sanctioned regulation define this form of institutionalised autonomy of the profession (see Ch. 3).

Control over Pay and Conditions of Work

Where the state is also the main employer of members of the occupation, national bodies are established to negotiate pay and conditions of work with representatives of the occupation (e.g.

Whitley Council Bodies). The occupation may be represented in these negotiations by its professional association, or by trade unions, or by other means. The occupation has greater autonomy and control over pay and conditions if a special negotiating body is established for it, if it is represented by one association, if the agreements reached are binding on all state employing authorities, and if alternative sources of income or employment are available (see Ch. 3).

One reason given by occupations for influence over decisions concerning pay and conditions is that pay grades and other conditions serve as a career structure for the occupation because they reward certain forms of work.Usually professions wish occupational skills to be rewarded, and to have control over assessment methods. However, management skills and responsibilities are easier to assess, and assessment systems do not need to be operated by the occupation.

Turning from the national level to the local level, the findings presented in Ch. 5 showed that employing organisations institutionalised different types of professional autonomy,with some variations, but also many consistencies.

Forms of Autonomy and Control Institutionalised by Employing Organisations

Profession-Management Autonomy

Members of an occupation are frequently grouped together for management purposes under a head who is also a member of the same occupation (profession-manager). The research showed that ,in all the professions investigated ,in public services in the UK central government recommended that health and local authorities appointed a senior member of the occupation to manage staff . Where the profession-manager is also a member of the top-level management team (e.g. nursing and social work), the control and autonomy of the profession is greater. The research discovered that the head's authority over staff, and in relation to general decisions about the plans and policies of the organisation, varied between professions and localities.

This form of occupational control can be termed "profession-management". Autonomy here arises as a result of the authority of the profession-manager to "protect" staff from control by other occupations and to make changes advantageous to the occupation. However, the autonomy of individual practitioners can also be reduced by profession-management.

One aspect of profession-management is the right of the profession- manager to gain direct access to the employing authority to present their case. Many occupations have to present their case to, or through, senior managers who are not of the same occupation. The right of direct

representation, not as an appeal after a decision, but in critical cases to influence a decision, is an important aspect of profession-management autonomy, and arises where a form of direct accountability to the employing authority is required.

Professional Autonomy at the level of the Individual Practitioner

"Professional autonomy" is most often used to describe the different types of freedom and control exercised by individual practitioners. This study is concerned with the types which are explicit, agreed and institutionalised in the organisation and policies of employing authorities.

Client/Practitioner Choice

One type of professional autonomy noted in earlier research is the freedom of a practitioner to refuse a client whom they judge that they cannot help, and this often corresponds to the right of a client to choose their practitioner [Jaques, Ed. (1978) Client/practitioner choice in personalised services)]. The discussion in Chapter 2 noted that some professionals claimed that this form of autonomy was a necessary condition for a confidential and trusting therapeutic relationship.

Case Autonomy

A second type of practitioner autonomy is Case Autonomy, "the freedom of a practitioner to exercise discretion in the assessment and treatment of a case without that discretion being reviewed or overridden by a higher authority, unless negligence is suspected or the limits to autonomy are infringed" [Øvretveit (1985c]) . If, for example, where a complaint is made, the practitioner can show their superior that established limits were observed (e.g. code of conduct, employing authority policies, departmental procedures) then, with "Case Autonomy" their case decisions cannot be examined or overridden. (Chapter 2 noted the arguments advanced for this type of autonomy: it was viewed as a condition for developing a trusting confidential therapeutic relationship: the threat of scrutiny would undermine practitioner confidence in uncertain situations, and, at a certain level of experience and knowledge, practitioners' judgments are said to be of equal value.Chapter 7 examines these arguments as explanations for the structures which were discovered.).

The research found that case autonomy did not rule out management by a higher authority, but only one type of managerial relationship. Where the practitioner's superior was not accountable for the practitioner's case decisions, then full-managerial authority was not found to exist. (State registration is not a necessary requirement for case autonomy to be possible (e.g. clinical

psychology)). "Case autonomy" is a more precise definition of the freedom from evaluation which Freidson proposed as the central differentiating feature of professionals.

Case-Coordinating Authority

A third form of institutionalised practitioner autonomy was found in multidisciplinary team organisation, and in medical consultant teams. Here the practitioner is assigned authority to coordinate the work of others involved in work on a case. This form of autonomy sometimes arises when an agency places one professional in a "gatekeeping" or liaison role between the client and other professionals and bureaucracies in order to "personalise" the service (e.g. "Key Worker").

This form of control is closely related to, and can conflict with, Case Autonomy. Case Autonomy refers to a professional's independence to make assessment and treatment decisions about a client. However, in assessing a case they may judge that another professional should be involved and wish to refer the case for parallel work, or to hand over the case. The judgment about whether, and to whom, to refer is a professional judgment which forms one aspect of case autonomy. However, if another professional is coordinating work on a case, and carries Case-Coordinating Authority, usually only they are authorised to judge when and whether to refer the case.

Thus the Case-Coordinating Authority of one professional may limit the Case Autonomy of another, especially if Case-Coordinating Authority is defined as the right to make an overall assessment of the general needs of a case, to refer and request treatments, and to terminate any further action by another professional on a particular case, as was found by Rowbottom and Hey (1978). The author's research into multidisciplinary teamwork found a variety of problems and conflict between the need for case-coordination, and the case autonomy of the many specialist professions in such teams.

In the past, "Case" and "Practice autonomy" (see below) institutionalised the right of consultants and GPs to make decisions about their own work, and to initiate and prescribe treatments undertaken by others. The research found that custom and practice, and in many situations institutionalised arrangements, provided doctors with automatic Case-Co- ordinating Authority ["Primacy", Jaques Ed. (1978)]. As Case Autonomy was established in emerging professions, doctors' case-coordinating authority was reduced to the right of referral and their "primacy" was challenged, especially in multidisciplinary clinical teams [Øvretveit (1986b)]. The law has become clearer on the subject of legal responsibility for the care of NHS clients [BPS (1986)], and in many community mental handicap teams, doctors no longer carry primacy, and Case-Coordinating

Authority is assigned to the most appropriate professional in team meetings by rotating chairpersons [Øvretveit (1986b)].

Practice Autonomy

A fourth type of practitioner autonomy is where the practitioner's autonomy extends beyond individual case decisions to decisions over how they run and manage "their practice". Practice Autonomy is ,"the freedom to exercise discretion in the immediate management of a practice, speciality or department, without that discretion being overridden or reviewed by a higher authority, unless budgetary or other limits and procedure are infringed". The "immediate management" may be their own organisation in a solo practice (e.g. time management and priorities, siting of work, case records), or management of staff or trainees in their own occupation, or the management of other occupations as well.

The research found that practitioners with Practice Autonomy were managed in various ways by the employing authority through the setting of limits to the practice. The exact extent of practice autonomy was found to depend on the number of, and way in which, the limits were specified, as well as the way in which the practitioner was able to influence the setting of the limits, and the way in which policies of the practice were negotiated and decided (i.e. the management structure and process). In medicine the process involved an elaborate negotiating and representational system involving each practitioner. In clinical psychology and physiotherapy, heads of service related to District and Unit Managers, and had the right of appeal to the DHA.

Summary : A Typology of Professional Autonomy

The above analysis drew together the research findings presented in Ch. 5, and the research into profession autonomy at the national level presented in Ch. 3. The four types of practitioner autonomy were distinguished as part of the author's field research to help staff to specify structures which were then institutionalised by employing authorities. The concepts of Case and Practice Autonomy, Case-Coordinating Authority and Client/Practitioner Choice therefore made explicit the different forms of autonomy practitioners were found to exercise, and staff then went on to use the concepts to specify and establish management structures. Thus at some sites one or more of these types of practitioner autonomy were institutionalised, and at other sites practitioners exercised one or more types of autonomy without it being institutionalised.

The conceptual framework may be used to compare forms of autonomy in different professions,and within one profession over time. The findings of the author's research are

summarised on the next page in Table 6.1 using this analysis. (The different types of professional management structures which were found in the research are summarised in Appendix 4).

Type of Institutionalised Occupational Autonomy	Nursing	Social Work	Physio-therapy	Clinical Psychology	Medicine
At the National level					
Membership of Professional Association a State requirement to Practise	Yes		Yes		Yes
Professional Association Mandatory Code of Practice				Yes	
Professional Association Voluntary Code of Practice		Yes			
Control of Training	Yes		Yes	Yes	Yes
Separate National mechanism for pay and conditions	Yes			Yes	
Autonomy Institutionalised by Employing Authorities					
Profession-management Autonomy (ie Professional Division)	Yes	Yes	Yes	Yes	Collegiate
Representation on top level Management Team	Yes	Yes			Yes
Practice Autonomy				Yes	Yes
Case Autonomy			Yes	Yes	Yes
Case-Coordinating	Rarely	Sometimes	Rarely	Sometimes	Usually
Authority Client/Practitioner Choice				Yes	Yes
Client Confidentiality				Yes	Yes
Most Typical Management Structure (Described in Appendix 4)	1A	1B	2A	2B	2C

Table 6.1: Summary and Comparison of Types of Institutionalised Occupational Autonomy (1978-1985)

PART 5: RESEARCH FINDINGS : CONCLUSION

Professional Organisation and Significant Changes

One conclusion from the research is that previous structural characterisations of professional organisation reviewed in Appendix 3 (e.g. Scott (1965), Etzioni (1969)) are limited, especially in relation to professions in state welfare service. The conceptions of "professional" and "bureaucratic" organisation do not help to understand the conflicts and strategies of different groups within UK state welfare institutions. The evidence is that there is a variety of different types of work organisation for professionals. The more accurate typology of management structures outlined in Appendix 4 makes possible a structuralist understanding of organisational conflict and cooperation between members of the same and of different professions. It also makes it possible to investigate the relative effectiveness of different structures within one profession,to trace differences between professions,and changes within one profession.

The research reported revealed that practitioners, both individually and in different groupings, exercised control and independence over their work in many different formal and informal ways. It showed that previously unrecognised forms of institutionalised control and autonomy were of significance to professions, the most important of these being the role and authority of head profession-managers and the size and nature of profession- management structures. An analysis of the research findings produced typologies of professional autonomy and of management structures (Appendix 4) which in turn made it possible systematically to compare professions. The typologies also made it easier to clarify the significant changes which have taken place,as will be shown below.

It was argued that the main research method provided a way of gaining accurate and reliable details of structures and of autonomy, and insights into processes of change. The research discovered conclusive evidence that during the late 1970's social workers and nurses were managed within one structure, with a head profession-manager with relatively high structural authority (described as "Type 1" structure in Appendix 4). Practitioners came under the managerial authority of their managers, and the institutional autonomy of a practitioner twenty years into their career would be the same as at two years after qualifying.

Although the research discovered one or two examples of large physiotherapy services organised within Type 1 structures, most physiotherapists at this time were organised within departments in structures characterised by Type 2A. A career grade (Senior) was formally established at the

national level in 1975, and most structures institutionalised the autonomy of Senior graded practitioners in a form described above as Case Autonomy.

Clinical Psychology structures provided Career Grade practitioners with a greater degree of autonomy (described as Practice Autonomy) and newly-qualified practitioners soon acquired Case Autonomy. Most management structures were departments which could be represented as Type 2B.

Career grade medical practitioners (e.g. consultants) with patient contact also had Practice Autonomy and managed junior doctors(Type 2C). Although "Cogwheel" structures aimed to develop group management in "divisions", consultant "firms" remained the central organisational entity and divisional structures operated as one-way representative or pressure groups for consultants. Both the head profession-manager, such as there was one (District Medical Officer), and administrators monitored limits to Practice Autonomy.

The author's later research showed a decrease in profession-management autonomy in all professions. Head profession-managers in social work in the 1980s came under the greater control of Social Services Committees. Although the managerial structure Type 1 remained, members had an increasing influence at all levels of the structure, especially over appointments of social workers. In nursing the 1984 Griffiths' reorganisation led in most districts to the abolition of the District Nursing Officer role, and frequently also Director of Nursing roles in Units. Nurses came under the management of Unit General Managers which significantly reduced their profession-management autonomy.

Similarly, the few District head profession-managers in physiotherapy came under the management of Unit General Managers , and departmental heads became jointly-managed by the Unit General Managers and a District physiotherapist professional superior (Type 3A). The "fragmentation" of district services into smaller departmental groupings in Units significantly reduced the management autonomy of the profession. Although there was no evidence of major changes to practitioner autonomy, the profession-managers were in a weaker structural position to "protect" and advance practitioner autonomy.

In clinical psychology the research found that recent changes had reduced practitioners' Practice Autonomy, especially where practitioners were placed under joint management in teams(Type 3B). As with physiotherapy, district services were placed under one or more Unit General Managers, but profession-management autonomy was not reduced as much because of the Practice Autonomy of heads of department and senior practitioners (Type 2B).

Little research was undertaken by the author into medical organisation since 1985. The available evidence showed that Unit General Managers were increasingly questioning and sometimes negotiating various limits to consultants' previously wide Practice Autonomy (e.g. waiting lists, "throughput", clinical budgeting). There was some evidence of a weakening of the influence of the representative "advisory" pressure group structure. District General
Managers were not required to have District Medical Officers and could choose their district officers and professional representatives on top-level District Management Boards.

Professional Autonomy

The research showed that professional autonomy was a complex phenomenon made up of a number of different elements. Firstly,Chapter 3 showed that state regulation was not as critical to professional autonomy as Freidson suggested. Freidson's (1970) thesis was that certain occupations had achieved a qualitatively different form of control over their work through gaining state support to acquire institutionalised autonomy. He proposed that the state empowered a profession to define and control certain aspects of work and sanctioned a division of labour through state regulation. However, the author's empirical research in the UK revealed that state regulation did not enable professions to exercise any detailed control over the content or conditions of work of the average practitioner .

In the particular case of welfare professions in the UK, where the state is virtually the monopoly employer through local employing authorities, direct central government control is greater. One example of detailed control is the guidance issued by the DHSS regulating referral arrangements between doctors and physiotherapists.

The research showed that, certainly in the UK, features of local employment structures were far more important to professional autonomy and to defining the work of the occupation than were mechanisms of state regulation. Further, it showed that central government played an important part in recommending types of structure and features of structure which employing authorities established for professional groups.

Previous research has not recognised that head profession-manager roles were a key feature of the institutionalised autonomy and control of occupations in public services in the UK,or the significance of these roles for the professions. Managers in these positions extended and maintained occupational autonomy in a variety of ways. They "protected" practitioners from direction or evaluation by other occupations and, because of their structural position and authority, were able to resist plans and policies disadvantageous to the occupation. They played a part in creating structures institutionalising aspects of practitioner autonomy, in extending

definitions of the work of the occupation and in increasing employment opportunities by establishing extra posts.

The creation of these roles was not always welcomed by practitioners, some of whom felt that profession-managers reduced Practitioner Autonomy, and that new grading structures emphasised managerial skills and undermined practitioner career structures.

These findings also highlighted the ambiguity of the term "occupational autonomy and control" : occupations established different types of autonomy with state support, but they were also controlled. They only achieved this autonomy as a result of state authorisation. Whilst profession-managers have in the past extended the autonomy of the occupation, financial cuts and managerial efficiency initiatives in public services increasingly required such managers to use their authority to implement policies which restricted the autonomy of practitioners and which were against the interests of the occupation. Research into the role of head profession-managers revealed that "occupational control" involved both control of the occupation by its own members and control by the state and employers of the occupation. The author's later research showed a decline in the authority of head profession-managers, a dismantling of profession-management structures, and a reduction in profession-management autonomy in all of the professions of the study.

The thesis proposed that knowledge of these structures was important to an understanding of the authority and autonomy of professions in modern welfare societies. The state supported or required certain elements of structure (e.g. head profession-manager roles), and local employing authorities created and sanctioned structures which provided different types and degrees of authority and autonomy.

If institutionalised autonomy distinguishes professions, and if this characteristic is important for understanding why a variety of differences exists between professions, then, in the UK, management structures are a significant feature of the organised autonomy of certain professions. In contrast to Freidson it is not proposed that occupational characteristics derive entirely from institutionalised autonomy, but that a study of institutionalised autonomy is a more productive avenue for investigating occupations because it brings differences into sharper focus. The next chapter pursues this approach by considering changes in structure and autonomy, and the possible reasons for the differences which were discovered.

CHAPTER 7 : EXPLANATION OF DIFFERENCES IN INSTITUTIONALISED AUTONOMY

PART 1: INTRODUCTION

The research found that each of the five occupations had acquired different forms of authority and autonomy. At the national level the state established regulatory structures which provided each occupation with different forms of control over their workers and training institutions. At the local level , state employing authorities established management structures which also provided each occupation with different forms of control .

These structures and the different forms of authority delegated to different occupations now require to be explained. Why do the differences exist? How did they come about? And, what are the consequences?

The purpose of this chapter is to explain the differences in institutionalised autonomy which were found in the research. In doing so the chapter relates the research to the theories of professions reviewed in chapters 2 and 3, and to theories of professional organisation reviewed in Appendix 3, and explores the nature of the relationship between professions and the state. Chapter 8, to follow, draws together the main theoretical conclusions and argument of the thesis.

The research findings presented in this chapter to support or disprove different explanations are of a different order to the findings presented in Chapter 3 (state regulation) and Chapter 5 (details of management structures). Some evidence was noted in the course of research,but most evidence was gathered retrospectively and the chapter is often forced to judge the plausibility of explanations without reliable evidence. However , it will be argued that there is sufficient evidence to move the thesis from a critique of Freidson's theory towards a more general theory of professions which is relevant to modern state welfare societies,which is the purpose of this chapter.

The starting point of the chapter is Freidson's proposition that,

> "From the single condition of self-direction or autonomy I believe we can deduce or derive virtually all the other institutional elements that are included in most definitions of professions"
>
> [Freidson (1970a)]

Freidson's proposition is that there is a logical association between autonomy and the characteristics of professions included in the definitions reviewed in Chapter 2.
It would be wrong to conclude from this statement alone that Freidson proposed a causal link,although the proposition does direct attention to such a possibility.(It is also of note that autonomy is freedom from direction ,which is not the same thing as self-direction,a conceptual issue which will be considered in the next chapter).

However a further statement suggests that Freidson was proposing more than a logical association,

> "most of the commonly cited attributes of professions may be seen either as a consequence of their autonomy or as conditions useful for persuading the public and the body politic to grant such autonomy."
>
> [Freidson (1970a)]

Up to this point the thesis has put to one side the question of whether aspects of "autonomy" are a cause or consequence of professional attributes. Instead it concentrated on gaining empirical evidence about structures and processes which regulated workers and defined their work in order to gather evidence about the different types of autonomy and about differences between professions.

The thesis certainly took the view that the social structures for defining work and regulating practitioners were importantly related to attributes of professions. (Indeed, the review in Appendix 3 suggests that the "semi-professions" were "defined" by their work organisation). This view,however, was assumed by the thesis rather than proven, and provided the main reason for investigating these structures in detail: the question now is exactly how are these structures related to "attributes of professions", and are there other explanations for differences in autonomy apart from typical characteristics of the workers and of the occupation?

Clearly Freidson held that "professional attributes" were both a consequence of autonomy, and were actively used by occupations to achieve autonomy. By gaining empirical evidence this thesis is now in a position to consider the central proposition of Freidson's theory. The thesis has detailed evidence of different forms of autonomy, which can now be more precisely related to

particular attributes of occupations and of practitioners. It has evidence of changes in autonomy over time within each occupation. It also has less well documented, but still useful, evidence of the processes through which occupations within employing authorities acquired certain forms of authority : the author was present at, or took part in, discussions where each occupation put forward and sometimes won their claims for certain structures and authority.

PART 2: THE METHOD OF EXPLANATION

Problems of Explanation

The following problems were confronted in developing a satisfactory explanation,and in finding and evaluating evidence for and against Freidson's proposition and for other explanations for differences in autonomy.

Firstly, the strategy of explanation should not start by assuming that the aspects of structure and autonomy did produce occupational attributes, and concentrate only on these (possible) relationships: a wide range of explanations for differences in structure and autonomy should be considered. Freidson's proposition should be made to compete with other possible explanations. If, as a result of considering a wide range of possible influences, certain structures and patterns of autonomy are found to be consistently related to, and possibly formative of, occupational attributes, then the case for Freidson's proposition is stronger. The strategy of explanation adopted is therefore to consider a wide range of possible explanations.

Secondly, it is difficult to prove or disprove the proposition that certain structures and autonomy produce a range of characteristics commonly attributed to "the profession", rather than the opposite: that it is the characteristics which produce and account for certain structures and autonomy. Which came first? Evidence of a strong association would not be proof of causality or of a directional influence.

It is possible that Freidson's proposition cannot be proved or disproved. He did propose that occupations exploit certain attributes to achieve autonomy,and evidence of active agitation would suggest that occupations were also aware of the importance of institutionalised autonomy to their futures, but this does not resolve the cause or consequence question.

Consequently the strategy adopted below was, (a) to consider evidence of an association, and, where consistent associations were found, (b) to imagine and seek evidence for mediating influences, intermediate variables, or causal mechanisms in either direction.

Looking ahead to the conclusion,the thesis took the view that where an association was found to exist ,occupational attributes were both produced and reproduced by the structures discovered. It is certainly the case that some attributes are produced by certain structures - training institutions are established for the purpose of equipping practitioners with specialist skills and knowledge. The important question is not which came first, but rather how do occupations use certain attributes in particular situations to acquire authority and structures advantageous to their interests?

The perspective adopted below also develops an explanation which is different from a strictly causal explanation. Firstly, the explanation distinguishes between necessary preconditions, which do not exert a "direct influence" on structure, and are themselves only weakly affected over the longer term by management structures (e.g. training, professional culture and tradition, class), and more direct and "causal-like" factors (e.g. government directives).

Secondly, by viewing structure in an historical context, the perspective assumes that certain "objective" preconditions as well as human action lead to structure becoming institutionalised, and structure then begins to "exert an effect" back on the originating influences - this is termed below the "ratchet-effect" of structure. Thirdly, the perspective holds that explanation in terms of causality, or even "directional influences" is not the ultimate or only form of explanation, and that a valid form of explanation is also to show how observed social phenomena can be understood in relation to a unique combination of conditions and forces.These then were strategies adopted to examine systematically possible relationships between characteristics of professions, structures, and autonomy.

The third difficulty in developing an explanation was that possible influences and factors were considered after the event and the necessary evidence was often not available. The evidence which was found was frequently in a form which did not allow conclusive proof or falsification of hypotheses because the method for gaining the evidence was designed for purposes other than to test the particular hypothesis in question.

The fourth difficulty was that both the analysis and the following presentation were carried out by considering each factor in turn, and this limited a consideration of the interaction between factors. Factors do not exist in isolation but influence and mediate each other. A combination of factors may well have an effect which is difficult to predict and to analyse. In considering each factor the analysis aimed to remain sensitive to mediating and interacting influences, and considered the effects of combinations in the final summary explanation, but these strategies were only a partial and an unsatisfactory solution.

Although there were problems in developing a satisfactory explanation, certain features of the research design did make it possible to rule out some explanations. The advantages of the research design for developing explanations were, (a) the comparative nature of the study (five "welfare professions" employed by two types of government agency), (b) comparisons within one profession over time were possible (changes in both occupational characteristics and management structures and autonomy took place), and (c) precise and detailed data was gathered about different management structures and autonomy over time, and across professions.

Method of Investigation

In order to minimise these problems and to build on the strengths of the research to develop the best explanation, the chapter adopted the following strategy of investigation:

1) Identify determinants of structure proposed by previous research, or which staff and the author considered in the course of research projects, or which were suggested in retrospect by research subjects.

The review in Appendix 3 of previous research found that other studies had proposed or proved that certain factors or combinations of factors determined specific aspects or general patterns of structure (Appendix 3). The relevance of these findings to the subject of this thesis was assessed in relation to, (a) the type of organisation investigated in the research (ideally state welfare agencies in the UK), (b) the specific aspects or pattern of structure studied (ideally actual autonomy, authority patterns, or overall management structure), and (c) how well previous research defined the factors and variables suggested or proven to explain aspects of or patterns of structure (e.g. "market", "technology", particular characteristics of workers).

2) Hypotheses were framed to propose that certain factors were, (a) associated with, or (b) determined aspects or patterns of structure or autonomy which were found in the author's research.

3) Available evidence was examined which could prove or disprove an association. If evidence of a consistent association was found across professions, then possible mechanisms were identified and evidence of their operation sought.

4) Hypotheses of Combinations: Drawing on research, possible combinations or conditions were hypothesised to be, (a) associated with, (b) determining of structure, and evidence was sought to prove or falsify the combination hypothesis.

PART 3: ASPECTS OF STRUCTURE TO BE EXPLAINED

An important part of the strategy of explanation is to clearly define the critical aspects of structure to be explained.The previous chapter has already summarised these aspects, but mainly in terms of types of professional autonomy. This chapter draws in part on previous research into determinants of structure (reviewed in Appendix 3). These studies defined structure in slightly different ways. Consequently it is useful at this point to summarise those aspects of structure which were found to be critical for professional autonomy in a way in which it is easier to make comparisons with the findings from organisational studies. This recap, but from the point of view of organisational studies, also helps to ensure that the evidence from other research studies relates to the same aspects of structure which are under consideration in this thesis.

The following briefly summarises the particular aspects of structure which are to be explained. This is followed by a summary of significant characteristics of each occupation.

The thesis investigated management structures within large public employing authorities. The author's early field research found that, within employing authorities, each profession was entirely managed within its own hierarchical division. Towards the end of the research single nursing hierarchies were divided into smaller divisions, as were some physiotherapy and psychology hierarchies, and in some cases practitioners in the latter professions came under joint management.

Significant differences between professions were found in four related aspects of structure:

(1) The size and nature of the professional grouping or division, e.g. single managerial hierarchy of all members of the profession employed (described as "Type 1" in Appendix 4 ,e.g. nursing), or collection of medical firms ("Type 2C" structures in a medical division).

(2) The authority of the head profession-manager in an employing authority, as indexed by the number of practitioners managed, their authority in relation to practitioners ("full-managerial", "joint", or "monitoring" authority), and their formal position and authority in management teams.

The degree of practitioner autonomy was defined by two aspects of structure:

(3) Supervision and Evaluation by superiors: whether professional superiors were authorised and expected to undertake supervision - the nature and frequency, and the sanctions superiors were authorised to apply for breaches of regulations or poor performance.

(4) Formal regulations which ruled out certain activities and required particular actions: primarily those of the employing authority but also including those laid down by the profession; the number and precision of the regulations defined the degree of autonomy of the practitioner.

The following summarises the most outstanding differences between professions in terms of these aspects of structure (described in more detail in Chapter 6).

Nursing and social work managerial structures were characterised as "Type 1", "Autonomous Professional Managerial structures" (Appendix 4). One head profession-manager was managerially accountable for the work of all staff in the occupation, had "managerial authority" over them, and a position on the top level management team of the employing authority.

Physiotherapy structures were characterised as mostly "Type 2A "with two variations. In the first the head profession-manager (District Physiotherapist) had less than managerial authority in relation to all staff employed. They did not have authority over individual case decisions, and shared authority over certain aspects of staff managed in other Units with Unit Managers ("Dual Influence"). They were not full members of top management teams and had less structural authority than similar level nurse and social work managers. The second variation was where there were two or more groupings of staff, each with a profession-manager accountable both to their Unit Manager, and to a profession "leader-advisor" with a coordinative role, and less structural authority than the district head. ("Type 3A").

Clinical Psychology structures were characterised predominantly as "Type 2B". There was frequently a separate single management structure for the occupation with one head profession-manager, but this head did not have managerial authority over qualified staff who had case and practice autonomy. As with "Type 3A" in physiotherapy, they sometimes shared authority over aspects of staff management with Unit Managers. This variation (where there are two or more groupings of staff and a profession "leader" who coordinates heads of groupings), was more common in psychology because of fewer members of staff and Practice Autonomy. Clinical psychology had less management autonomy and the head or leader less management authority than physiotherapy, but practitioners had more individual autonomy.

In medicine the profession "leader" had even less structural authority over members of the occupation. Management autonomy (which involved one head with some form of control over all members of the occupation working in the authority) was limited by the weak authority of the profession-leader, which has been termed "monitoring authority". Each senior member of the occupation had Practice and Case Autonomy and access to top management ("Type 2C") :

management and autonomy was primarily the autonomy of each firm or division within the "Cogwheel" structure.

Thus in medicine, individual autonomy was greatest and occupational management autonomy the least because even a member of the same occupation had little authority over senior colleagues. The reverse was true for nursing and social work, where heads of profession gained autonomy largely because of the extent and strength of structural authority they were delegated over all staff in the occupation employed by the authority.

Characteristics of the Occupations

In considering explanations for these differences in structure, the chapter considers whether certain characteristics of the workers and the nature and degree of their organisation could explain the differences. The chapter earlier noted Freidson's proposition that these characteristics were both a significant influence in forming and maintaining the different management structures and autonomy, and the possibility that they themselves were produced and reproduced by these structures. Accordingly the chapter examines evidence for and against particular individual, social and economic characteristics being associated with types of structure and autonomy, and evidence of any mechanisms or formative influences in either direction.

Table 7.1 lists some characteristics of the occupations which are considered (NB estimates only). These were selected on the basis that earlier research reviewed in Chapter 2 suggested that one or more of these characteristics distinguished professions from non-professions, or was an important dimension for comparing "degree of professionalisation".

Dimensions of Comparison	Social Work	Nursing	Physio-therapy	Psychology	Medicine
Number employed by State Welfare Authorities (1980)	50,000	360,000	8,000	2,000	37,000
Number employed by a typical Authority	400	1,800	40	10	200
Professional Association & Organisation					
Age/History (years to 1987)	17	70	50	60	150
Percentage membership	50%	40%	100%	100%	100%
General degree of Unity	Unified	Unified	Unified	Divided	Variable
Unions	NUPE	Prof.Assn. (R.C.N.) COHSE NUPE	ASTMS	ASTMS	Prof.Assn. (B.M.A.)
Local professional organisation	Weak	Weak	Strong	Strong	Strong
Management structure (Appendix 3)	1A	1B	2A (3A)	2B (3A)	2C
Training/Education					
Required entry qualifications for training	"O" Levels	"O" Levels	"A " Levels	Degree	Degree
Length from "O" Levels (years)	2	3	5	7 - 8	10
Type	Practical	Practical	Practical/ Theoretical	Theoretical/- Practical	Theoretical Practical
Career					
Average length (years)	10	15	30	40	40
Unemployment	None	None	Little	None	Little
Pay/Income					
General level (£1,000)	10	9	10	14	20
Income Range (Practitioner)	6 - 15	6 - 13	7 - 13	7 - 21	9 - 40
Private Practice	None	Little	Some	Some	Some
Social					
Status	Average	Average	Average	Above Average	High
Social valuation/recognition	Low	High	Indifference	Indifference	High
Class composition (R G classification)	3	3	2	2	1
Sex composition	Female 80%	Female 95%	Female 90%	50%: 50%	40% : 60%

TABLE 7.1: Occupational Characteristics on Salient Variables (estimates only)

The questions which guide the analysis to follow are: what factors or influences have been proposed to explain the particular structures and autonomy found in this study? , What evidence is there that these factors are consistently associated with these structures?, Is there any evidence that these factors or influences were themselves produced by the structures, or were themselves altered as a result of the structures?

The discussion does not aim to evaluate professionals' claims for certain forms of autonomy. The question is rather why managers and employing authorities accepted certain claims from certain professions at one time (e.g. 1974) rather than another (e.g. 1984), regardless of their "objective validity", and decided to establish certain structures. In this sense the discussion is concerned with a common process which operates at the national and local levels - the use of power or certain potentialities in a particular situation to acquire authority.

By seeking consistent associations between factors and structure the following also tests the hypothesis that it is not so much "objective determinants" which require or "cause" structure, but more how professional groups use their power and develop their arguments, which lead to institutionalised autonomy. If, for example, no consistent associations are found to exist over time, and if it does appear that structures can only be explained by a combination of influences at a particular time, then this would support the "power" thesis. The method for seeking an explanation, then, by initially searching for "objective" and consistent associations, does not assume the "power" thesis.

The chapter now considers possible factors and influences which are grouped under the following headings: the nature of the work and its requirements of workers (Part 4); Salient characteristics of a typical member of the occupation (Part 5); Characteristics of the occupation and social factors (Part 6); and characteristics of state employing authorities and of their environment (Part 7). Part 8 provides a summary explanation and draws out some general propositions.

PART 4: NATURE OF THE WORK AND ITS REQUIREMENTS OF WORKERS

This section considers whether certain characteristics of work and tasks are associated with, or require certain forms of autonomy on the part of the worker doing the work. The discussion notes at the outset the difficulty of separating so-called "objective" or inherent features of the work, from attributes required of individuals to do the work, and both of these from socially-determined aspects of the work and of individuals. This interrelation and the importance of separation is demonstrated in the idea that certain work is "complex". However, work or a task is not of itself "complex". To describe work or a task as "complex" is to minimise through shorthand the act of an observer or a worker who constitutes certain behaviours or activity both as work, and as complex work. It is "complex" in the view of an individual who defined it as such and in relation to other tasks and work.

A central proposition of the thesis is that the constitution of tasks and work is a social act, and that certain structures and regulations are significant in defining the work to be undertaken by occupations. Further, that professions are occupations which have acquired the authority to define features of their work, and certain forms of autonomy in relation to managers and employing authorities. The following, however, is concerned to identify and examine both the influence of arguments, and the objective possibility that certain features of the work require certain forms of autonomy. The discussion will not assume at the outset that the way in which work is defined is conditioned by the structures to be explained; rather it will begin by examining the possibility that the nature of the work determines the structure, first by seeking evidence of association between types of structure and aspects of work.

The discussion also notes the tendency in previous studies to search out distinguishing features of the work and of the workers to explain autonomy, and the tautology of consequent explanations. To further explore the proposition that there is nothing inherent in the work of certain occupations which distinguishes them as professions (which was advanced in Ch 2), and that it is how occupational groups exploit aspects of the work to acquire institutional autonomy which is important, the discussion begins by considering both features of work which are common to all the occupations, and variations within each profession.

Human Services Work: Common features of the work of the five occupations

A feature common to the work of the members of the five occupations considered is that the purpose of the work is to help people in need or in crisis, and involves direct and frequent contact

with clients in distress , and contact with a variety of other people. All members of the occupations are "people workers" [Bennett and Hokenstad (1973)] in their primary client focus, and in their interactions with colleagues, managers, students and others : human relationships form the context of, and the medium through which the work is carried out. Practitioners in all the occupations require skills and personalities which enable them to cope with and deal with people. In addition, members of all the occupations could be said to share broadly similar values in wishing to prevent suffering and to enhance individual and social welfare.

It would be expected that the organisational structures and cultures of all the occupations would differ in some respects from occupations in manufacturing and commercial organisations. In particular, that structures which detracted from, rather than enhanced, human relations, or which were contrary to the common values of members, would be actively or passively opposed.

The discussion is, however, concerned with three particular aspects of structure: the overall division into profession-management groupings (profession-management autonomy) ,which is likely to be independent of these considerations; the degree of discretion,as defined by rules and regulations; and the nature and frequency of supervision (Case and Practice Autonomy).

Apart from the "people nature" of the work and, at a general level, shared values, there are few other aspects of work which are common to all the professions, and which could be associated with the three types of autonomy under examination. This is not to suggest that the differences are only between professions: there are frequently more differences in the nature of the work within professions than between them. In terms of the nature of the work and the everyday task, psychiatry has more in common with social work than with surgery.

Conception of client and aims of intervention

It is rather the conception of the object of intervention which is shared by members of the same profession, rather than the particular methods or work tasks. In general ,doctors are concerned with physiological and biological functioning: their perspective constitutes the individual as a biological system, and as an object, and their interventions are direct and of a "causative" form (surgery, drugs, radiotherapy, etc). The nature of the work and its success lies in science-based techniques, selected because the interventions work regardless of the "patient's" subjective state: the personality of the "patient" and their feelings are relevant mainly to ensure their complicity with the prescription, and to "keeping the customer satisfied", rather than being viewed as central to the possibility of success in achieving work objectives.

In contrast, social work, at least in ideology, constitutes the "client" as a subject and as a person, and aims to "support" and enable the person to assume responsibility. The social worker works through a relationship with the "client" (be it individual, family, or community) and conceives the client as an active agent , potentially capable of solving their own problems. The work of nurses, psychologists and physiotherapists can be placed at different points along this dimension of "client as subject-object".

On the basis of this analysis there would appear to be a disjunction between the authority structures in social work and in medicine in terms of the authority involved in the client-practitioner relationship. The typical social worker - client relationship strives for "equality" and to reduce the authority component and to "empower" the client ,yet the management structure is the most hierarchical and autonomy the least. There is no evidence to support the proposition that practitioner autonomy is related to the type of relationships with clients which each profession aims to achieve. Later sections will consider the implications of the occupation's conception of object of intervention for the type of client-practitioner relationships it wishes to cultivate and the implications of this for management structures and the "resonance" of authority relationships.

Although the nature of the work and tasks of practitioners in the same profession is similar when viewed in terms of the theoretical assumptions and intentions underlying practice, there are also many differences within professions. Why, then, were management divisions constituted by profession in the 1970's, rather than on any other basis (e.g. client grouping)? ,Why do the profession-management structures take the consistent form which they do?, and Why, for example, do <u>all</u> GPs, most medical consultants, psychologists and physiotherapists have Case Autonomy, regardless of their particular field of work?

Professionals' claims about their work and necessary organisation

To answer these questions the discussion first considers explanations and arguments proposed by professionals about their work. Two approaches to investigating whether certain work necessitates certain structure are to examine situations where structures undermine the proper carrying out of the work, or to examine the reasons proposed for not adopting certain structures. Both rely on practitioners' views. Members of the occupations studied often argued that the particular nature of the work they undertook required certain forms of autonomy which were precluded by certain structures.

The experience of individuals undertaking a particular form of work and their views about how structures impede or facilitate their work provide valuable insights and suggest possible explanations for the reason why certain structures are formed and maintained. That individuals in

the occupation claim that their work requires certain forms of autonomy, or that certain structures are appropriate or inappropriate, does not discount the explanation, but requires that it is treated with caution and as one of many explanations.The discussion first considers two related arguments,stated in propositional form to direct attention towards evidence for and against the propositions.

Proposition: *"the professional's role is to apply and develop new approaches to solving problems. Profession-managers with a particular practice-orientation could drive out as yet unproven but promising approaches."*

Proposition: *"Regular scrutiny of case decisions questions the practitioner's judgment, and undermines their confidence to act in uncertain situations when they only have their experience and intuition to guide them."*

A variation of this argument was noted by Carr-Saunders and Wilson (1933) in connection with state registration for doctors: that different perspectives and approaches in medicine were often, at least initially, without scientific foundation, and that "heresy-hunting" could be to the ultimate disadvantage of the public and the profession. In the course of the author's research the argument was frequently used by psychologists to maintain Case and Practice Autonomy and in a context of national debate about the "proper innovative role" of health psychologists. It is of note that whilst professionals argue that only they have the expertise to regulate the work of their colleagues,when the time comes to do so,they argue that they do not have the expertise, and for each expert witness arguing that a particular approach is safe and accepted practice,as many can be found to testify that it is harmful.

Although much has been said about the importance of theoretical knowledge in professional work, practitioners are regularly faced by clients and problems demanding solutions where there is no theory or scientifically-established procedure to guide their action [Argyris and Schon (1973)]. A distinctive feature of professional work is frequent uncertainty, and that practitioners are required to act with only their experience and intuition to guide them - the notion of profession as an art as well as a science. Further, the idea of a superior who could or does scrutinise case decisions, and of being held to account for decisions which are difficult to justify on explicit and scientific or rational grounds, is said to undermine the confidence to act in uncertain situations. Professionals resistance to managerial strategies codifying and routine procedures (Braverman (1973)), such as computer-aided diagnosis or standard forms and records, is sometimes founded on this notion of the requirement for flexibility of response.

This argument is in fact the opposite of the argument proposing that professions are distinguished by the application of scientifically- established knowledge, and that the proper application of scientific knowledge requires a high degree of autonomy. There is truth in both arguments [Elliot (1972) p 129], but neither explains Case nor Practice Autonomy. It could equally be argued that the requirement to take decisions with little basis in theory in uncertain situations is a strong reason for greater scrutiny and accountability. Further, the argument does not explain the differences in management structures - if it did, occupations with a less well-established scientific basis such as social work could be said to be more likely to require Case Autonomy.

From the perspective of this thesis, the central issue is the authority of the practitioner : practitioners are aware that their interventions are frequently of unproven effectiveness, and their anxiety and uncertainty in crisis situations is not assisted by a further anxiety of having to justify the intervention in rational terms on a routine basis to a superior. It certainly does not help the practitioner in trying to maintain their authority in relation to clients for the client to know that the practitioner is routinely supervised, and for the client to be told that the practitioner's superior took a different view and "suggested" an alternative course of action.

The practitioner must have confidence in their own ability, in order properly to deal with the "authority problems" in their relations with clients. Some practitioners', and clients', confidence is enhanced by routine supervision (termed "managerial support" by social workers and some nurses), but it can undermine the practitioner's confidence in the many uncertain, unpredictable, and impossible situations which they face.

The professional and organisational "solution" is frequently a member of the same profession as superior who "understands": it is the contention of this thesis that their "understanding" is primarily of the problems of authority in the client-practitioner relationship, rather than of technical questions. What is critical is that they were ,or are a practitioner, not their specialist theoretical knowledge.

A closely related argument is put by professionals in support of claims to autonomy, and in frustration with managers who, "just don't understand our work". This argument, below, highlights a possible correspondence in authority relationships between superiors and practitioners, and between practitioners and clients,

Trust and Confidentiality

Proposition: *"A personal trusting and confidential relationship between client and practitioner is necessary to successfully help the client. A superior with authority to review, and override case decisions is incompatible with this necessary condition of our work."*

Jaques (1978) proposed that the requirement for "personalised care" arose out of "the nature of illness",and that some doctors' independent practitioner status (Case and Practice Autonomy), "arises primarily to provide the patient with the personal confidential doctor-patient relationship so essential for adequate treatment of the anxiety bound circumstances of illness".

The core of the argument is that client-practitioner confidentiality must be assured for the client to seek out the doctor, and for the doctor and client to exchange information freely. It is ,however, a particular aspect of managerial authority which conflicts with this requirement- the authority to seek detailed information from the doctor if they were a subordinate- and which breaks the complete confidence between client and doctor.

This is certainly a powerful argument ,and an explanation for Case Autonomy in medicine, and explains the different hierarchical structures in some fields of medicine. However, it does not, of itself, explain the managerial "Type 2C "structure below consultant practitioners, nor the "diffusion" of Case Autonomy into the wider Practice Autonomy, nor the general structure of medical committees within employing authorities. In short, the "requirement" of client confidentiality does not of itself explain the high degree of institutionalised autonomy which is above and beyond the conditions necessary for client confidentiality.

It could, however, equally be argued that certain forms of scrutiny and peer evaluation would increase clients' trust in doctors. Peer review, medical audit and other management functions can be carried out in ways which maintain confidentiality. This would assure clients that the doctor was not only fully qualified and competent, but that there were systems and regular checks to ensure that he remained so, as is the case with relicensing and audit in the USA. Only voluntary peer review is possible with Case and Practice Autonomy and doctors in the UK are not required to undertake systematic or even informal performance checks. The argument appears to apply only when managerial structures are proposed, and is forgotten when peer review is considered.

Further, it is arguably just as important in social work to achieve a trusting and confidential relationship as in medical work. Indeed the reality of practice is that such relationships are more often achieved in the social work agency service, even with managers regularly supervising workers, checking records and overriding decisions, and with regular changes of worker, than in

the six-minute family doctor consultation. The fact that a social worker is an agent of local government, and is known to keep records on clients, impairs but does not prevent a personal and "confidential" relationship [Øvretveit (1986a)] . Indeed by sharing and writing records with clients, social workers have been able to circumvent this disadvantage, and increase clients' confidence and trust, leaving doctors struggling with the contradictions between their above argument and their refusal to share records with patients. Neither does personal choice of medical practitioner appear to be a requirement for successful client- practitioner relationships, or a reality within 1980's public welfare services.

"Resonance" of authority relations

There is perhaps a more general point related to the above proposition, which suggests that practitioner philosophies emphasising equality with and valuation of clients, and which minimise authority in the relationship, are incompatible with hierarchical managerial structures. The social work philosophy and the social services hierarchical structure frequently conflict, and team leaders try to minimise the disjuncture and contradictions through their style, but cannot ignore their institutional position and authority.

The traditional nursing philosophy conflicted less with the hierarchical structure of authority in nursing,and the authority of nursing management structures was frequently "reproduced" in relationships with clients. In the case of the medical profession a different morphology of authority relationships operates, more akin to the public school prefect-succession principle: House Officers and Registrars, subject to consultants' authority in the hierarchy, wait their turn for consultant grade, and when their time comes, perpetuate the same structure of authority in their relations with their patients and junior doctors.

One way of testing these ideas would be to place profession-client relationships on a dimension ranging from "active client" to "passive client", and to investigate whether "passive client work" is associated with managerial hierarchies, and whether work where clients take ,or are required to take ,an active role involve forms of organisation with different authority relations.There is some evidence for this proposition in the correlation between the "democratic" organisation of some community mental handicap and mental health teams and the type of relationships team members establish with clients(Øvretveit(1986b)).

It is difficult, however, to prove or falsify the hypothesis of a "resonance" between the authority relations within work organisation, and the relations between practitioners and clients. There is some evidence that client-junior doctor relations are affected by clients' knowledge of supervision, and their belief that they are "getting second best".

In summary, the "requirement" of confidentiality, and of a personalised and trusting relationship, then, is common to all the professions. It is more necessary in the case of social work, where the relationship is the primary medium through which the social worker achieves their helping aims, yet social workers are organised in a managerial hierarchy with routine supervisory review. Of significance is the fact that only doctors were able to exploit and assert the argument to achieve institutionalised autonomy which went beyond the confidentiality "requirement", and indeed shaped much of the structure of the NHS.It appears that it is not the truth or falsity of the claim which is important, but how it is used and received, and the institutional consequences, which are critical.

The above discussion suggests a hypothesis for more rigorous testing: the more important the client's trust and confidence is to the practitioner achieving their work objectives, and the more central the relationship to the work, then the more likely management structures will emerge which provide for Case Autonomy. A corollary is that where the client-practitioner relationship is central and managerial structures are adopted, then practitioners will discourage review of case decisions and experience frustration if managers regularly scrutinise or alter such decisions, especially where work success requires the client to undertake an active role.

Another work-related factor proposed to explain types of autonomy is the potential danger to the client if a member of the profession did not intervene, or if the quality of the practitioner's intervention could be impaired by rules and supervision.Evidence for and against this factor will be considered first in relation to "emergencies".

Flexible Response in Emergencies

Proposition: *"Without a high degree of practitioner autonomy, and authority to determine critical aspects of the context of practice, the practitioner is not properly able to use their skills and knowledge to help clients in danger, and life will be put at risk. Even if regulations are established, the practitioner has a moral obligation to ignore them if doing so will save life."*

At question here is ,a) whether occupations are only able to properly use their skills and knowledge if they have greater autonomy, and b) that life and death situations make this requirement of overriding importance. It is certainly the case that the life-threatening aspect of medical work is related to autonomy, and this feature is not present to the same degree in the other occupations, apart from certain "crisis" social work. However in cases of suspected child abuse, for example, the "danger" of the situation in social work leads to high structure rather than autonomy : close supervision, and numerous rules and procedures. Clearly the "danger"

element of the work must be linked with other elements such as degree of skill and knowledge (as indexed by years of training) to form associations with autonomy. However, the more links which are established, the more circular the argument becomes ,and the more difficult it is to view elements separately. There is a constellation of elements which closely interrelate and which involve danger, client vulnerability, length of training and amount of skill and knowledge

Further, "danger" exists only where there is the possibility of human intervention : many specialist skills and knowledge are applied and developed to save life, and a person only becomes "at risk", "in danger", or "in need" if the possibility of solution exists. One approach therefore is to consider how needs and the possibility of their being met are constituted, and this requires examination of how professions develop areas of expertise, and then capitalise on the potential which this opens up. This line of enquiry leads in the direction of an analysis of how markets for specialist skills are developed and "dependencies" created.

Returning to the original proposition : where the practitioner has the skills, knowledge and experience to be able to save life, and an ideology and /or code of ethics which puts this objective above all else, it is likely that external rules and regulations which restrict their ability to do so will be ignored. The argument that, given the skills and knowledge, autonomy is necessary to be able to properly use skills to save life is a powerful one and clearly important in institutionalising the "required" autonomy. These factors are important in explaining the relative autonomy of certain doctors in comparison to workers in other occupations, but it is also important to question how it was that doctors came to achieve this position, and to note how the argument is generalised to justify medical authority over a range of decisions beyond the "context" of the work setting: how "shroud-waving" has been used to acquire institutionalised authority and autonomy far beyond situations of danger.

The final argument frequently put by professionals for Case Autonomy is the difficulty of evaluating professional interventions, especially if the"requirement" of confidentiality is to be upheld.

Expertise Required for Evaluation

Proposition: *" Management of practitioners, even by a senior member of their own profession, is impossible because such managers rarely understand enough of the work of the speciality to judge case decisions, or to decide case and task allocations."*

Where there is advanced sub-division into specialities within a profession, and a senior member of the profession would not have experience in most of the specialities, then the possibility of a full-

managerial relationship in relation to case work practitioners is precluded. This argument is similar to the argument that a lay person could not judge competence to practice. The important issue is how professions exploit the potential arising from the belief that non-specialists could not judge negligence or incompetence.

Again, of note is how the problem of evaluation by non-specialists is generalised to suggest that non-specialists would be unable to delegate appropriately any tasks, and that any form of management is impossible. At this point the discussion notes that the nature of the social work task renders it amenable to evaluation by lay persons in terms of both process and outcome, and that the autonomy of social workers is the least. The social work task is both "transparent " and "highly visible" in a number of respects. Part 5 to follow further examines the significance of the specialist character of professional work for management structures.

So far the discussion has centred on the authority of superiors, mainly in supervision, and has not considered the other aspect of Case and Practice Autonomy: the number and nature of rules and regulations limiting the discretion of the practitioner. By considering practitioners' arguments against structures which reduce autonomy, the discussion also has not considered "positive" influences or determinants of autonomy ,and the advantages of professional autonomy to the organisation and clients.

The account noted earlier that, whilst it is difficult to separate features of the work from characteristics of the worker, it is possible to examine work and tasks on a dimension ranging from more "objective" characteristics of work or tasks (e.g. repetitiveness, danger to client or worker, etc), to characteristics which imply requirements, abilities or responses of the worker, such as the application of theory, or emotional stability (what the work demands of the worker).The discussion which follows assumes that some factors are more closely related to attributes of the worker than others.

Supervision, Rules and Technology

Bell (1965) carried out a series of studies which investigated the interrelation of rules, supervision ,technology and tasks in a hospital. He found that a number of factors influenced both the degree to which employees' activities were directed, and the selection of the means, or surveillance by which direction was carried out. A direct association was found to hold between the predictability of demands on workers and the use of rules and surveillance [Bell (1965)], and an inverse relationship between rules and surveillance and the skills of the workers and the complexity of the technology [Bell (1966)]. Bell concluded that,

> "The more unpredictable the work environment, the less there will be close supervision. Further, as closeness of supervision increases, the extent of rule-usage also increases."

Many studies have proposed and found that high "task predictability" is associated with high degree of "structure" and high degree of "formalisation" of work organisation, and that the more routine and uniform the tasks, the more the structure approximated to Weber's ideal type of bureaucracy [Litwark (1961), Perrow (1967), Burns and Stalker (1961), Lawrence and Lorsch (1967), and Hage and Aiken (1969)].

A related "economic" argument is that workers should not, and cannot be bound by many highly-specific organisational rules if they are properly to use their skills and knowledge in situations which are frequently unpredictable in nature and required response. This study certainly found a strong association between both years of training and importance of theoretical knowledge to the task (NB: not years of experience), and degree of autonomy.

However, there is an element of circularity in the observation that many detailed rules of procedure are not ,and cannot be set beforehand for unpredictable work. If supervisors have to frequently supervise workers in such situations it is more economic for the supervisor to do the work themselves . It is better to employ professional workers who have been trained to apply flexibly rules of diagnosis and procedure to individual cases without constraining their discretion with too many organisational rules.The observation and explanation,however, does not explain why or how certain types of work came to be undertaken by particular occupations.

The important issues are, whether the work requires or demands a non-rule-bound flexible response, how such work is constituted and defined, and whether work which does require a flexible response is the consequence of occupations increasing their knowledge base and training, rather than "inherent" in the work or in the "problems" to be solved.

If professions achieve management autonomy they are more able to constitute work and needs as complex and as requiring their skills, and this is to their greater advantage than having to rely on management to conclude that the only skills available to meet needs which managers must provide for those of members of the occupation. The latter is the effect of the indirect power of professions resulting from their control of training and a labour market; the former is direct authority in the constitution of tasks.

Technology and Structure

The review of the relationship between "technology" and structure noted considerable variation in definition of "technology", and problems in separating "technology" from social structure(Appendix 3). Particular problems arise when "task" definitions of technology are used which entail operational procedures, procedures which are themselves aspects of structure,or where professional techniques or practice theory are subsumed under a definition of "technology".

The way in which technology and task are defined and classified depends on the purposes and assumptions of the study. Classifications related to aspects of structure include: operations, materials, knowledge, technologies (Hickson et al (1967)); long-linked, mediating, and intensive technologies [Thompson (1967)], programmed and unprogrammed decisions [Simon (1958)]; and task predictability [Bell (1965)].

Some studies have shown that the technologies of different medical specialities are associated with different forms of organisation [Rosengren and Lefton (1969) pp 119-144)]. Perrow (1965, pp 650-677) showed that contrasting definitions of "client material" are associated with technology and hospital structure. If the discussion is confined to technological hardware it can be seen that the medical profession is the only occupation which uses this form of technology extensively in its work. However, there are many types of medical work which do not require specialised equipment, and technology has not prevented managerial structures in other occupations.

If the definition of technology is broadened to include a variety of techniques for achieving work objectives, it is possible both to distinguish the work of the professions from lay activities, and to enter into an examination of work objectives and methods. The discussion above noted that each occupation used a variety of systematic methods, with varying bases in scientific theory, to achieve certain objectives. Both methods and the theories could be said to constitute a technology. In connection with methods, social work and psychology explicitly use the client-practitioner relationship as the primary vehicle of intervention, whereas nursing, medicine and physiotherapy mainly use direct physical or chemical methods of intervention to effect treatment. However, structure cannot be explained solely by reference to the client-relationship as a vehicle for achieving work objectives.

Thus if a "narrow", "hardware" view of technology is taken then there is no consistent association between professions and the structures which this chapter seeks to explain. If the definition is broadened to include work processes, including aspects such as duration and frequency of client

contact, the physical siting of contact, etc, then associations do begin to hold between e.g. "community" work and methods and greater de facto autonomy for practitioners in comparison to hospital or residential work.

However, of greatest significance are the theoretical assumptions, noted earlier, held by different professions about the nature of the object of intervention and appropriate methods for "successful" interventions. The discussion earlier focused on the client-practitioner relationship as the critical variable.The account has therefore already examined "technology" as a potential influence on structure by considering different elements of "technology" in other discussions.

To pursue the questions raised above about how work is defined, whether "complexity" is "inherent" in certain tasks or "problems", and the question of the interrelation between number and nature of organisational rules (one aspect of autonomy) and amount of training and theoretical component of the work, the following considers certain characteristics of typical members of each profession.

PART 5: SALIENT CHARACTERISTICS OF TYPICAL MEMBERS OF EACH OCCUPATION

Training, Education and Knowledge

Characteristics which distinguish the occupations of this study, and which have been put forward to explain professional management structures are , length of training, amount and level of education, and the abstract, theoretical and specialised nature of professional knowledge (Ch. 2).

There is clearly an association between length of training and type of management structure. Medicine has the longest training and the structure is managerial up to the Case and Practice Autonomy of consultants and GPs. Social work has the shortest training and the autonomy of practitioners is least. The strong association between length of training and degree of institutionalised individual autonomy is present in a variety of occupations with few falsifying instances, but this association does not of itself explain the structure. Amount and level of education is similarly strongly associated, but this observation alone does not take the explanation much further.

A strong association between the abstract and theoretical nature of professional knowledge and degree of institutionalised autonomy is also to be found.However, it is the specialised character of

the knowledge which suggests one factor which could play a part in accounting for differences in structure.

The discussion noted above that specialist knowledge certainly limits the extent to which managers can assess performance in terms of process, and limits their ability to decide details of task allocation. It appears that the more specialised the knowledge (N.B. not the task) resulting from an increasing division of labour, and the more rapid technical and scientific development becomes, the more occupations are able to claim and gain management autonomy and individual autonomy. It is a resource which individuals and occupations can draw on to claim areas of authority and to increase degrees of autonomy ,and can also actively develop through research and "specialist" divisions. This strategy is similar to the way in which any worker attempts to extend their autonomy by becoming expert about activities on which management is dependent, but about which management is inexpert (e.g. computer specialists and autonomous data processing departments).

Specialised theoretical knowledge is an extra resource in such strategies, and even prevents evaluation of objective outcome as well as of process in some cases, thus preventing certain forms of management structure (Type 1). However, it is not an adequate explanation of a particular structure to account for it in terms of factors which prevent other structures such as a managerial structure from being adopted or maintained. This factor does not explain the institutionalisation of Case and Practice Autonomy, where the practitioner is in principle exempt from scrutiny and from having decisions about individual cases or the internal management of a practice overruled, even by other experts.

Effective Application of Skills and Abilities

One approach is to seek evidence or proof for or against the proposition that Case and Practice Autonomy and Type 2 and 3 structures promote or maximise the use of theoretical knowledge and training. That is, that the practitioner knows how to apply their theoretical knowledge and training most effectively, and that restricting their autonomy results in an inefficient and ineffective use of resources.

There is clearly an association between length of training, level of knowledge, and the number of high-level practitioner posts. Social work and nursing have fewest high-level practice roles institutionalised in their structures, and medicine the greatest number. A management structure and policies which prevented an individual drawing on, and using, training and abstract knowledge in exercising discretion in case work or in running a practice would be inefficient, and also causes practitioner frustration and "wastage". Although practitioners in all professions complain of

"unnecessary" restrictions to their autonomy, there are more high-level practice roles established in some professions than in others.

This argument in part explains the greater number of high-level practice roles in psychology and medicine, but, again, does not explain the Type 2 Case and Practice Autonomy structures, nor the difference between Type 2B structures predominant in psychology and the Type 2C structures of medicine. The Type 1 managerial structures also provide a variety of high-level roles, and practice roles with full accountability in such structures are possible with managers in the same profession (e.g. social work, nursing). Why, then, is there a tendency in the five professions of the study and in others towards increasing numbers of higher-level practice roles, which develop into roles with Case and Practice Autonomy, autonomy which is institutionalised in the management structure?

The increasing number of high-level roles could be explained as a result of the development of the theoretical and technical knowledge base of each occupation, and as a result of the development of the abilities of the individuals who enter the profession.

Individual Work Capacity

Jaques' (1976) theory of the development of individual work capacity and of the relationship between this factor and structure can also be applied to understand the differences between professional structures. An application of this theory to the professions leads to the proposition that different occupations attract individuals with different actual and potential work capacity. A plausible hypothesis is that the higher entrance and training requirements of clinical psychology and medicine selects individuals who are able to undertake higher levels of work than individuals entering the other occupations.

The theory proposes that the overall hierarchical shape of management structures, and the number of roles at different levels, reflect the distribution of work capacity of individuals in the occupation. It proposes that, given the level of work capacity on qualification and the predicted work capacity development profiles of individuals, individuals would naturally develop roles and work which reflected their increasing work capacity. Thus the higher level career grades in clinical psychology and medicine reflect the abilities of individuals in the profession. The theory does highlight the influence of psychological and individual characteristics on structure and suggests that this could be a factor influencing the social creation of high-level practitioner roles.

The theory does partially explain the rise in the level of work of the career grade in each profession over time, and the shape of each hierarchy and the proportion of practice roles at different levels in

each profession. However sufficient evidence has not yet been reported to support the theory ,and its scientific status remains contentious.Further,and explanation derived from this theory would not explain Case and Practice Autonomy. Again, it does not explain why practitioner roles undertaking higher level of work are exempt from managerial scrutiny of the detail of case decisions.

In summary, the discussion above noted the strong association between, on the one hand, length of training, level and type of education, abstract theoretical and specialised knowledge, and on the other, the different management structures. Although these factors do not entirely explain the structures, their significance is perhaps in the fact that they can be used by the professions and individuals to legitimate their claim to, and defence of, autonomy.

Training and knowledge characteristics are related to the nature of the work which is to be undertaken by the professional. The individual ability to undertake high-level case work may be one element in explaining the proportion of high-level practice roles in psychology and medicine, but the explanation is circular and difficult to prove. However, none of these factors explains Case and Practice Autonomy, nor how, for example, psychologists were able to establish Type 2B structures.

For employing authorities, however, the characteristics of members of the occupation appear as given . For occupations with less training and knowledge base, managers have more flexibility in reconstituting tasks and in forming a division of labour and structures suited to management rather than professional ends.

The discussion now considers the extent to which certain social characteristics of the occupations, and factors in society, may be associated with forms of autonomy. It assesses evidence for and against factors such as occupational coherence, class and sex composition, either influencing or creating favourable conditions for certain forms of autonomy to be established. In addition it considers whether forms of autonomy and management structures could themselves have influenced occupational characteristics.

PART 6: CHARACTERISTICS OF THE OCCUPATION AND SOCIAL FACTORS

Size of Profession-Management Division

The discussion first considers the number of members of each occupation in relation to the size of each management division, and whether this variable is associated with certain structures.

The Aston studies [Pugh and Hickson (1976)] suggested that the larger the organisation, as indexed by different variables, then the more likely that it will exhibit "bureaucratic" features, one of which is a managerial structure(i.e. Type 1). Blau (1970) proposed that, "increasing size generates structural differentiation in organisations along various dimensions at decelerating rates". One form of differentiation is by profession.

District Health and Local Authorities are large organisations in terms of most indices of size, and if the unit of definition is widened, the NHS constitutes one of the largest "organisations" in the world. Most of the workers employed are termed "professional" and there is a variety of different professions within each authority. The units of organisation under consideration here are the management structures of five professions within these public service organisations.

There is an association between the increase in size of employing authorities,with the expansion of welfare services in the 1960s, and the grouping together of single occupations within separate management structures. But was the creation of these separate structures a result of increasing size? Were there not other possible bases for division, apart from by "professional function"? Recent public service reorganisations have not based their primary management divisions on professions (e.g. "Griffiths" NHS Reorganisation, 1984, and London Borough community services).

Argyris (1972) argued that, "Size may be correlated with, but may not be said to generate or cause, structural differentiation." (p 12), and Woodward (1965) in another context found that size was not significant in explaining differences between the organisations of her study. (In fact she noted that, "The size of the management group gave a better indication of the "bigness" of a firm than the total number of employees." (pp 41-42)). Coleman (1961) also concluded that the degree of specialisation did not increase with the size of school. In referring to these studies for evidence, however, care must be taken to compare similar features of structure.

In general, large size itself does not necessarily produce an overall managerial pyramid structure. If large numbers of professionals are employed, why then should they be managed in separate occupational groupings?

There is an association between numbers employed and type of structure in the five occupations in typical employing authorities. Nursing has the largest number (approximately 800 staff), followed by social work (including unqualified, approximately 400), medicine (approximately 300), physiotherapy (approximately 40), and psychology (approximately 10). (Figures arrived at by dividing national numbers by number of employing authorities).

There is some evidence of an association between the size of the management unit, and the type of management structure and nature and degree of practitioner autonomy. Why does this association exist, is it coincidental, and what intermediate factors could there be which might explain the association? Does management of a large labour force require a managerial structure and does this factor override other factors and suppress certain influences? How does this observation contribute to an explanation of differences between structures?

Control and use of Labour

Reference has already been made to the rapid post-war expansion of welfare services and to the large increase in the number of members of all five professions in state employment. It is possible that the combination of increased numbers and the rising cost of welfare services were key factors in decisions to form single occupation structures in nursing and social work. Was it not possible ,however,that creating such large structures might itself create groupings which could form opposition and make it more difficult to impose cost-control measures?

Management theory was one aspect of the "environment" of the time which influenced decisions to create high-level profession-manager posts. It was argued that members of the same profession could best understand how to make the most effective use of an increasingly skilled labour force, and would be better able to command obedience. The more staff that were employed, the greater the structural authority of these roles, which in turn resulted in greater management autonomy for the occupation.

The part played by certain social factors in the creation and maintenance of different management structures is highlighted by Marxist perspectives. One element of the Marxist theory of the state is that welfare services are established by the state to provide basic services and favourable conditions for capitalist exploitation of labour. Health and social services are viewed primarily as

services for the maintenance and reproduction of labour power, and secondarily as serving a social control function.

Within these services the employment and management of labour is influenced by, but not determined by, "capitalist logic". Marxist perspectives, however, have failed to develop the labour theory of value and the theory of the falling rate of profit to understand features of public service employing organisations [Hindess (1978)]. The same "laws" of capitalist economics do not apply directly. However, management techniques for labour control and exploitation can be applied to reduce costs, and are particularly relevant in highly labour intensive services. Changes in work organisation and technologies in public services can be viewed as being driven by the requirement to maximise exploitation of labour to reduce costs, in order that a higher proportion of taxation and state capital can be diverted to direct aid to capitalist enterprise.

From a Marxist perspective the organisation and management of nursing and social work can be explained in terms of a requirement for effective control over a large labour force to maximise the use of labour. In contrast, the management structures in medicine would be explained in terms of a complicity between members of the ruling class, which also resulted in assigning authority to members of this profession to direct other occupations and manage the service. Doctors were either "members of the ruling class" or could be trusted to pursue actions advantageous to that class. However, the rising costs of the service, in part resulting from medical autonomy, forced greater control and management of these now-salaried workers. Moves to adapt managerial techniques to control medically-generated expenditure were made (e.g. budgeting arrangements) and previously "representational" structures were adapted to perform management control functions, albeit self-management by the occupation.

A Marxist approach would thus explain the formation of management structures largely in terms of the concerns of the "ruling class" to control labour and reduce costs in labour-intensive public services. That the structures may promote profession-management autonomy is a risk, but a minor consideration in view of the gains to be made. These economic pressures, however, would not explain the details of structure and aspects of autonomy.

One feature of public services, regular national reorganisations, does provide an environment and conditions for a variety of social and other forces to make their impact on structure: an "unfreezing" before a period of "fossilisation". They provide a political "conjuncture" [Althusser & Balibar (1970)] for occupations and other interest groups to advance their claims before consolidating their position in preparation for the next reorganisation. This provides regular opportunities for achieving authority and for developing forms of institutionalised autonomy, but

to exploit these opportunities occupations have to be aware of what is at stake, to recognise their power and to develop a political role.

Occupational Power

To what extent can the different forms of autonomy be explained in terms of the power and influence of each profession at national and local levels? First it is necessary to outline a view of the nature of "occupational power", and how it is exercised.

Studies have examined how organised labour and occupations exercise different types of power to secure conditions from employers and the state which are advantageous to their interests. We are here primarily concerned with the likely part played by the power of each of the five occupations in negotiating management structures which maximise forms of autonomy.

This study takes the view that occupational power depends primarily on : a) the proportion of workers who are members of an occupational association, b) degree of organisation, c) cohesiveness of membership and number of sectional interest groups, d) members' consciousness of their interests, e) formal or other relationships between the occupation and the state and employers, and finally, f) the attitudes and support of members of the public towards the occupation (involving "social valuation"). In considering these components for each occupation, the account builds on the author's research into occupational associations presented in Ch. 3.

First, does each occupational association represent its membership? Membership of an occupational association is not a condition of employment for most occupations in state services, unless membership is tied to state registration (Ch. 3). Many social workers are not members of BASW (membership totals approx. 12,000; state employment totals approx. 26,000); many nurses are not members of the Royal College of Nursing (membership approx 65,000; state employment approx 360,000). A large proportion of workers in these two occupations are members of public service unions such as NALGO, NUPE and COHSE. The Chartered Society of Physiotherapists (CSP), however, is a registered trade union and represents most workers in the occupation. Registration and thereby membership of the CSP is a condition of employment in the NHS. Clinical Psychologists are organised within a division of the British Psychological Society (BPS) which is mainly a professional interest group and less concerned with matters of employment and management. All are members of the BPS. Some clinical psychologists are represented by ASTMS. The British Medical Association has a strong union role and claims to represent most of the profession.Thus the power of each occupational association deriving from membership and representation varies.

Second, is the association well organised, with a national representative structure, and is it a cohesive entity? In particular, could the occupation be said to "speak with one voice" over aspects of autonomy and management structures? Bucher and Strauss (1963) drew attention to the diversity of interest groups or "segments" in occupations and in occupational associations. A fragmented and divided occupation and association has far less power to influence the state and local employers who are considering management arrangements. This issue is related to the question of the level of consciousness amongst workers about their interests: is an occupation "in itself" also an occupation "for itself"? In particular, is there widespread awareness of the significance of management structures, their effects on forms of autonomy, and the effects of both on the short and long-term interests of the profession?

What evidence, then, is there that occupational organisation, cohesiveness, and membership awareness about employment issues, were all factors which could in part explain the differences in structure described?

Clinical psychology rates the lowest on all of these factors,and the authority of head profession-managers and the degree of management autonomy is also the lowest of the five occupations. Members of the occupation who are aware of the significance of management arrangements for autonomy are divided over the question of management roles. There are those who are in favour of strong head profession-managers (the nursing and social work route to autonomy and control) and those who view such roles as reducing practitioner autonomy ,and as"distorting" career structures and the nature of the work of the profession away from its traditional clinical base (those who prefer the medical model of autonomy). "The profession" rarely speaks on management matters, and when divisional committees do issue statements they are accused of misrepresenting members' views and of having an undemocratic structure.

Dissension within the medical profession is well documented and was carefully exploited by ministers in state manoeuvres leading to the passing of the 1919 National Insurance Act and the 1948 NHS Act [Stevens (1966), Parry and Parry (1976)]. However, the profession unites when "clinical freedom" is threatened, and the professional association both represents most doctors, and agitates forcibly over matters relating to clinical autonomy. Important influences in the creation of medical structures were the profession's awareness of interests and autonomy under threat, a united voice on this matter, and a strong and well-established professional organisation . The sanctions which could be taken if disadvantageous structures were "imposed" are also important factors which themselves derive from occupational organisation and coherence. The threat that most doctors would not participate in the creation of the NHS in 1948 was a key factor in their acquiring Practice Autonomy and a variety of other advantageous conditions. This threat was

effective because alternative income and employment was available and because the state depended on their cooperation.

Formal and informal negotiation mechanisms have existed for a long time between the medical profession and the state and were, and are, one element which enables the occupation to defend autonomy when it is threatened. However, a further element of occupational power which is particularly important in the case of the medical profession are the attitudes and ideas of the public and of other health service workers. The medical profession can claim public support if Practice Autonomy is threatened by appealing to such notions as the independent family doctor. However, the profession is perhaps less able to gain public support for moves to increase autonomy and control. It is possible that trust in the medical profession has diminished in recent years, and that the public are more aware of the sometimes overt self-interested stance of the profession.

The state and the public are less dependent on physiotherapists, and the power which they may exert as a group is minimal. However, the history of the creation of head profession-manager roles and acquisition of management autonomy shows that the possibility of sanctions is only one aspect of occupational power, and that the part played by occupational associations can be an important influence in establishing employment structures which extend autonomy [Øvretveit (1985a), Øvretveit et al (1982), Larkin (1981 and 1983)]. In the case of physiotherapists the occupation was mostly united in its wish to escape from management by doctors, had links and influence with the state, and fought a long campaign at national and local levels to establish head profession-manager roles. Their relative success, in comparison with psychologists, in securing management autonomy is largely due to sustained and united occupational agitation. Managers and the association have also played a part in establishing structures providing for practitioners' Case Autonomy (e.g. Halsbury Senior grades).

The leaders of the nursing profession and the power of the professional association have also played an important part in nurses acquiring management autonomy. The association supported the Salmon Report (1966) proposals for head profession-manager roles, but long before this the profession had campaigned for management autonomy. In fact the Salmon Report can be viewed as the culmination of a consistent occupational strategy first articulated by Nightingale,

> "The whole reform in nursing, both at home and abroad, has consisted in this: To take all power over nursing out of the hands of the men, and put it into the hands of one female trained head and make her responsible for everything regarding internal management and discipline." [Quoted in Abel Smith (1960) p 25]

Carpenter (1977) shows how an important factor in the creation of nursing structure was nurse reformers' crusades to develop the occupation: the structure was viewed as part of a strategy driven by a single-minded commitment to develop the occupation. He shows how the autocratic structure was adopted by nursing reformers to help to create and advance an occupation of nursing, and that the structure was acceptable to doctors and nurses because it reflected the social relations of the period. We note here that once the structure was formed and the tradition established, it could later be developed and used by the state for purposes such as maximising the use of labour. The development of nursing is a clear example of how local management structures enabled an occupation to develop autonomy and control, and indeed enabled the creation of an occupation itself. The management structures, and the hospital work context, created conditions for collective consciousness and action.

The occupation has been less certain about developing high-level practitioner roles, and about establishing Case Autonomy. Such a strategy conflicts with nursing tradition and culture, highlights latent class antagonisms within the occupation, and could undermine management autonomy and the now significant management interest group in the profession.

Social workers were ,until 1985, the only occupation of the five to have taken strike action. The results have shown that such action is an ineffective sanction for social workers: the power to withdraw labour does not involve matters of life and death. The professional association represents about half of the workers of the occupation and its power is mainly exercised in relation to "professional matters". The association is the youngest of the five occupations - its formation in 1970 was too late to significantly influence the Seebohm recommendations for unified departments. The association has promoted high-level practitioner roles, but has little power to ensure that employers create structures to provide for practitioner autonomy, although it has played some part in "protecting" workers from employer demands which infringe codes of conduct.

In summary, there is some evidence that the shape of management structures and the existence of certain forms of autonomy can be explained partially by the power of occupational associations and their willingness and determination to engage the state, employers and other occupations over management arrangements. Professional associations, which existed largely to pursue "professional interests", acted to defend practitioner autonomy rather than to promote management autonomy. The two exceptions were physiotherapists, who discovered management autonomy to be a way of also establishing practitioner autonomy, and nurses who gained influence and power by establishing and operating managerial structures.

At the local level head profession-managers in physiotherapy and clinical psychology were important in establishing and defending Case and Practice Autonomy. In medicine these forms of autonomy were established at the national level, and local groups defended "attacks on clinical freedom". In physiotherapy the traditional organisation was managerial and headed by doctors, developing into Type 1 autonomous profession management [Øvretveit (1985)]. Physiotherapist managers, supported by a DHSS circular on referral (HC(77)18), established practitioner autonomy by a process similar to case law, and themselves defined management structures to allow for Case Autonomy, which were then institutionalised by
employing authorities. Psychology management structures were defined in a similar way, and institutionalised at the local level.

Social Class and Sexual Composition of Occupations

Taking a wider perspective, it is possible to see that a variety of social forces and changes influenced members of each occupation and led to their seeking greater autonomy. In addition, that the structures themselves reflect aspects of the wider society, and that class, status and role features of the wider society may also partially explain the structures.

First, some simple observations about the class and sexual composition of each occupation. The class origin and present class classification of most doctors is social classes 1 and 2, and most doctors are men. This profile is more pronounced at the higher levels of the profession: there are few women, and few working class or black men or women occupying consultant and medical managerial roles [Grey (1978)]. There is a clear hierarchy and status structure within the occupation and specialities which reflect divisions within the wider society.

There are about as many men as women clinical psychologists [BPS Bulletin (1984)] but there are far more men in roles with Practice Autonomy or in profession-manager roles. No figures are available for the numbers of psychologists from different classes, but psychologists are classified by the Registrar General in categories 1 or 2.

Ninety per cent of physiotherapists are women, but many of the one hundred or so profession-manager roles are occupied by men. Most physiotherapists are classified in, or were members of families in social classes 1 and 2.

Most nurses and social workers are women. These are no recent figures on the proportion of each occupation from different social classes. Again, a high proportion of men occupy profession-manager roles.

Thus roles with Practice and Case Autonomy and greater structural authority are likely to be occupied by men, from higher social classes. In short, the class and sex profile of each occupation and the distribution of roles in the management structure closely parallels the divisions, power, and advantage patterns of the wider society. To some extent this observation is not remarkable: class position is related to income and type of employment, and career opportunities in each profession favour men. How, then, does the association between, on the one hand, class and sex and, on the other, forms of autonomy, help to explain structure? What is the significance of these observations for an explanation of the different management structures and autonomy of each profession?

The following suggests that men and women from different class backgrounds are selected into each occupation in various ways. Subsequently, wider social forces and changes influence different classes and men and women in different ways, thus having a differential impact on each profession, which in turn influences structure. For example, increases in autonomy may in part be attributed to changes in the role of women in society.

Elliot's (1972) discussion of recruitment into occupations largely explains the sex and class profiles noted above. He explains the social composition of an occupation as a product of individual processes of commitment (possibility, cost, and social commitment) and of the selection mechanisms used by the occupations themselves. Career opportunities also need to be added to these factors and, although this may not be an important factor in an initial choice of occupation, it is a factor explaining why men or women of different social classes remain in an occupation and develop a commitment to certain structures.

Thus occupational structures can be understood both as a result of a certain social profile, and as themselves as reproducing of that profile. However, to examine how class and sex might influence and explain structure it is necessary to consider changes in structure over time and how social forces may have affected different social groups.

A feature of each of the five occupations which is important in accounting for management structures and aspects of autonomy is the sexual composition of each occupation.

The changing role and position of women in society

It is likely that each occupation was affected by changes in the role and position of women in society during the 1960s and 1970s.Statistical information on the period 1951 to 1971 shows a rise in the number of women in employment roles, and a rise in the number of women returning to work after childbirth. Changes in women's work since the 1950s were summarised by a Central

Office of Information pamphlet in the following way:

> "Women's working lives have thus been transformed. Instead of work being an interlude between school and motherhood, work now increasingly tends to follow motherhood and continues for a great many years. Women are now in a position to be reliable permanent employees filling skilled and responsible positions."

The only detailed evidence relating to the occupations under consideration is a small MCRU (Medical Care Research Unit) survey of physiotherapists. The survey compared career patterns of physiotherapists qualifying in 1952-1958, 1959-1964, and 1965-1970. As the survey was carried out in 1975, full comparison was not possible because the most recently qualified had not completed their careers, but certain trends stand out. In the group of physiotherapists qualifying between 1965-1970, fewer finished their career after marriage (2 compared to 7 in the group qualifying between 1952-1958), but more finished their career on the arrival of their first child (24 compared to 10 in the 1952-1958 qualifying group). However, more of the later qualifying group were continuously employed in physiotherapy (14 compared to 9), more combined marriage and practice (14 compared to 4), and fewer interrupted their careers (20 compared to 47). In comparing her 1975 survey with Martin's previous survey of physiotherapists, Ward comments,

> "In her survey in 1964 Martin was well aware of the increasing tendency for women to work after marriage, but it was still such a relatively uncommon occurrence that she asked the married respondents who <u>were</u> working why they were doing so. By the time of the MCRU study of 1975 the perceived situation had changed so radically that the appropriate question appeared to the investigators to be the reverse of this, so that we asked all those <u>not</u> currently practising, married or single, why they were not doing so."

Although it is not possible to generalise from such a small survey, the following links between wider social changes and autonomy are plausible. It is likely that these changes in behaviour were accompanied by changes in attitude. In the 1960s and 1970s it became more socially acceptable for women to work outside the home, and there is evidence that this change in attitude was the most pronounced in the social classes from which physiotherapists were drawn. Although women's primary role in society continued to be regarded as mother and housewife, it was increasingly accepted as legitimate, if not necessary, for women to have an employment role. In addition, an increasing number of women no longer viewed childbearing and rearing as their main career but an interruption to a career in employment roles.

A social climate in which it was more acceptable for women to work may in turn have led to a greater occupational commitment on the part of women in each occupation. Drawing a greater part of their self identity from their employment role, women in these occupations may have begun to regard their work as a more important and significant part of their lives than they had previously done, and looked for ways of contributing more than their traditionally circumscribed roles allowed. More may have come to view the occupation as a career rather than something to do before and, possibly after, their "primary career" of mother and housewife. This would have resulted in a longer term view. Seeing their own lives as more closely bound up with the future of the occupation, women would be more willing to put forward their claims and engage in occupational politics.

Thus the increased autonomy of nurses, social workers, physiotherapists and clinical psychologists can be partially explained in terms of changes in attitude towards women's employment in the 1960s and 1970s. These changes in attitude may have produced higher expectations about employment roles and led to increased occupational commitment. In addition, higher numbers of women returning to work after childbearing and lower labour turnover may have resulted in greater occupational solidarity and a stronger capacity to organise and advance occupational claims.

A second social change in the 1960s and 1970s was that women were increasingly demanding equality in all areas of life and were less willing to accept a subservient role. During this period members of the occupations considered "escaped" management by doctors. Most relationships between doctors and members of the four other occupations are also male-female relations as are profession-manager and practitioner relationships. They are likely to be imbued with expectations and assumptions about appropriate male and female behaviour and relationships. These expectations and assumptions changed in the period under consideration, as a result of many influences. The women's movement sensitised women to their traditionally subservient and passive role, and encouraged women to question and challenge all traditional male-female relationships. The late 1960s also saw a challenge to all traditional authority relations and an increasing value placed on ideals of democracy and participation.

It is not clear how strong these influences were on the social groups under consideration, but it is likely that they were affected by them. Thus the pressures which led to the Equal Pay Act (1970) and the Sexual Discrimination Act (1975) probably also fuelled changes in the relation between doctors and members of each profession. It is also possible that the cohesion of each occupation was enhanced by women's developing consciousness of their common interests.

In summary, a number of sociopolitical factors are likely to have influenced the formation and maintenance of the structures, and could in part account for differences between them: expansion of welfare services as an explicit government policy; introduction of modern management approaches in welfare services to reduce costs, and development of the feminist movement and increased union activism.

PART 7: CHARACTERISTICS OF STATE EMPLOYING AUTHORITIES AND OF THEIR ENVIRONMENT

This section considers whether specific features of the employing organisations - local state welfare authorities - and of their environment may contribute to producing the differences in the autonomy of the five professions. The environment and nature of public employing authorities is different in a number of respects from that of industrial, commercial and voluntary organisations,and these differences need to be borne in mind when considering the possible effect of some of the factors considered earlier.

One feature of the "environment" of public welfare authorities emphasised in earlier chapters is the influence of national state "guidance" or directives, which either directly determine or constrain a variety of aspects of the organisation and functioning of these authorities. Although other organisations also operate within a framework of regulations (The Companies Act, The Employment Protection Act, etc), their goals, priorities, structure, methods of operation, and continued existence can be decided by the owners, managers or workers themselves. Choice is available to state employing authorities and their managers, but a far greater range of social and circumstantial constraints apply.

Amongst the state requirements which are relevant to the subject of this thesis are:

- statutory requirements to provide a range of basic welfare services;

- directives about organisational structure and procedures to be adopted, both general and comprehensive (e.g. regular reorganisations), and detailed and specific;

- particular regulations pertaining to the workers employed, involving different requirements for different occupational groupings (e.g. pay grades,

conditions of work, procedures for appointment and regrading and, in the case of medicine, number of consultant grade posts).

In addition, there are certain conditions or contingencies which are largely decided at a national level and by the state, which employing authorities have to take into account.These include :

- the availability of skilled labour, and the different labour markets for each occupation; and,

- changes in function or organisation of external boundary organisations (e.g. other public employing authorities or voluntary agencies).

Public employing authorities, largely because of their statutory functions, have a relatively stable financial base. They may and do face financial crises, but their continued existence and pursuit of basic objectives is rarely threatened. Their environment is "turbulent", however, in its political character. Whilst being financially insulated from fluctuations in direct consumer demand, consumer influence is frequently mediated and exerted through national and locally-elected representatives. Most decisions will favour one client group and directly or indirectly disadvantage another. Changes in government can bring about major policy shifts requiring responses such as reorganisation, privatisation, or hospital closure. Locally-elected representatives may decide policies requiring long-term fundamental changes, or immediate responses. Accountability, both to national bodies, and to local communities, is of a different character from accountability to shareholders or governing bodies : the particular requirements of public accountability and its effects on decisions about structure will be examined below.

The decisions made by public welfare authorities profoundly affect a large number of people. They have a "high visibility" and are under constant scrutiny, and frequently criticism. The external and internal political environment in which they operate is never far from the minds of managers, who tend to recommend structures which are minimally acceptable to all , and which are opposed by the least number of least powerful interest groups.

It is within this context that the influences on structure which were considered above are mediated and interpreted. The discussion now examines specific factors or considerations relating to the external and internal environment of state employing authorities which may have influenced decisions about the type of management structure adopted for professional groups. The discussion considers influences on the decision to organise professionals "by professional function", in professional divisions or groups, and with management structures of Types 1, 2 or 3. The research did not discover any major differences between authorities in the general type of

structure adopted for each profession, and hence at this level of detail and for the purposes of this discussion there is no need to examine variations in types and sizes of employing authority for their influence on structure.

Accountability for Statutory Functions

Proposition:*"If an employing authority is accountable for statutory functions, and an occupation is authorised to carry out these functions, then the management structure for members of the occupation carrying out these functions will be a managerial structure to maximise accountability."*

This proposition is derived from the theoretical link proposed earlier between authority and accountability(Ch.4), and from the observation that most public service organisations without large numbers of professionals involve traditional managerial structures. The theory involves two elements: staff control, and legitimate powers. Firstly, if employing authorities and their senior managers are accountable for specific statutory functions they will need agreed authority in relation to staff to ensure that staff properly carry out these functions. If employing authorities are required to, for example, ensure that all newly-born children and their mothers are visited for advice and checks, then the staff carrying out this work will need to be organised with a managerial structure,where managers have authority to review cases and take action quickly if they are not satisfied with the performance of a staff member carrying out the statutory functions delegated to them.

Secondly, in the more specific case where the state requires employing authorities and their agents to carry out functions which are against the immediate interests of members of the public, then their powers to do so are further legitimated by accountability systems with authority to call the employing authority and their agents to account for the use of their powers. This is related to the observation that a prominent feature of "social control occupations" such as police and prison officers involve managerial structures. The theory is that although "the public" establishes laws and systems to administer them, there will be sections of the public which do not support the law, and in effect one group will be sanctioning the use of force against another group. In such situations power is legitimated by effective accountability systems.

It is important to separate statutory social control functions from other statutory functions in this way. This is because the first aspect - assigned authority to ensure functions are carried out - applies to any organisation. The need to ensure effective management structures and staff accountability is just as important in commercial organisations as in public service organisations. However,it is only public service organisations which are authorised and required by law to carry

out functions against the wishes and interests of individuals "on behalf of the community", and it is this power which requires effective accountability.

Is there evidence, then, that managerial structures do maximise accountability? The evidence is circumstantial. Most public services and commercial organisations with few professionals are organised in managerial hierarchies. Certainly at the time of the research, many managers and public employing authorities probably believed that accountability required that managers were assigned authority characteristic of the managerial hierarchy. Most organisation and management theory of the time put forward this view, and it would have been consonant with managers' ideologies. The working assumption then is that there would have been a tendency to organise staff with statutory, and especially statutory social control functions in managerial hierarchies.

Is it possible, then, that the management structures of the five occupations can be explained in terms of their undertaking statutory functions? It is true that some social workers and nurses carry out statutory functions, and that managers in social work only fully and regularly exercise their managerial authority in statutory cases through close and regular supervision. It is also true that physiotherapists and psychologists rarely carry out statutory functions (apart from those arising from a duty as a state employee), and that each has Case Autonomy.

However, when considering medicine it becomes clear that it is necessary to distinguish carrying out statutory functions as a result of being an agent of a state employer and having been assigned those functions, from being authorised by the state by virtue of qualification (and hence usually, of occupation) to undertake certain functions. Qualified members of the medical profession are authorised to undertake a variety of statutory duties, regardless of whether they are employed in public services (e.g. death certification, sickness certification and certification of mental illness). In the main, the occupation has been able to avoid being delegated statutory duties which do not enhance its power and status. Where it is in the occupation's interests to assume sole responsibility for a statutory function, then the occupation advances the argument that only doctors are sufficiently qualified, or can be trusted responsibly to exercise the powers required. However, a managerial structure, or any other non-professional accountability system, is rarely thought necessary to ensure medical accountability for statutory functions. (Recent child abuse cases have questioned medical qualifications for statutory functions in this area, and a lack of accountability for "medical" decisions).

Thus the different structures of each organisation cannot be explained solely in terms of their undertaking statutory functions. Social work and nursing undertake statutory functions as a result of being in state employment, and, in the case of social work, the increasing number of these functions have been both a cause and consequence of the managerial hierarchy, and have

prevented practitioner autonomy from developing. Doctors undertake statutory functions of a similar order, but are not organised in a managerial hierarchy, and are not required to regularly account for the use of their statutory powers.

It is probable that statutory functions per se are not the critical issue, rather that in considering whether to enact a statute, Parliament considers how it might be implemented, and various occupations (and agencies) lobby to avoid or invite their undertaking the function according to whether it advances their interests in the situation to do so. The issue is rather, which function, at what time and in whose interest?

Turning from specific statutory functions, frequently involving social control, to the more general statutory function of service provision, the discussion now considers accountability for service provision as a possible explanation for structure.

Bureaucratic Accountability for Statutory Services and Professional Accountability to the Individual Client

The above discussion proposed that hierarchical managerial structures were widely assumed in practice and in theory to enhance accountability, and that the tendency would be to adopt such structures for staff employed in welfare services where accountability was important. However, at the time of the study each occupation was organised within a separate hierarchy, not within an overall pyramidal hierarchy, and that only social work and nursing occupational hierarchies were managerial.

In arguing against managerial hierarchies,occupations of the study invoked conceptions of "professional accountability": that as professionals they were not, and could not be held accountable by their employers for all aspects of their work because they were accountable to their professional associations (who were the only ones who could assess their actions), to courts of law, to their "consciences", and to their clients. It was argued that only other professionals had the authority (i.e. by virtue of their knowledge) to call them to account.

The discussion has already considered the nature and possibility of professional accountability as a technical process, complicated by the specialist character of the professional's knowledge and skills. A professional superior who can assess actions is a part solution, but does not resolve the underlying issue, which is the conflict between the professional's accountability to their clients and their accountability to their employer through their superiors.

It is argued by professionals (and many social scientists) that professionals are primarily accountable to their clients, in the sense that their values and codes of ethics put the welfare of the client whom they are helping ("the client in contact") above all other considerations. Their immediate duty to clients is a higher duty than that which they owe their employer, and this duty is incompatible with managerial authority to override their case decisions, especially if it is on non-professional grounds (e.g. to "close a case" to free time for other work). This is associated with a view of the organisation as serving the professional to provide their services, rather than the professional serving the organisation.

This thesis contends, however, that the root issue is not conflict between "bureaucratic" and "professional" "accountability" and "authority", but conflict between the needs and interests of "current clients", and potential and future clients. Professionals in private practice are only responsible for meeting the needs of clients who seek out their help: they are only concerned about potential clients if business is poor , or if they wish to develop their business. In general, professional practitioners are only accountable in law for their actions in relation to their current clients.

State bureaucrats (including professionals in management positions) ,on the other hand ,are accountable for providing a defined service to a range of current, potential and future clients. U.K. state welfare services were established to provide services to all, and various Acts delegated the duty to do so to employing authorities and their managers. If employing authorities and managers are to be held accountable under various Acts for ensuring the fair distribution of resources, they need authority to curtail professionals' actions in order to provide services to other clients on the basis of equity and democratically-determined policies.

Conceiving the conflict as one between the needs and interests of current clients against those of potential and future clients illuminates certain issues especially the "bureaucratic-professional conflict debate"(Appendix 3) , and avoids unnecessary analyses of "the meaning of professional accountability". For example, it distinguishes the responsibility of managers to ration resources from their responsibility to ensure high professional service standards. Reviewing cases or work to check standards of practice is different from reviewing cases to judge whether resources should be allocated.

Much conflict over "managerial" and a "professional accountability" arises because of failure to make this distinction. If the conflict is viewed as arising from "professional accountability and authority", analysis centres on questions about technical issues of evaluation : can the manager properly assess professional standards. Although these questions are important, they distract

attention from what is proposed here to be an essentially political issue of resource distribution. From this point of view the role of professionals is as advisers about potential and future client needs. In addition the approach views the conflict as similar to those occurring between any worker who develops loyalties towards and relationships with clients, and their supervisors.

Returning to the question of the different management structures of the five occupations, does the above analysis help to explain the different management structures of social work and medicine?

In medicine, it is argued that issues of life and death require that the interests of the individual client be put before all other considerations, and that doctors' superiors should not have sanctioned authority to affect a decision made by a doctor about either treatment or conditions relevant to treatment. The same, however, could be argued for a social worker involved with different "at risk" cases.

The main point, however, is that the NHS was established on the principle that the interests of the sick individual came above all other considerations, and that the public was persuaded that this required "clinical freedom" for doctors. That doctors were able to generalise the autonomy acquired as a result of this argument is another issue .The point is that the NHS Acts institutionalised and sanctioned Case Autonomy : NHS employing authorities are required to provide a "personal medical service" and to uphold this principle, even if it is in conflict with other requirements such as equitable distribution of resources

Why should only doctors (and doctors' clients) be "protected" in this way? With limited resources Case Autonomy becomes more of a political issue. One argument is that other professions do not have the same lengthy and rigorous training, and in short, cannot be trusted to exercise responsibly the same autonomy. The Royal College of Psychiatrists (1984), in advancing a claim, not just for Case and Practice Autonomy, but for Case-Coordinating authority in all multidisciplinary teams, argued that a consultant had 6 years' undergraduate and 10 years' post-graduate experience and was generally required to have two registered qualifications, "There are few areas of human endeavour where such a long apprenticeship is required and where there are so many obstacles to achieving the position." (The BPS presented an identical claim in 1986 (BPS (1986)).

In short, one reason why there are <u>medical</u> roles created in the NHS with Case and Practice Autonomy (Medical Consultants and GPs), and why trainee doctors are managed and do not have this autonomy is because the NHS was established to ensure a personal medical service, with one professional, a doctor, who would protect and advance a client's interests in the complex

bureaucracy of the NHS. This was a result of both the medical profession's bargaining powers in the creation of the NHS and subsequent reorganisations, and of the power of the argument that in matters of life and death the individual's interests come first.

However, rising costs of health services have required that doctors' authority to expend resources be limited. Their Case and Practice Autonomy also involves Case-Coordinating authority to initiate an ever-increasing range of expensive diagnostic and treatment procedures, and to initiate the work of other staff. The health authority is accountable for the expenditure of public funds and for providing a range of health services to a variety of clients. Untrammelled Case Autonomy, which involves decisions initiating costly procedures, can result in resources not being available for other client groups, resources which have been apportioned on a rational and democratic basis.

The need to balance these conflicting requirements could be said partially to explain the shape of medical management structures: Case and Practice Autonomy to deploy available resources in the best interests of the client; limits to Case Autonomy established through agreement with colleagues and individual negotiations with top managers or the authority itself; and managerial structures for trainees with long apprenticeships before being in a position to initiate costly procedures and actions.

Local authorities, however, established social work to provide an agency service. As the Barclay Report (1980) notes, "To a very large extent the expectations that employers have of their social workers are directly determined by legislative imperatives." (p 251). There was not an over-riding requirement to provide practitioners with a large degree of autonomy to respond flexibly to clients' needs in life-threatening situations. Where these situations arise social workers in fact have less autonomy than usual and systems and reviews are established to closely monitor their actions. There was not a powerful and established profession to argue for Practitioner Autonomy : the nature of most of the work did not require it, the practitioners could not be "trusted" to the same extent, and employing authorities were elected and had a stronger local accountability. The interests of the public at large were put above those of the individual client, and clearly so in the case of statutory social control functions. The organisation and management structure was not created primarily to provide a personalised service. Continuing conflict and frustration arises as a result of a profession holding out service to the individual as an ideal and ethic, and a structure which places continual and specific checks on the possibility of achieving this ideal in order to achieve a variety of goals.

In summary, the accountability of a health authority to provide a personal medical service as established in NHS Acts has been interpreted by doctors and others as requiring Case and

Practice autonomy and Case-Coordinating authority. Accountability for providing a balanced range of health services with finite resources explains why medical collegiate management structures have been developed to reconcile competing demands. Where it has been possible to organise other professionals in hierarchical managerial structures, health authorities have done so to maximise the accountability of staff and to ensure the best use of public funds. The accountability of local authorities to central government for an even greater number of detailed statutory functions, and to local communities through elected representatives, in part explains the managerial structure of social work.

PART 8: SUMMARY EXPLANATION AND GENERAL PROPOSITIONS

The following outlines the final thesis explanation for the different structures and forms of autonomy which were discovered in the author's research. The evidence for the explanation is limited,and it is not offered as a validated explanation but one which could suggest future lines of enquiry. It draws together the above hypotheses which were not disproved and which retained their plausibility. It accounts for the phenomena by emphasising the interaction and mutually-reinforcing effects of certain factors and conditions, at particular historical conjunctures.

The account was not able to explain the pattern of types of autonomy in each occupation by reference to previously cited features of the work of members of the occupation. Plausible explanations were only possible by considering the mutual influence of a variety of factors. Amongst these, the presence or absence of occupational agitation appeared to be as important as certain "objective" characteristics of the work. The evidence supported the conclusion that critical factors were: how occupations exploited certain objective features of their work and the situations in which they found themselves, the predisposition of those in authority to be swayed by their arguments, and that certain conditions made occupational agitation to achieve and maintain aspects of autonomy more likely.

The explanation suggests that there were certain factors and aspects of situations which prevented particular types of structure being established and certain forms of autonomy from developing. For example, in some health professions one factor was opposition by the medical profession to loss of control. The explanation also suggests that certain factors predisposed or created favourable conditions, and finally that there were factors which promoted or directly influenced the establishment of certain structures, such as government prescriptions.

Medical Structures

An important factor was the power of the profession which influenced the framing of the 1946 NHS Act and subsequent acts to provide for a personal medical service. There is nothing in the Act which requires Case and Practice Autonomy, but the profession established that this was a necessary condition for "personal doctoring". A variety of arguments have served as a resource to the profession in its defence of "clinical freedom". The two which appear to have carried most weight being that restrictions to autonomy in life and death situations endanger patients, and that scrutiny undermines a confidential and trusting personal relationship. These arguments were used to ensure that the structures which were finally established took the form of coordinating mechanisms for senior consultant practitioners with practice autonomy, which were operated by the practitioners themselves (collegiate management).

A managerial structure exists in fields of medicine where a personal service and relationship was not viewed as the overriding consideration, as in community medicine and some mass-screening clinics. It also exists below the level of hospital consultant posts. Doctors undertake a long training to enable them to exercise responsibly the authority of consultant or GP posts, and because the number of such posts is limited. Consultants carry full managerial authority over junior doctors because they carry case accountability for medical work undertaken by their juniors.

As a result of consultants' Practice Autonomy, their management of junior doctors, and the collegiate management structure, top level medical roles in the employing authority have little structural authority in relation to their colleagues. Management autonomy in the occupation does not exist in the same sense as it does in the other occupations because this one role has only monitoring authority over colleagues. Where these individuals can gain consensus amongst colleagues, the group autonomy and collective power of the occupation at local levels is considerable.

The top level medical role also carried monitoring authority in relation to head profession-managers in physiotherapy and clinical psychology. Differences between employing authorities were largely due to whether these head profession-managers were able to convince employing authorities and top level management teams in reorganisations that they should be accountable to the top administrator.

Consultants' authority in relation to practitioners in other occupations has diminished, and such changes have been supported by the state, in part in response to agitation by each occupation. Consultants have no authority in relation to social workers as a result of the transfer of their

employment from the NHS to local authorities in 1970. Consultants' authority in relation to nurses has diminished from prescriptive, to prescriptive authority in certain areas, largely as a result of the development of nursing management structures and nurse managers' authority. In physiotherapy the development of skills, techniques and theory, supported by management autonomy, has led to changes in consultants' referral authority from prescriptive, to authority to rule out certain treatments and to be kept informed. Clinical psychologists, like the other professions, once managed by doctors, have developed Case and Practice Autonomy as a result of their rapid development and application of specialised techniques and theory, and of their own management structures.

Thus, where "clinical freedom" for doctors once included the authority to prescribe the work of others, and automatic Case-Coordinating authority, it now refers to authority to initiate the work of others through referral, and other occupations have gained different forms of institutionalised Case Autonomy.

Clinical Psychology

The example of clinical psychology clearly shows that occupational power is not the only factor accounting for institutionalised autonomy. In contrast to medicine, the professional association played a minor role and had little power to influence decisions at national or local levels. However, a similar management structure to medicine (Type 2B) has evolved, the main difference being that junior practitioners have Case Autonomy.

Clinical psychology developed a separate management structure as a result of rapid expansion of the occupation into priority areas such as work for the elderly, mentally handicapped and mentally ill. This change was supported by a government report on the profession(Trethowen Report(1977)).

Three factors are important in accounting for the type of structure which has developed. First, unlike medicine, the cost consequences of Case and Practice Autonomy in psychology are negligible. There are few psychologists and the main resource consequences of their assessment and treatment decisions concern how they spend their own time. Secondly, the structures were created largely by local profession-managers. They were able to establish their arguments with employing authorities, who were indifferent to the "peculiarities" of five or ten staff, unless there was opposition from the medical profession. The government report was a useful resource in their negotiations. Thirdly, the length of training, level of education, and degree of specialised knowledge are equal to those of doctors [BPS (1986)] which provided further ideological ammunition to profession-managers proposing structures.

Within the profession, head profession-managers promoted and supported the ideology of the individual applied scientist [Kat (1986)], and were themselves usually more interested in their own clinical work than in undertaking detailed management of colleagues or juniors. In medicine, Case and Practice Autonomy were asserted and won at a national level by a powerful occupation. In psychology it was gained by individuals, and institutionalised by employing authorities as a result of the efforts of head profession-managers. Uncertain of their role and status, individuals and the occupation reached for the medical model of organisation, but with provision for Case Autonomy for juniors. In so doing they were able to draw on arguments about length of training, education and specialised knowledge to assert similar "professional" credentials. These and other factors did not require the Type 2B structure, but it was possible to convince others that they did.

Without a tradition, but seeking to assert a professional role, individual psychologists were particularly sensitive to "interference" with case or practice decisions. Profession-managers refused to pursue medical and other complaints against psychologists which would infringe Case Autonomy on the principle that if they did not uphold the professional status and responsibility of their colleagues and juniors, no-one else would.

Further factors are the values and world view of psychologists. There are many competing orientations within the occupation, but they all share a focus on the individual and this concern is reflected in individualistic attitudes in their own organisation and practice, further reinforced by the middle-class origins and values of most of the occupation. Managers with managerial authority are difficult for psychologists to accept in principle and in practice.

Finally, a large proportion of psychologists' work is psychotherapeutic work where trusting and confidential relationships with clients are particularly important. It is possible for psychologists to argue that their work is undermined by a manager with authority to scrutinise and override case decisions.

Physiotherapy

In comparison with psychology, the Type 2A structures providing for Case but not Practice Autonomy in physiotherapy can be explained mainly in terms of the longer and stronger tradition of managerial structures, the lower educational and training requirements, the fewer high-level practitioner roles, and the larger proportion of women in the profession.

The development of managerial autonomy was more difficult than in psychology because of the medical basis of the profession's work - both the theoretical and practical base. The

institutionalisation of managerial autonomy, however, was aided at the national level by an active and cohesive professional association, direct and indirect government support, and the greater size of the occupation than in the case of clinical psychology.

As with clinical psychology, profession-managers played a key role in establishing and defending case autonomy. When management autonomy was first established, Type 1 structures were typical, and physiotherapy managers would override practitioners' case decisions as requested by doctors. Now, supported by government guidelines on referral, physiotherapy managers will defend practitioners' Case Autonomy. Recent theoretical and technical developments have prevented full management of practitioners in certain specialities by the profession-manager. Certain experienced and knowledgeable practitioners have established de facto Practice Autonomy, and an increasing number of high-level practitioners may well lead to Type 2B structures being institutionalised.

Nursing

Three factors are important in accounting for the Type 1 nursing management structures: history and tradition, the large size of the occupation, and no distinct theoretical or technical basis on which practitioners can develop high-level practice roles. Nursing autonomy has largely developed in the space left open by medicine. A managerial structure modelled on army principles was established by early nurse reformers as an explicit strategy for developing the occupation, in part influenced by feminist ideology. With increasing numbers of nurses, the hierarchies and power of the profession grew. Government concern with rising labour costs led to the structures being adapted for more efficient control of labour. This led to the occupation gaining management autonomy, a seeming paradox, in the creation of large single-profession management structures.

A powerful interest group of nurse managers emerged in the profession, whose position and authority could be threatened by developments in Case Autonomy. Unlike physiotherapy and clinical psychology managers, they did not support these developments by institutionalising case autonomy in the structures they established. In addition, there was less scope for developing high-level practitioner posts and the occupation lacked a distinct knowledge base, despite persistent attempts of nurse researchers to develop one.

Social Work

An indeterminate knowledge base and the possibility of, and insistence of scrutiny of social work by lay members of employing authorities in part explains the fact that Case Autonomy does not

exist in social work. More important, however, is the tradition of accountability and local political control within local employing authorities.

Economic considerations and requirements for effective coordination led to the creation of single structures for employees undertaking social work in local authorities, most of whom were unqualified and not members of the professional association. Management autonomy grew as a result of this change but developments in theory and practice did not result in institutionalised autonomy for practitioners. Important counterbalancing influences were an increasing number of statutory duties, higher work loads, and local democratic traditions and structures which emphasised accountability to the employing authority. The requirement for accountability and cost control, and the managerial authority structures which were viewed to be necessary, prevented practitioners from developing Case Autonomy. In such a climate the occupational associations and professional managers were not able to assert occupational values and defend or promote practitioners' autonomy.

General Proposition for Further Testing

The available evidence thus supports the following general proposition : where an employing authority wishes specialised work to be undertaken, which requires an extensive training and reference to an abstract theoretical body of knowledge, and involves direct contact with clients of a potentially lethal nature or where client trust and confidence in the practitioner is critical to success, then profession-management structures providing for Case Autonomy are likely to be established (described as "Type 2" structures in Appendix 4).

The determining factors will be the ability of practitioners to collectively and coherently advance their claims and to use their power to institutionalise Case Autonomy, as well as the predisposition of managers to be convinced by these claims, which in turn depends on a variety of factors.

Where, in addition, the occupation has a tradition of, and opportunities for private practice, is sufficiently coherent in membership to organise and exercise power in collective action, and has established links with local and national ruling elites, then management structures providing for Practice Autonomy will be established(Type 2B or 2C).

Where large numbers of the occupation are employed and controlled, and the efficient use of labour is of prime importance, and where detailed accountability is possible and necessary, managerial structures will be established, under the management of a head profession- manager who is able to delegate and assess the work of practitioners(Type 1).

These general propositions are supported by the evidence of the thesis and can be proved, disproved or refined by examining other welfare professions and other state welfare services in the U.K. and abroad. The final chapter draws on these propositions in a model representing a process through which professions achieve authority.

CHAPTER 8 : THEORETICAL IMPLICATIONS AND CONCLUSIONS

PART 1: INTRODUCTION

This chapter considers the implications of the research findings for Freidson's theory of professions and for developing social scientific knowledge of the relationship between professions and the state. The chapter first considers each of the central propositions of Freidson's theory in the light of the research findings. Drawing on these findings, and logical criticisms of Freidson's use of the concept of autonomy, the thesis proposes that the concept of authority is more relevant for understanding both the nature of professions and the relationship between professions and the state in modern society . It concludes with a model representing the relevant factors in a process through which professions are authorised by the state to determine aspects of their work and conditions of work.

PART 2 : IMPLICATIONS OF THE RESEARCH FOR FREIDSON'S THEORY OF PROFESSIONS

Autonomy ,Expertise and the State

Freidson's first proposition was that,

> "Most of the commonly cited attributes of professions may be seen either as a consequence of their autonomy or as conditions useful for persuading the public and the body politic to grant such autonomy."
>
> [Freidson (1970a), p 135]

Freidson's second proposition was that an occupational group was more likely to be "self-directing" in its work when it had acquired a "legal privilege" which protected its work from being undertaken by other occupations.

His third proposition was that "self-direction" was only possible if an occupation could control the production and the application of knowledge and skill in its work, and that

"full autonomy" of this type was not possible if others could reasonably criticise or evaluate the way in which members carried out their work.

Medical Dominance

The main subject of Freidson's 1970 study was medical dominance.He proposed that a clear distinction should be made between a profession which was dominant in a particular field,and others. He came close to offering a definition of "a profession", not in terms of "autonomy", but in terms of "dominance":

"One might call many occupations "professions" if one so chooses, but there is a difference between the dominant professions and the others ..... in essence the difference reflects the existence of a hierarchy of institutionalised expertise."

His central arguments were that, the only "truly autonomous" occupation in health services was medicine, and that the profession's autonomy was sustained by the dominance of its expertise in the health division of labour.

The Research Evidence

One of the criticisms of Freidson's theory advanced in Chapter 3 was that he did not provide evidence to support the proposition that professional autonomy was upheld by the state. The only mechanism mentioned by Freidson was state licensing arrangements and no evidence was presented of such arrangements .

Seeking to test Freidson's theory in the U.K.,the author considered evidence of state support for professional autonomy in five welfare professions.The author's research found evidence of three kinds of structures and processes at the national level for regulating and controlling professions.

First the professional association of each profession had a certain control over its members,especially if the state had delegated certain functions to it,such as inspecting training schools. Second,there were bodies set up to decide the pay and conditions to be provided by state employing authorities(national review bodies and whitly councils).Third, state registration councils were set up by acts of parliament to administer a register,and to decide training and qualifications.

The details of these arrangements showed that,

1) Few regulations prevent an unqualified person from undertaking a particular activity such as a physiotherapy treatment or an injection. Only Acts of Parliament make it unlawful to carry out certain activities . Of the few prohibited acts the two main examples are, a) an unqualified person who undertakes a "surgical operation ", could be prosecuted for personal assault,or b) ,if they delivered a baby without a qualified midwife present, they could be prosecuted.

2) Apart from these few activities,the state regulates a field of work by the mechanism of state registration,which only prohibits in law someone from pretending to be state registered.

3) State registration applies to nursing ,physiotherapy and medicine,but not to social work and psychology.

4) To operate state registration the state sets up state councils which also regulate training. These councils include representatives from the professional association to help in this work.

5) The main control arises because usually the only way to practice the profession is as an employee of a state or voluntary agency,and because employers usually stipulate professional qualifications as a requirement to practice.

6) Because the state has been the monopoly employer of welfare professions,a set of institutions such as whitly councils and pay review bodies have been established ,mostly for negotiating pay and conditions.These institutions probably have a greater influence over conditions of work and the futures of the professions than the licensing arrangements.

The conclusions from this research were that,

1) State regulation through licensing does not assure professional autonomy and a protected market in the absolute way which Freidson suggested.

2) The state only acts to regulate in this way when parliament is persuaded that practice by incompetent or unqualified practitioners is a danger to the public.

3) Professional influence at this level is complex and indirect - mostly through the professional association influencing training and qualification requirements.(Only clear negligence ,not incompetence, would result in removal from the register).

4) Professions argue both that they are the best qualified to judge negligence,incompetence and to regulate practice, but also that in many specialties and at certain levels of experience even other professionals are unable to properly judge quality of work because of differences of view within the profession about what constitutes good practice

Although Freidson did not define autonomy and dominance,it was possible to conclude that the above evidence of the actual structures and processes of state regulation of five professions in the UK does not support Freidson's theory that autonomy is upheld by state licensing arrangements,or that these structures institutionalise medical dominance.

The questions which the thesis then addressed were, if these structures do not provide professions with the control which Freidson suggested, what else might explain the division of labour which undoubtedly exists in,for example,a hospital? How is it possible to explain the differences in the autonomy of practitioners in each profession if the differences cannot be explained by state regulatory structures?

The second part of the thesis research was to find out exactly what were the differences in the autonomy of each of the five professions,before then considering why the differences existed.

Following Freidson's line of inquiry,which was to focus on institutional arrangements, the research concentrated on formal structures and rules which circumscribed the activities of typical practitioners at different stages of their career, and on the details of management structures(Ch 4).

The three main points emerging from these findings (Ch 5) were that,

1) In the UK,state employing authorities provide professions with different types of autonomy and control through their management arrangements.

2) There are differences between professions in terms of the autonomy and control institutionalised in the structures.

3) There have been changes over the last 20 years-notably a decline in the authority of the medical profession over other professions,and a replacement of profession-management with general management.

The research discovered that, certainly in the UK, features of local employment structures were far more important to professional autonomy and to defining the work of the occupation than were mechanisms of state regulation. Further, it showed that central government played an important part in recommending types of structure which employing authorities established for professional groups. It was also necessary to specify different types of autonomy and to use concepts of control and authority to understand the position of professions - a point which will be considered below.

Previous research has not recognised that head profession-manager roles were a key feature of the institutionalised autonomy and control of occupations in public services in the UK, or the significance of these roles for the professions. Managers in these positions extended and maintained occupational autonomy in a variety of ways. They "protected" practitioners from direction or evaluation by other occupations and, because of their structural position and authority, were able to resist plans and policies disadvantageous to the occupation. They played a part in creating structures institutionalising aspects of practitioner autonomy, in extending definitions of the work of the occupation and in increasing employment opportunities by establishing extra posts.

These findings therefore qualified and developed Freidson's insights through reference to empirical evidence about occupations in U.K. state welfare services.

In seeking to explain these findings (Ch 7),the third part of the thesis returned to Freidson's central proposition that,

> "Most of the commonly cited attributes of professions may be seen either as a consequence of their autonomy or as conditions useful for persuading the public and the body politic to grant such autonomy."
>
> [Freidson (1970a), p 135]

The chapter considered the evidence for and against a variety of explanations including Freidson's. It concluded that differences in autonomy were related to differences in occupational characteristics, but that this insight had to be taken further to explain both occupational differences, and the different types of autonomy in each occupation. By drawing on the evidence of different social structures and processes which regulated

practitioners (at the national and local levels), and of how these structures were established, the thesis was able to investigate the ways in which occupational characteristics were related to autonomy and the relationship between the state and the occupations of the study.

It concluded that insofar as the state did uphold medical dominance and professional autonomy ,it was through management arrangements instituted by its employing authorities. In addition, that these arrangements had a profound ,and often unrecognised effect on the working conditions of practitioners and on the future of each profession. The implications for the professions of the state ceasing to be the monopoly, or main employe, would be significant .

Conceptual Criticisms of Freidson's Theory

The empirical research also highlighted conceptual weaknesses at the centre of Freidson's theory, and a discussion of these now leads the thesis to a consideration of the theoretical implications of the research which extend beyond Freidson's theory.

Evidence from the research of the different types of autonomy and control highlighted logical problems with Freidson's theory . First, the central concepts of the theory - autonomy, dominance and control - are not defined. Freidson's only definition of autonomy is a dictionary one, simply as self-direction in work and freedom from evaluation by others.

The research found that "professional autonomy" was a complex phenomenon made up of a number of different elements - there were many types of professional autonomy. There were also many types of "medical dominance",ranging from majority membership of state registration councils, through district medical officer management of "paramedical heads of service", to individual consultants prescribing treatments to be carried out. This is without considering concepts of "ideological dominance" in health services. The research and analysis of different types of autonomy made it possible to investigate exactly how, and to what extent medicine controlled other health occupations,and the influence of the state.This conceptual development made it possible to contribute to theoretical debate about the "decline of medical dominance"(Øvretveit(1985)),and about the relationship between professions and the state.

The second ,and related point,is that Freidson confuses autonomy with authority,and both with the vaguely-defined "dominance". Freedom from external control is not the same as

self-direction . Not being directed by others is simply the absence of control by others. However,self-direction often also requires active and positive support from others. In the case of employed professionals it requires active authorisation by the employer,and for self-employed practitioners,often active authorisation by the state to carry out potentially harmful interventions,and the willingness of insurers to provide indemnity insurance.

Thus "escaping medical dominance" may lead to professional autonomy in one sense,but it does not necessarily also empower a profession or a professional to be self-directing.

The thesis develops these points below through a discussion of the difference between autonomy and authority,and of the basis of professional authority. It develops the conceptual and theoretical argument of the thesis by relating the findings to other social scientific knowledge.The discussion starts with Weber's conception of authority in bureaucracies.

PART 3 : PREVIOUS CONCEPTIONS OF "PROFESSIONAL AUTHORITY"

In seeking to explain professional organisation and professional-bureaucratic conflict, a number of studies took Weber's discussion of "legal-rational authority" as their point of departure. Appendix 4 noted that, for Weber, the critical feature of the "legal-rational" type of authority was that it was, "accepted as legitimate by those "subject" to it because of the "legality" and rationality of the "normative" rules and the right of those elevated to authority under such rules to issue commands." [Weber (1947) p 328].

The importance of Weber's analysis of authority was to propose different bases for power to be exercised legitimately. In the ideal types of authority ,Weber drew attention to the nature of the shared values and norms which underlay individuals willingly accepting the directives of others.

Placing the legal-rational type of authority in the context of the social system of a bureaucracy, Weber sought to demonstrate that individuals accepted the right of a superior to issue instructions on the basis of both, (a) the office and authority of the superior being established through a rational-legal process, and (b) the rational nature of their instructions in their being derived from, or relatable to, policies and procedures established through a rational-legal process.

This thesis will draw on the evidence presented earlier to argue below that professional authority is a variation of legal-rational authority, not a qualitatively different type of authority as has been proposed by previous studies.

Many studies of professionals took their lead from Parsons's view that bureaucratic authority was different from the "authority of technical competence", and that Weber "has thrown together two essentially different types." [Parson's introduction to Weber (1947) pp 58-59]. Parsons justifies his view of professional authority as a distinct type by considering the power of doctors in private practice in relation to their clients, and the different basis of authority of bureaucrats and of experts in organisations.

Parsons first noted the importance Weber attached to technical competence as a basis of bureaucratic efficiency. For Parsons, Weber's use of the terms "knowledge" and "technical competence", "immediately suggests the "professional" expert such, for instance, as the modern physician." Parsons then noted that most physicians worked in private practice, not in bureaucracies, but that this did not stop them, "issuing orders to patients" and, furthermore, that patients complied with the orders. For Parsons,doctors in private practice were not bureaucrats, but they could get patients to consent voluntarily to following the doctor's orders, and therefore doctors were exercising a form of authority which was different from rational-legal authority.

Parsons then turned to ,"the organisation of authority within a corporate group" ,and noted that, for Weber, "It is not logically essential to it (a legally-defined office) that its exerciser should have either superior knowledge or superior skill as compared to those subject to his orders." Parsons viewed it as essential to distinguish technical competence as a source of authority, even if to do so was a "difficult and subtle problem", i.e. that essential to the authority of certain roles was the possession by individuals of technical expertise, rather than their ability to interpret bureaucratic rules.

Parsons then noted that where professional services were carried out in complex organisations there tended to be a "company of equals", which was a different structure from the administrative hierarchy. He concluded that, "Weber's neglect to analyse professional authority is associated with a tendency to over-emphasise the coercive aspect of authority and hierarchy in human relations in general." (p 60).

Subsequently many structural-functionalists as well as theorists and researchers with different perspectives adopted Parsons' view and explained conflict in terms of the different bases of "professional" and "bureaucratic" authority. [Blau and Scott (1963) p 61, Toren (1969) p 152,

Gross (1967), Etzioni (1964) ,"The basis of professional authority is knowledge", and Jaques (1976) ,"As Parsons points out in his introduction, if Weber had recognised such systems (of professional colleagues) as different it would have altered his perspective on several issues." p 51)].

This thesis takes a different view, which it seeks to demonstrate by logical argument below, and by reference to the author's research .

Firstly, Weber was not concerned with "powers of coercion in the case of recalcitrance", as Parsons suggests, but with why individuals willingly accepted the instructions of others whom they ,or others, placed in power.

Secondly, the possession of knowledge and technical skills by individuals frequently means that they have power in certain situations, but knowledge alone is not authority. They achieve authority when others recognise that knowledge and that they can apply their knowledge and technical skills competently. The "recognition" of that knowledge is dependent on the perceiver's understanding,not on the "objective" nature of that knowledge.

This thesis proposes that the basis of the authority of the practitioner in the practitioner-client relationship is of the "legal-rational type". The evidence of state regulation presented in Chapter 3 described the process and structures through which the state authorised occupations to decide, on behalf of the population, the necessary initial competence to practice. The client willingly complies with the practitioner's instructions because they believe that the practitioner is competent to practise, and is following codes of ethics and systematic procedures. The basis of the practitioner's authority is not knowledge per se, but their social certification of competence and a judgment by others that the practitioner can be trusted to use their skills and knowledge responsibly to help an individual in a vulnerable situation.

The power of the practitioner is, to use Parsons' (1947) words describing rational-legal authority, "legitimised by having been "enacted" or "imposed" by a legitimate agency and procedure". In this case the agency and bureaucracy in question is,firstly the professional association which judges competence and regulates practitioners on behalf of the state. In many cases the public, through their political representatives also authorise these associations to carry out regulation and certification on their behalf,because they are persuaded that they do not have the expertise to judge competence. In addition, state employing agencies require proof of initial qualification, which further authorises the power of the practitioner employed by a state agency in the eyes of a client contemplating placing themselves in a vulnerable situation. There are three distinct agencies and procedures which legitimise the power of the practitioner.

By focusing on the process through which professionals achieve authority in this way, it is possible to show that "technical competence" or "knowledge" is an important, but not the only basis of "professional authority", and to open up for examination the political and social nature of professional authority.

The "Occupational" and the "Administrative" Principles of Work Organisation

It is of note that Freidson (1970) also questioned Parsons' logical distinction between the "authority of office" ,and the "authority of knowledge" (or "technical competence"). Freidson accepted that,

> "In a strictly logical sense, the capacity of the office-holder is to influence the behaviour of others (that is, to exercise authority is a function of the office he holds), with no necessary relation to how much he may have to know to do his official job". ..... "Legal "competence" is a question of "power" in this sense; technical competence is of a different order."

Freidson accepted Parsons' distinction, but criticised it on the basis that, "it does not tell us how each kind of "authority elicits obedience" (exactly the question of concern to Weber). He suggested that the authority of the office-holder "works" because,

> "It frequently rests on his capacity to sanction his subordinates - to withhold or grant monetary rewards for example. Part and parcel of the office is legitimate access to such sanctions. But, logically distinct from that of the office-holder, the "authority" of technical competence has no clear sanction at its disposal. How therefore does it move others to "obey"?" (p 109).

This interpretation, and Freidson's general approach, emphasises the coercive or persuasive aspect of authority, whereas Weber's insight was to draw out the voluntary basis of legitimacy. Freidson touches on the central issue in later posing the question thus,

> "The problem of professional authority is the same as the problem posed to all workers who give consultative services to laymen. Any expert whose work characteristically requires the cooperation of laymen is handicapped because laymen know neither the occupational rules of evidence nor the basic content of skill. What distinguishes the professional from all other consulting experts is his capacity to solve some of these problems of authority by formal institutional means. His solution

> minimises the role of persuasive evidence in his interaction with his clientele." (pp 109-110).

It is this insight which was the starting point of this thesis, but one which Freidson did not pursue. Unfortunately Freidson did not go on to explore the significance of the fact that the process by which professions (as opposed to other experts) establish authority, and the nature of that authority, is, "official and bureaucratic insofar as it is formally established by law". Instead, he pursued a line of argument that proposed that the main sanction available to doctors to influence skeptical clients was the doctor's "gatekeeper" control over access to scarce resources,such as diagnostic and treatment facilities. Again, this is to emphasise the coercive over the voluntary aspect of authority. It also demonstrates the argument of the thesis,because the "gatekeeper" sanctions are authorised and institutionalised by the state and the decision to do so is influenced by considerations apart from "technical competence".

The approach taken by Freidson, and the fact that he did not explore the implications of his original insight, are demonstrated in the way he uses the concept of authority in a later discussion of "professionalisation" in "post-industrial" society (Freidson (1973)). In this paper Freidson argued that concepts for analysing social organisation in modern society needed to be reconsidered, and in particular, "the principle of authority which establishes, coordinates and controls specialised labour". In the past, managers,

> "establish the organisation, determine the set of tasks necessary to attain their production goals, employ, train, assign and supervise men to perform those tasks and coordinate the interrelations of various tasks to gain their ends." (p 50).

In "post-industrial" society, however, work is more "knowledge-based" and workers' tasks are increasingly, "not created by or dependent on management, nor are the qualifications to perform them so dependent". Skills which are complex and abstract by their nature resist managerial rationalisation, but in addition the control and autonomy of professions make it even more difficult for management to subject the new "class" of workers to the same rational principles of work organisation.

The main differences between this thesis and Freidson's position can be demonstrated at the point where Freidson argues that the division of labour and specialisation which "continues unabated" is determined by the "occupational principle". Freidson states, "The occupational principle represents a basis for organising jobs and work in a division of labour which is entirely different from the administrative principle."

Firstly, the thesis argues that the process through which professions achieve authority is a bureaucratic process, and the structures of professional authority are bureaucratic structures. Secondly, Chapter 3 showed that the structures of regulation at the national level did not define a division of labour, and did not provide professions with the degree of authority which would be necessary to sustain Freidson's thesis of the centrality of the "occupational principle of organisation", especially in state welfare agencies.

The fact that occupations are often authorised to undertake certain regulatory functions represents a particular constraint for managers. However, the author's research showed that although managers did not have the same degree of control over professionals as they did over other workers, they still determined general objectives and coordinated professional labour according to "bureaucratic principles" of organisation.

Thirdly, in state bureaucracies in the past, medicine was authorised to coordinate members of various occupations, but again, medical authority was of the rational-legal type, achieved mainly, but not only, because its claims to expertise were accepted. The research findings were that in the 1980s, in the NHS, the authority of medicine diminished, not because its claims to expertise were disproven, but because general managers and other occupations acquired authority.

The important issues ,which underlie both the question of the basis of professional authority in relation to clients ,and the nature of professional organisation, are : the nature of specialist expertise, its opaqueness to non-experts ,how society comes to grips with the problems and potentialities of specialist expertise,and how experts exploit expertise for their own interests.

The chapter now outlines the thesis conceptions of power and authority, which informed the above discussion, and applies these conceptions to define the thesis perspective on professional authority and autonomy.

PART 4 : THE THESIS PERSPECTIVE

The central questions addressed by the theorists above , are, what is the basis of professional power in relation to clients?, and what is the basis of professional power in bureaucracies? The thesis adopted the following perspective.

First, power is defined in general terms, following Weber, as,

> "The probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests." [Weber (1947) p 152]

By also adopting Weber's conception of authority, the thesis focuses on legitimate power and on the social structures and processes through which professional power is legitimised. The thesis draws on the conceptions of Brown (1960), Kogan et al (1971) and Jaques (1976), who applied this perspective to understand how power was authorised within bureaucratic social systems and, in particular, the authority of executive roles.

These writers conceived of power as a quality of an individual or group which enabled them to cause others to act (e.g. personality, knowledge, etc), two forms of which were persuasive, and coercive power. Authority was viewed as, "the institutional transformation of power channelled and limited within a social system", and as "the exercise of power in a manner which others have said is allowable and are prepared to support".

Jaques (1976) made an important distinction between power authorised, "by the group towards whom the power is being used" (legitimate or authorised power), and where a group, "sanctions the exercise of power against a third party". In Weber's (1947) terms an "autonomous group", and a group ordered by an outside agency, an "heteronomous group" (p 148).

To develop the conception of "legitimate" or "authorised power" to understand the authority of professionals, the thesis adds the following ideas.

Firstly, the thesis takes the view that certain attributes of individuals or groups only become relevant as power attributes in certain social situations at certain times: power should not be located entirely within individuals, or groups, but viewed as the result of the individuals or groups having access to, or possession of, a resource which is necessary to others. Only in certain situations does the attribute of knowledge, the ability to withdraw labour, or the ability to purchase a commodity, become power : in this view individuals do not "possess power" outside of a social situation.

Secondly, the thesis emphasises the significance of perceptions of power. Power is always potential - if it is exercised it becomes force or authority. Power always involves some element of "bluff" and power negotiations are situations where various parties develop conceptions of their own and of other's power. In the process through which power becomes legitimised, it is

individual's and group's perceptions of their own and of other's power which is important. These perceptions arise in various ways, sometimes on the basis of real or mythical examples of the exercise of power, and are changed in the process through which individuals and groups achieve authority.

It is the perception of the power of the medical profession, and of the power of the practitioner to prevent suffering which is important,the latter being an element of the "faith cure". Central to the power of professions is lay person's difficulty of judging profession's claims and competence, but this uncertainty is characteristic of any power situation.

Thirdly, individuals and groups may use power to achieve authority over areas unrelated to their power. The legitimation of power is not always a recognition and authorisation of a type of power which was "originally present". For example, individuals and groups may explicitly or implicitly threaten to use various types of power unless they are authorised to act within a particular area. Coercion may be involved in the legitimation or authorisation of power.

Jaques (1976) defined authority as, "the exercise of power in a manner which others have said is allowable and are prepared to support", that is, as one type of power relationship where B agrees beforehand to accept the influence of A. This usually involves the agreed limitation of the influence of A to a specific area. Jaques emphasis was on the process by which individuals and groups recognise each other's power and established rules or positions of authority.

However, the process by which others agree the powers which A may exercise, may involve A in an overt or covert display of power to coerce agreement. A may use a variety of powers to gain agreement that in the future they may routinely and legitimately use powers in a specific area. Frequently people are explicitly or implicitly coerced into "agreeing" the authority which will govern them, and the resulting power is legitimate only in a sense that others unwillingly and grudgingly recognise that they have little alternative. Appeals to the concept of the individual's existential choice do not alter the fact that the "agreement" of an individual in a high unemployment area to a wage cut involves coercion. Thus to achieve a position of authority, and to gain agreement from others that power may be exercised, an individual or group may have implicitly or explicitly coerced others into agreeing.

Power also always involves a reciprocal relationship in which those exercising power are dependent on, or recognise the power of those over whom power is exercised. The exercise of power always involves a recognition by the exerciser of the power of those over whom the power is exercised. (This was explored by Hegel in the dynamic of the master-slave relationship(Hegel (1966)).

Finally, the thesis holds that authority also depends on accountability : it is not just that positions and regulations must be agreed and supported by all to be authoritative, but accountability systems are also necessary to ensure that those provided with power justify their interpretations of agreed rules and policies. As Lockwood (1964) noted,

> "Whereas the legitimacy of authority tends to take the form of general principles, acts of authority are always more specific than the derived rules of authority, no matter how well developed the latter. Thus the "exploitable" ambiguity surrounding the derivation and interpretation of the legitimacy of specific acts means that authority is never given, but is always contingent upon its exercise." (p 246-7).

The system of accountability therefore enhances and further legitimises authority. Rational-legal authority cannot exist without accountability,and the type of accountability which operates is closely linked to the type of authority which exists.

Professional power, authority and autonomy

Drawing on the above conceptions of power and authority, the following continues the earlier discussion of the nature of professional autonomy. From the perspective of the thesis the authority of the individual practitioner in relation to clients does not derive from expertise per se, but rather from their social position granted by their professional association and/or their state regulatory body which recognises their initial competence to practice.

By focusing on these social structures and processes, it is not necessary to assume that particular occupations do or do not have certain knowledge or skills. Claimed expertise becomes one of a number of considerations in the decision to grant authority to an occupation or individual over a particular function. The areas of interest become how claims to expertise are advanced and perceived, and the nature and consequences of the structures which are created.

For example, Chapter 3 showed that through state regulation some occupations (nursing, medicine, physiotherapy) were delegated authority to determine qualifications to practice and to regulate training and practitioners. In these cases it was not expertise per se which led to state regulatory structures. The fact that lay persons could not judge competence only became important, and justified authority of this type being delegated, because of the vulnerable position of clients.

One of the reasons that psychology and social work have not acquired the same authority is that they are not able to sustain the claim that incompetent practitioners are a danger to the public. The authority of these professions is not less because their technical expertise is less (although this may be so in the case of social work), but because the state and the public have not been persuaded that the significance of their expertise is such that state regulation is necessary.

The "problems of authority" for a practitioner noted by Freidson are reduced by membership of a professional association, but the authority of the practitioner here is of a different order from that deriving from state recognition. The function of professional associations is not to judge competence to practice, but to defend and advance their members' interests. However, the client is assured that the professional has the qualifications for membership and that certain forms of regulation and accountability may exist, and is therefore more prepared to submit to their powers.We are more likely to believe and trust a used-car salesman if he is a member of the Association of Second-Hand Car Dealers with a certificate in the office and the associations' ten point pledge to the public on the wall : this is recognition by other "experts",and suggests the possibility of redress.

Finally, where practitioners are employed by welfare agencies and, in particular, by state welfare authorities, practitioners also derive authority from their position as employees of the authority. Clients comply with advice and instructions in part because they are assured that the employing organisation has judged competence to practice, and that the employing organisation is liable for incompetence. Client coercion through monopoly of services is less
important than the willing compliance of clients through their accepting the authority of the practitioner as a result of their social position.

It is the particular conception of power and authority as applied to professions which distinguishes this thesis from Freidson's. The differences become clearer when considering the nature of professional power and authority within organisations. Freidson emphasised institutionalised autonomy as the central feature of professions, and autonomy was the basis of his theory of professions and of medical dominance. The chapter noted earlier that Freidson defined autonomy mainly in terms of control over content and terms of work, self-direction in work, and as independence from evaluation by others.

This thesis takes the view that autonomy derives from delegated authority. One example is where an occupation is authorised by the state to carry out certain functions, and, as a consequence, acquires a certain form of autonomy, but it is autonomy which is institutionalised by virtue of authority being delegated.

The state may be persuaded, for a variety of reasons, that training for a particular type of work should be regulated. Members of the occupation may be chosen to be the best persons to assess training schools and to set standards to be attained by trainees before their skills can be made available to the public.The state and the public,however,do not decide to "institutionalise the autonomy" of the occupation. Rather the state empowers members of the occupation to carry out certain functions on its behalf. It authorises members of the occupation to carry out these functions, and as a result the occupation acquires a certain "independence".

By focusing on authority rather than autonomy, the thesis emphasises the processes and relationships through which individuals and the public empower professionals. By concentrating on autonomy, albeit institutionalised autonomy, it is possible to lose sight of the way in which autonomy is achieved, and that the positions attained by professionals are because clients and the public put them in these positions, even though the processes and structures through which they do so are complex.

Freidson's view of the nature of professions deriving from institutionalised autonomy minimises the social processes and relationships which establish and sustain that autonomy; processes and relationships which are kept to the forefront through the concept of authority, which is also more closely linked to the concept of power, than is the concept of autonomy.The concentration in the literature on autonomy reproduces the preoccupations of professionals,and distracts from an understanding of the basis of their power.

The thesis was able to go further than to present a critique of Freidson's theory, because it considered the different structures and types of authority, rather than the less crucial question of autonomy. Autonomy derives from authority, or is authority viewed from the perspective of the profession or the professional. The thesis conceives of autonomy simply as independence from direction, or as degree of freedom.Of greater importance is delegated authority to act and to direct others, and the process through which authority is achieved.

There is a number of implications arising from this view of professional authority and from an understanding of the processes and structures within modern society authorising professions to carry out certain functions. One consequence of the above analysis is that, rather than viewing "the problem of professionals in bureaucracies" as a conflict between two inherently different sources of authority, a number of questions can be viewed in a different light.

For example, how do managers and employing organisations deal with the consequences of certain groups of workers being authorised by the state to determine such matters as the numbers trained, the skills and knowledge available and codes of practice to be observed? Does the state

have a duty to intervene in the public interest if too many or too few practitioners are available in the short or long term, or if the training and skills are increasingly irrelevant to needs expressed by the public? Where the state is also a monopoly employer, primarily because public welfare requires it to provide basic services, these questions assume added significance. What are the consequences of the withdrawal of different forms of state authorisation ?

An emphasis on the process through which authority is achieved by professionals as individuals and groups, and on the nature of the authority they acquire, reveals specialist and expert knowledge as just one factor in the decision to delegate authority over certain functions. It enables investigation of a variety of other factors, such as the relative power of the different interest groups which enter into the process leading to the authorisation of professions and of professionals.

PART 5: A MODEL OF PROFESSIONAL POWER AND THE STATE

The main concepts and arguments of the thesis may be drawn together in a general model representing a process through which professions establish their authority (Fig.8.1).The model highlights the main variables in the process , illustrates its self-reinforcing nature,and shows the relationship between the state and welfare professions.

The model builds on the conclusions of the review in Chapter 2 and identifies the main necessary objective preconditions, without which an occupation will not be able to gain institutional autonomy and authority. It emphasises the significance of a "subjective" component in the process: how an occupation becomes aware of itself and its role as a social group, develops an ideology and organisation, and agitates and negotiates to exploit various situations and events to acquire institutionalised advantages.Chapter 7 suggested that this component was important in explaining differences and changes in autonomy.

Institutionalised autonomy and work organisation then acts back on these influences, modifying them in a "ratchet effect". The coherence and agitation of the occupation is less important where one or more of the objective preconditions become significant in relation to social issues or changes.

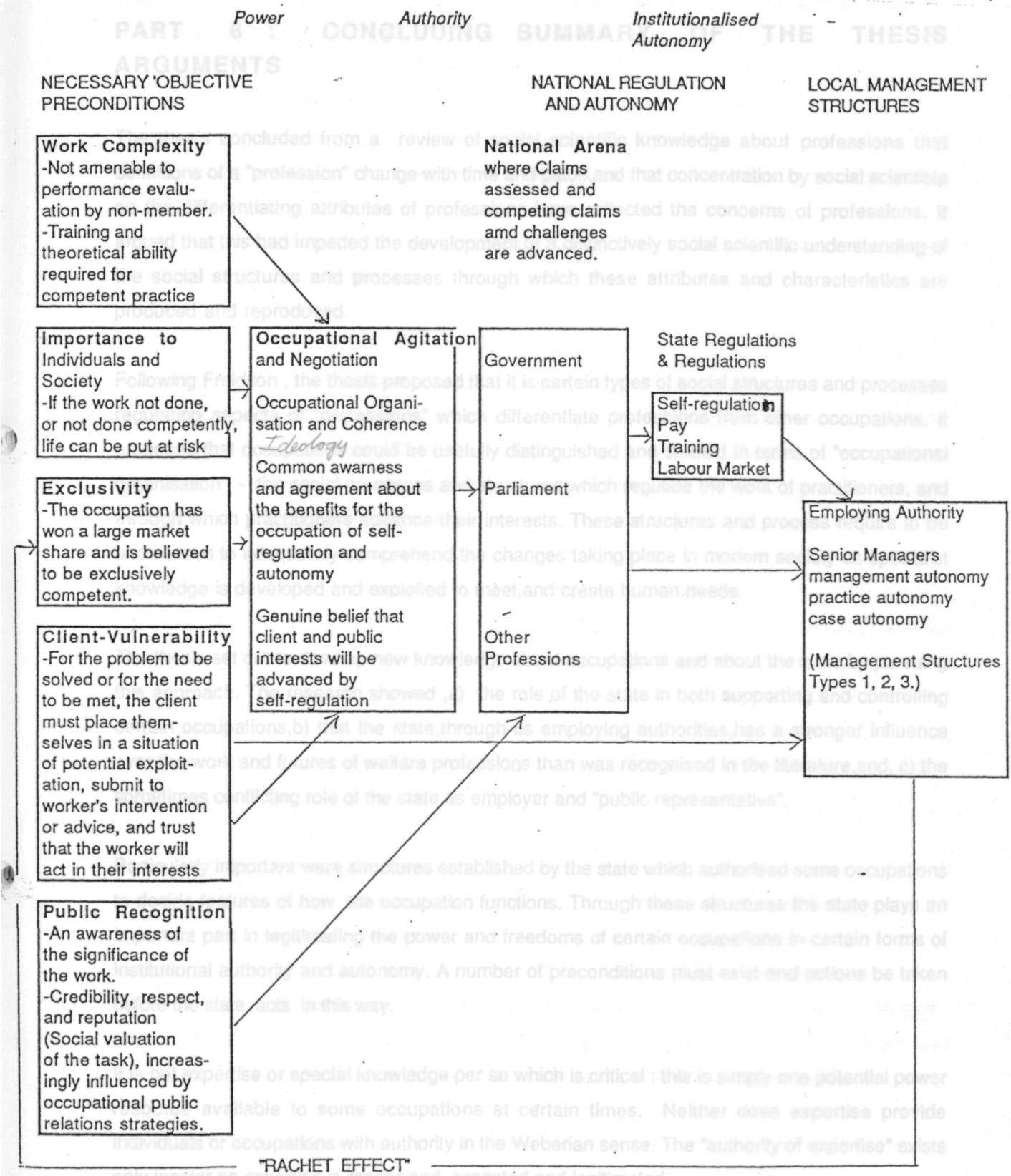


Fig.8.1 : A Model of Professional Power and the State

PART 6 : CONCLUDING SUMMARY OF THE THESIS ARGUMENTS

The thesis concluded from a review of social scientific knowledge about professions that definitions of a "profession" change with time and place,and that concentration by social scientists on the differentiating attributes of professions have reflected the concerns of professions. It argued that this had impeded the development of a distinctively social scientific understanding of the social structures and processes through which these attributes and characteristics are produced and reproduced.

Following Freidson , the thesis proposed that it is certain types of social structures and processes regulating aspects of "professions" which differentiate professions from other occupations. It proposed that occupations could be usefully distinguished and studied in terms of "occupational organisation" - the social processes and structures which regulate the work of practitioners, and through which practitioners advance their interests. These structures and process require to be understood to adequately comprehend the changes taking place in modern society as specialist knowledge is developed and exploited to meet,and create human needs.

The thesis set out to develop new knowledge about occupations and about the state by pursuing this approach. The research showed ,a) the role of the state in both supporting and controlling certain occupations,b) that the state,through its employing authorities,has a stronger influence over the work and futures of welfare professions than was recognised in the literature,and, c) the sometimes conflicting role of the state as employer and "public representative".

Particularly important were structures established by the state which authorised some occupations to decide features of how the occupation functions. Through these structures the state plays an important part in legitimating the power and freedoms of certain occupations in certain forms of institutional authority and autonomy. A number of preconditions must exist and actions be taken before the state acts in this way.

It is not expertise or special knowledge per se which is critical : this is simply one potential power resource available to some occupations at certain times. Neither does expertise provide individuals or occupations with authority in the Weberian sense. The "authority of expertise" exists only insofar as expertise is recognised, accepted and legitimated.

The discussion drew on the research to develop the thesis that expertise and special knowledge are attributes or resources used by certain occupations to acquire institutionalised authority and autonomy. The state frequently delegates to the occupation regulatory authority because the

occupation establishes the claim that only members have the expertise to undertake the regulatory functions which the state has judged necessary, usually to "protect the public".

The thesis argued that the "source" of the authority of such occupations and the basis for their autonomy is not expertise per se, but the powers delegated by the state in Acts of Parliament and in regulations, structures and policies set by government agencies. An understanding of the process through which occupations acquire and are delegated authority and autonomy, and of the different types of authority and autonomy and their consequences, is therefore of importance to an understanding of professions.

The research evidence showed that national regulatory structure established by the state usually only empowered an occupation to regulate aspects of training, to set qualifications of basic competence, and to discipline for negligence. The state did not delegate authority to "define the work" of the profession, neither did the state define or arbitrate over a division of labour or over boundary disputes. The national regulatory structures did, however, set certain conditions and constraints which influenced decisions and negotiations in the work setting about the work and conditions of work of practitioners.

Because the state was a monopoly employer in the U.K., the claims of welfare occupations for certain forms of authority and autonomy were considered by the state in a particular light. The consideration of the necessity for regulation ,and implications of the claim have been conditioned by the state's role as employer. The state is less likely to establish an autonomous regulatory body run by the occupation if the decisions made by the body are likely to conflict with the interests of the state as employer.

The state and its employing authorities establish structures to manage the workers it employs to provide welfare services. One of the purposes of these structures is to define the work of individuals, with varying degrees of precision. Decisions about the type of structures balance the views of the occupation about its work and how it should be organised against the views of lay managers and employing authorities. Therefore in the case of "welfare professions", the state, through its employing authorities, has a far greater involvement in defining the work and conditions of work of welfare professionals than with other occupations.

The state not only delegates authority and autonomy to regulatory bodies at the national level, it also strongly influences its employing authorities to establish certain management structures which institutionalise forms of authority and autonomy at the local level. Here again, certain preconditions and power negotiations affect the particular structures which are established, "specialised knowledge" being one of many considerations. As a result authority and autonomy

are institutionalised in the management structures which are sanctioned, and certain types of structure are established for each profession.

Whilst a variety of professional attributes and characteristics influences the management structures and types of autonomy which are established, these structures themselves profoundly influence the future characteristics of the profession.

The authority and various forms of autonomy achieved by these professions derive from the state, and can be withdrawn by the state. As a result of monopoly employment, and the determination of management structures and conditions of practice by the state, the state has come to determine the nature and future tasks of welfare professions to a greater degree than ever before. The relationship between the state and the professions may well change in the future with various consequences for professionals and clients. By describing and analysing details of the relationship, this study has aimed to provide a more informed basis for considering future changes,and to contribute to an understanding of the future role of the state and occupations in developing and applying scientific advances.

APPENDIX 1 : INDEX OF RESEARCH DOCUMENTS AND SOURCES

Notes

This Appendix lists the main documents referred to in Chapters 3 and 5 each of which provide data on management structures and different types of professional autonomy . The different data sources, methods and validity of data are discussed in Chapter 5 and in Appendix 2 .

In each part of the Appendix documents are listed under the headings :

1. Government Recommendations and Reports
   Proposing structures, regulations and procedures to be adopted by employing authorities.

2. Official Employing Authority Documents
   Statements agreed by employing authorities about structures which should exist.

3. Author's Field Research and Workshop Documentation
   List of field research reports and notes, and of notes on local and national workshops.

4. Other Research and Reports
   List of previous social-analytic research referred to, as well as other relevant research and reports.

All documents referred to in the format "Doc. 1234 (1982)" are social- analytic reports to managers and practitioners, which have been cleared by them for research publication. They are available from HSC, BIOSS, Brunel University.

PART 1: PSYCHOLOGY ORGANISATION

1. Government Reports and Professional Association Recommendations

Trethowen Report (1977)

BPS (1981), "Guidelines Concerning Job Descriptions for Clinical Psychologists", Divisional Newsletter, pp 15-20 (August 1981), British Psychological Society, Leicester.

BPS (1983), "Code of Conduct for Psychologists".

BPS (1986), "The Role of Psychologists in Multidisciplinary Teams".

2. Official Health Authority Documents

NP.01, Northumberland HA (1983), "Management Structure and Unit Management Arrangements".

EP.01, Eastbourne HA (1984), "Management of Medical Support Departments".

BP.01, South Birmingham HA (1985), "District Psychology Service".

NP.02, District Psychologist (1983), "Report on Clinical Psychology Services".

NP.03, Kat (1980), "Clinical Psychologists and Primary Care in Northumberland".

DPFN, District Psychologist (1985), "Dudley Psychology Services Operational Policy".

McPFN, District Psychologist (1986), "Macclesfield District Psychology Service Policy".

OPFN, District Psychologist (1986), "Oxfordshire Clinical Psychology Services".

NWFN, District Psychologist (1984), "Norwich Clinical Psychology Services Policy".

3. Author's Field Research and Workshop Documentation

NPFN, "Northumberland Workshop Notes".

MPFN, "Manchester Workshop Notes".

EPFN1, "Eastbourne Issues Letter".

EPFN2, "Eastbourne Workshop Notes".

BPFN, "Notes on Meeting with District Psychologist".

McPFN, "Macclesfield Workshop Notes".

DPFN, "Dudley Workshop Notes"

OPFN, "Oxford Workshop Notes".

NETCN (1983), "Notes on North-East Thames Conference on Organisation".

H&KFN (1986), "St Helens and Knowsley Workshop Notes".
GFN (1987), "Gwynedd Workshop Notes".

Regional Workshops

RWN.01, (Sept 1984), "West Midlands Region Workshop Notes".
RWN.02, (June 1986), "Northern Region Workshop Notes".
RWN.03, (March 1987), "West Midlands Region Workshop Notes".

Brunel Workshops

BWN.01 23/24 Nov 1983
BWN.02 13/14 Feb 1984
BWN.03 23/24 Feb 1984
BWN.04 13/14 Sept 1984
BWN.05 27/28 Sept 1984
BWN.06 30/31 Oct 1984
BWN.07 31 Jan/1 Feb 1985
BWN.08 13/14 Feb 1985
BWN.09 3/4 Oct 1985
BWN.10 15/16 Oct 1985
BWN.11 4/5 March 1986
BWN.12 22/23 April 1986
BWN.13 30/31 July 1986
BWN.14 3/4 Dec 1986 (Specialist Health Professions)
BWN.15 15/16 Dec 1986
BWN.16 31 March/1 April 1987

(Field research up until August 1985 is summarised in Øvretveit (1985), "Organisation of Clinical Psychology in the NHS". HSC , Working Paper, Brunel University).

Other Conferences/Seminars where concepts and organisation discussed

Conference Note (10 May 1982), "Regional Representative Structures", King's Fund Centre, London.
Conference Note (1984), "Grading and Organisation", King's Fund Centre, London.
Conference Note (1984), "Organising District Psychology",
S-E Thames Region, David Solomans House.
Seminar Note (1984), "Planning Organisational Structure", Oxford Region, Warneford Hospital.

4. Other Research

Doc, 3044 (1979), "Brunel National Workshop on Models of Clinical Organisation" (22/6/1979).

Regional Workshop Notes (1978), "Notes by Bernard Kat on Concepts and Models of Organisation" (11/5/1978).

Doc. 1956 (1976), "Notes on Regional Workshop at Brunel" (pp 47, 48).

Doc. 2015 (1977), Role of Doctors and Psychologists in different settings", "Professional Organisation and Psychologists' role in local policy making", (pp 56, 57).

PART 2 : PHYSIOTHERAPY ORGANISATION

1. Government Reports and Recommendations

"Cope Report (1951), Report of the Committees on Medical Auxiliaries, London, HMSO.

Recommended statutory registration for medical auxiliaries (almoners, chiropodists, dieticians, medical laboratory technicians, OTs, PTs, and RGs, radiographers and speech therapists). Registers and recognition of approved training courses and examinations should be the responsibility of a single council with a number of constituent professional committees.

"Piercy Report" (1956), Committee of Inquiry on the Rehabilitation, Training and Resettlement of Disabled Persons, Ministry of Labour & National Service, London, HMSO.

Proposed the policy that there should be a "consultant in charge of hospital rehabilitation services".

Circular HM(62)18 (1962), Physiotherapy in Hospitals, London, DHSS.

Issues the following guidelines suggested by the Standing Medical Advisory Committee:

Para. II "Doctors should prescribe physiotherapy with the same precise therapeutic indications in mind as they have when prescribing drugs, and the dose should be adequate to achieve the desired effect in the shortest possible time."

It continues:

"All too often therapy is prescribed in general terms and the important details

such as frequency and progresssion of treatment, as well as arranging for attendance at medical review clinics, are left to the discretion of the physiotherapist."

(Cancelled by HSC(IS)185 in 1975)

"Oddie Report" (1970), The Council for Professions Supplementary to Medicine, Report and Recommendations of the Remedial Professions Committee, London, C.S.P.M.

Recommends closer integration between remedial professions as essential, started by common training.

"Tunbridge Statement" (1972), Statement from the Committee on the Remedial Professions to the Secretary of State, London, HMSO.

Identifies four areas of difficulty: Remuneration (low), Career-structure (not attractive), Professional role (needs clarification in relation to doctors), and Research (evaluation).

"Tunbridge Report" (1972), Rehabilitation: Report of a sub-committee of the Standing Medical Advisory Committee of the Central Health Services Council, London, HMSO.

Developing and running an effective rehabilitation service requires a medical qualification.

"McMillan Report" (1973), The Remedial Professions: A Report by a Working Party set up in March 1973 by the Secretary of State, London, HMSO.

Members of the remedial professions should co-ordinate, organise and administer their own services.

"Burt Report" (1973), The Council for Professions Supplementary to Medicine, Report of Remedial Professions Committee, London, C.P.S.M.

Recommends: amalgamation of PT and RGs, but not OTs; integrated training for common areas; representation of remedial professions' views to new Health Authorities by one member of any remedial profession.

HSC(IS)101 (1974), The Remedial Professions and Linked Therapies, London, DHSS.

Calls upon health authorities to designate senior therapists as having responsibilities for "advising management teams". (Replaced by HC(79)19)

"Halsbury Report" (1975), Report of the Committee of Inquiry into the Pay and Related Conditions of Service of the Professions Supplementary to Medicine and Speech Therapy, London, HMSO.

"Although we have been told that the present criterion of numbers supervised is not wholely satisfactory - and we agree - we have found no entirely satisfactory alternative." (grading p. 36).

"C.P.S.M. Report" (1976), Submission to the Royal Commission on the NHS, London, C.P.S.M.

Suggests Council should also be involved in manpower planning.

Circular HN(77) 124 (1977), Nursing and Remedial Professions - Joint Working Party Report, London, DHSS.

Winterton/Perry Report (1977), Report of the Sub-Group on the Organisation of the Remedial Professions in the NHS, London, DHSS.

Districts should appoint District Therapists to manage, organise and plan their services within the district, either through management or coordination.

HC(77)33 (1977), Relationship between the Medical and Remedial Professions - A statement by the Standing Medical Advisory Committee, London, DHSS

"In referring patients to therapists, doctors should give the diagnosis, where possible, and set out the aims of treatment with a note of limitations and contra-indications to a particular formof treatment."

HC(79)19 (1979), Management of the Remedial Professions in the NHS.

Central Management Services (1979), Staffing in the Remedial Professions, London, DHSS.

DHSS (1981), Physiotherapy in the Community and Open Access to Physiotherapy Departments for General Practitioners, London, DHSS.

2. Official Health Authority Documents

None

3. Author's Field Research and Workshop Documentation

Notes (10/3/80), "Notes on Role of District Physiotherapist".

Doc. 3097 (1980), "Role of District Physiotherapist and Organisational Structure" (10/3/80) (Doncaster).

Notes (11/3/80), "Notes on Superintendent Role and Job Descriptions".

Doc. 3099 1980), "Superintendent Role and Departmental Organi sation", 6/5/80) (Manchester).

Notes (18/2/80 & 3/3/80), "Clinical Experts and Management Accountability" (Barts.).

D.3093 (1980), "Physiotherapy Management Structures" (7/3/80) (Barts.).

D.3100(b), "Senior Practitioner Autonomy and Responsibility" (23/4/80) (Notts.).

D.3112 (1980), "Seniors' Authority and Autonomy" (1/5/80).

D.3104 (1980), "Career Structure and Clinical Supervisors" (31/3/80).

D.3090 (1980), "Clinical Autonomy and Management" (21/2/80).

D.3119 (1980), "First Report to C.S.P. Council" (20/6/80).

Regional Workshops

C.3284 (1982) North-West Thames (19/1/82)

C.3290 (1982) South-West Thames (10/2/82)

C.3296 (1982) South-Western (26/2/82)

C.3297 (1982) North-Eastern (11/3/82)

C.3304 (1982) Oxford (31/3/82)

C.3312 (1982) Wessex (15/6/82)

(Trent workshop (6/6/81) not documented; workshop on "Integrating Education and Clinical Services" (3/4 Feb 1982, 9/10 March 1982, and 17/18 March 1982) not documented).

C.3300 (1982) "Summary of Regional Workshops - Report to C.S.P."

D.3435 (1984) "Senior Practitioner and Superintendent Workshop",(Nottingham and Norwich).

Brunel Workshops

BWN.17 (1984), "Managing Physiotherapy in the New Districts" (20/21 Sept 1984).

BWN.18 (1984), "Managing Physiotherapy in the New Districts" (1/2 Nov 1984).

(Also BWN.15 and 16 referenced in Appendix 1, Part1).

(Field research published in six papers in professional journal "Physiotherapy" between 1981 and 1982 (see references under Øvretveit et al (1981), and in Øvretveit (1985a).

4. Other Research and Reports

Doc. 1583 (1974) "Models of Physiotherapy Organisation" (1/3/74).

Doc. 1591 (1974) "District Organisation of Physiotherapists and OTs" (13/3/74).

Doc. 1592 (1974) "District Organisation of Physiotherapists and OTs" (29/3/74).

Note (11/3/74) "Referral and Professional Discretion".

Doc. 1593 (1974) "The Professional Work of Physiotherapists" (29/3/74).

Note (25/4/74) "Models of Organisation".

Doc. 1642 (revised) (1975) "Organisation of Physiotherapy and OTs".

Doc. 1691 (1975) "Organisation Levels and Grading". (Previous Social-Analytic Research between 1968-1972 was summarised in Rowbottom et al (1973), and

from 1972-1978 was summarised in Jaques (ed.) (1978), Health Services, London, Heinemann, Ch 9, pp 155-178).

Doc. 3096 (1980) "District Physiotherapy and OT Organisation" (20/3/80) (Exeter).

Doc. 3215 (1981) "Role of District Physiotherapist" (3/7/81) (Exeter).

Doc. 3270 (1981) "Future Organisation of Exeter District Physio therapy Service" (7/12/81).

Doc. 3262 (1981) "Dual Accountability of Head Physiotherapist" (21/11/81) (Newcastle).

Crichton, A and Crawford, M (1963) Disappointed Expectations? Report on a Survey of Professional and Technical Staff in the Hospital Service in Wales, University College, Cardiff.
Reports failure of experiment at Cardiff to ease amalgamation of 3Rs through joint professional training.

"Mair Report" (1972) Medical Rehabilitation: the pattern for the future, Scotland, Scottish Home and Health Department.

Banks, J (1974) An investigation into the difficulties of recruiting Physiotherapists in the hospital service (with particular reference to Rotherham), Trent Regional Health Authority.

Hospital Advisory Service (1975) Annual Report of the Hospital Advisory Service for the Year 1974, London, HMSO. "The overall impression is that therapists feel distinctly isolated from the district administration and DMT" (p 22);
"It is recognised that where therapists are responsible for the management of their own departments, there is a more effective use of resources and more even development of services" (p 40).

Johnson, H and Paterson, C (1975) The Remedial Professions: A Report on Therapists' Attitudes to Training, London, The King's Fund College.

C.S.P. Report (1978) Evidence Submitted by the CSP to the Royal Commission on the NHS, London, C.S.P.

Alaszewski, A, Meitzer, H and Hainsworth, M (1979) Management, Deployment and Morale of NHS Remedial Therapists: An Extended Final Report, University of Hull, Institute for Health Studies.

C.S.P. (1978) "Rules of Professional Conduct".

C.S.P. (1984) "Referral: A Discussion Paper for Consultation".

Galley, P (1977) "Physiotherapists as first contact practitioners", Physiotherapy, Vol. 63, No. 8.

PART 3: NURSING ORGANISATION

1. Government Reports and Recommendations

Salmon Report (1966) Report of the Committee on Senior Nurse StaffStructure, HMSO, London.

Mayston Report (1969) Report of the Working Party on Management Structures in the Local Authority Nursing Services, HMSO, London.

National Board for Prices and Incomes Report No. 60 (1968). Pay of Nurses and Midwives in the NHS (Cmnd: 3585), HMSO, London.

Briggs Report (1972) Report of the Committee on Nursing (Cmnd: 5115), HMSO, London.

United Kingdom Central Council (UKCC) for Nursing, Midwifery and Health Visiting, "Code of Professional Conduct" (Nov 1984).

2. Official Health Authority Documents

Nottingham DHA (1982), Nursing Management Structure (Doc. N.011).

3. Author's Field Research and Workshop Documentation

North-West Thames General Hospital Nursing Project

Doc. 3122(Rev.) (1980) "Role and Work of a Ward Sister" (25/6/80)

Doc. 3120(Rev.) (1980) "Working Relationships and Role of Ward Sister" (28/7/80).

Doc. 3125(Rev.) (1980) "Case Work and Role of Ward Sister" (28/7/80).

Doc.3127(Rev.) (1980) "Organisation and Delegation of Ward Work" (30/7/80).

Doc. 3121 (1980) "Deputising for Ward Sister" (25/6/80).

Doc. 3132 (1980) "Relationships with Services and Departments" (15/7/80).

Doc. 3134 (1980) "Prioritising and Organising Ward Work" (7/8/80).

Doc. 3130 (1980) "Elements of the Role of Ward Sister" (1//8/80).

Doc. 3131(Rev.) (1980) "Observation of Ward Organisation" (9/9/80).

Doc. 3144(Rev.) (1980) "The Work of a Ward Sister - Summary" (15/12/80).

Doc. 3265 (1982) "Nottingham Nurse Management Structures"

Doc. 3424 (1984) "Ward Sister Role at St Charles Hospital" (18/1/84).

Doc. 3430 (1984) "Nursing Organisation for In-patients" (6/2/84).

St. Ebba's Mental Handicap Hospital Project

St.E.03 (1985) "Behavioural Service Operational Policy " (Key Worker Role).

St.E.FN.01 (1986) "The Work and Role of Nursing Officers" (April1986).

St.E.FN.02 (1986) "The Role of Ward Sister and Charge Nurses" (July 1986).

Community Mental Handicap Nursing Project

RVFN.01 (1986) "Organisation of the RVS Team" (Workshop Notes, 10/10/86).

RVFN.02 (1986) "Vanguard Zone and Extended Team Organisation" (Nov. 1986).

RVFN.03 (1986) "Organisation and Development of the RVS" (Nov. 1986).

Workshop Documentation

(Notes on Workshops at Northwick Park, 10/4/81 and 14/5/81; Barnet General, 18/5/81; St Mary's, 12/6/81; and Brunel, 29/6/81, 14/7/81, 15/7/81, 21/7/81 and 22/7/81, for Nurse Managers from North-West Thames Region).

Doc. 3161B (1981) "Ward Sister Roles in General Hospitals" (May 1981).

BWN.19 (1983) "Organising Nursing Services in the New Districts and Units" (1983)

(22/23 Sept.	DNOs and Dr. NS	17 attended
11/12 Oct.	DNOs and Dr. NS	16 attended)

BWN.20 (1984) "Accountable Management of Nursing in the Post-Griffiths NHS" (1984)

(1/ 2 Feb.	DNOs and Dr. NS	16 attended
10/11 April	DNOs and Dr. NS	19 attemded)

4. Other Research and Reports

1968-1972 Research summarised in Rowbottom et al (1972), Ch. 7. pp 119-147.

1972-1978 Research results reported in Jaques, Ed. (1978), especially pp 89, 100, 109 and 157-8.

Melia, A. (1980) "East Dorset Domiciliary Health Care Project", HSORU, Brunel University.

Docs. 3216 and 3272 (1980) "Exeter District Organisation Structure".

Doc. 3372 (1983) "Nursing Organisation at St Charles Hospital, Paddington".

PART 4: SOCIAL WORK ORGANISATION

1. Government Recommendations and Reports

Seebohm Report (1968) "Report of the Committee on Local Authority and Allied Personal Social Services" (Cmnd. 3703), HMSO, London.

Local Government Act (1972),HMSO,London.

Barclay Report (1982), "Social Workers: Their Role and Tasks", Bedford Square Press, London.

2. Local Authority Official Documents

Dorset Social Services Department (1986) "Manpower Review and Case Load Management".

Islington Social Services Department (1987) "Guidelines for Super vision".

3. Author's Field Research and Workshops

Field research notes on practitioner autonomy, documented as part of 2-year research into social work recording, summarised in Øvretveit (1985) "Social Work Practice and Case Recording: Preliminary Report to BASW Council", BASW, Birmingham,

and

Øvretveit (1985) "Client Access and Social Work Recording", BASW, Birmingham,

and

Øvretveit (1986c) "Social Work Records and Client Participation", Social Work Today, 30 June 1986, pp 14-15,

and

Øvretveit (1986a) "Improving Social Work Records and Practice, BASW Publication, Birmingham.

Workshops

Local workshops with practitioners and managers on case recording, case management and accountability:

SWWN.01 (1985), Bexley SSD (4/4/85)

SWWN.02 (1985), Oldham SSD (9/5/85)

SWWN.03 (1985), DHSS (Brighton Conference) (22/6/85)

SWWN.04 (1985), DHSS (Scarborough Conference) (22/7/85)

SWWN.05 (1985), Merton SSD (11/9/85 and 20/11/85)

SWWN.06 (1986), South Glamorgan SSD (5/2/86)

SWWN.07 (1986), DHSS (Kensington Conference) (21/3/86)

SWWN.08 (1986), Kent SSD (7/3/86)

SWWN.09 (1986), Greenwich SSD (4 workshops, March/April 1986)

SWWN.10 (1986), Kirklees SSD (24/7/86 and 25/7/86)

SWWN.11 (1986), Grampian Region SSD (3/10/86)

SWWN.12 (1986), Croydon SSD (14/10/86)

SWWN.13 (1987), Borders Region SSD (28/1/87)

SWWN.14 (1987), Social Work Services Group (2 workshops, 29/1/87 and 30/1/87)

SWWN.15 (1987), Dorset SSD (27/2/87)

SWWN.16 (1987), Islington SSD (3/3/87)

SWWN.17 (1987), Lewisham SSD (8 workshops during March, April and May 1987)

SWWN.18 (1987),Coventry SSD (2 workshops and team visits)

SWWN.19 (1988),Essex SSD.

Brunel Workshops

"Managing Residential Social Services", Two 5-day workshop courses in 1983 and 1984, attended by 11 and 13 senior managers from different English SSDs.

"Social Work Records and Practice", 9 workshops during 1985, 1986 and 1987, attended by approx. 160 social workers from England, Wales and Scotland. (Not documented).

4. Other Research and Reports

Kogan and Terry (1971) "The Organisation of a Social Services Department: A Blue-Print", Bookstall, London.

Rowbottom,Hey and Billis(1974)"Social Services Departments", Heinemann, London.

Billis, Bromley, Hey and Rowbottom (1980) "Organising Social Services Departments", Heinemann, London.

Payne (1979) "Power, Authority and Responsibility in Social Services", Macmillan, London.

Parsloe (1981) "Social Services Area Teams", Allen & Unwin, London.

Bamford (1982) "Managing Social Work", Tavistock, London.

Glastonbury, Cooper and Hawkins (1982) "Social Work in Conflict: The Practitioner

and the Bureaucrat", BASW, Birmingham.

Cypher (Ed) (1982) "Team Leadership in the Social Services", BASW, Birmingham.

BASW (1970) "Codes of Ethics for Social Work", BASW, Birmingham.

BASW (1985) "Revised Code of Ethics for Social Work", BASW,Birmingham.

PART 5: MEDICAL ORGANISATION

1. Government Recommendations and Reports

Bradbeer Report (1954) Report of the Committee on the Internal Administration of Hospitals, HMSO, London

Platt Report (1961) Medical Staffing Structure in the Hospital Service, HMSO, London.

First "Cogwheel" Report (1967) Organisation of Medical Work in Hospitals. HMSO, London. (Proposed in HM (68) 67).

Second "Cogwheel" Report (1972) Organisation of Medical Work in Hospitals, HMSO, London. (Proposed in HM (72) 43).

Third "Cogwheel" Report (1974) Organisation of Medical Work in Hospitals, HMSO, London.

"Grey Book" (1972) Management Arrangements for the Reorganised National Health Service, HMSO, London.

2. Official Employing Authority Documents

None

3. Author's Field Research and Workshops

"St Ebba's, Unit Operational Policies" (1985).

Multidisciplinary team organisation research listed in Appendix 1, Part 6.

3. Other Research and Reports

Doc. 1220, A.3 (1972) "Medical Organisation at Westminster Hospital Group".

Doc. 1956 (1976) "Medical Organisation".

Doc. 2070a (1978) "Doctors and the NHS".

1968-1972, Summarised in Rowbottom et al (1973), Ch. 5, pp 73-99.

1972-1978, Summarised in Jaques, Ed. (1978), pp 11-14, 22-23, 315.

1977 Workshops (10-11/2/77 and 30/6/77), Summarised in Cang, "Doctors and the NHS".

1980-1983, Reorganisation fieldwork on "advisory" structures, documented in Docs. 3206, 3224, 3260, 3276, 3278, 3212, 3287, 3302 and 3139, and summarised in Kinston and Rowbottom (1983),

"The New NHS Districts and Units", HSORU Working Paper.

PART 6: MULTIDISCIPLINARY TEAM ORGANISATION FIELD RESEARCH AND WORKSHOPS

MDT.01 (1984) Psychotherapy Unit, Doncaster.

MDT.02 (1985) Child Development Centre (Clywd), (July 1985).

MDT.03 (1985) Child Guidance Centre (Wrexham), (Nov 1985).

MDT.04 (1985) Mental Health Teams, King's Fund Conference, (June 1985).

MDT.05 (1985) Mental Health Teams, King's Fund Conference (Dec 1985).

RVS.01 (1985) Rhondda Vanguard Mental Handicap Service (May 1985 Workshop Report).

RVS.02 (1985) Rhondda Vanguard Mental Handicap Service (Oct & Nov 1985 Reports).

St.E.01 (1985) St Ebba's Behavioural Team Organisation (Nov 1985 Reports).

MDT.06 (1986) Southern Derbyshire Mental Health Team Workshop (April 1986).

MDT.07 (1986) Sunderland Mental Health Team (June 1986)

MDT.08 (1986) Doncaster Mental Health Team (June 1986).

MDT.09 (1986) Berkshire Specialist Community Services Team (July 1986).

MDT.10 (1986) North Derbyshire Bolsover Community Mental Health Team (Aug 1986).

MDT.11 (1986) Greenwich Terminal Illness Support Team (Aug 1986).

MDT.12 (1986) Macclesfield Mental Health Teams (Oct 1986).

MDT.13 (1987) North Derbyshire, Chesterfield Mental Health Team (March 1987).

MDT.14 (1987)Sunderland Mental Health Team(follow-up,Jan.1987)

MDT.15(1987)South Birmingham Psychologists from teams(March 1987).

MDT.16 (1987) Wrexham Mental Health Resettlement Team (March 1987).

MDT.17 (1987) Barking and Havering Mental Handicap Team (May 1987).

MDT .18(1987) Lincoln Mental Health Teams(June 1987).

MDT.19(1987) Lincoln Mental Handicap Teams(June 1987).

MDT.20(1987) South Birmingham Mental Handicap Teams(June 1987).

MDT.21(1987) South Birmingham Mental Health Teams(Sept.1987)

Field Research up to August 1986 reported and summarised in:

Øvretveit (1986) "Organisation of Community Multidisciplinary Teams", HSC Working Paper, BIOSS, Brunel University.

APPENDIX 2: THE SOCIAL-ANALYTIC METHOD FOR ORGANISATIONAL RESEARCH

INTRODUCTION

The five types of data described under category "B" in Chapter 5 ("Descriptions of existing and future organisation") were gathered using the social-analytic method for organisational research. The following describes the distinctive features of the method .This description differs from earlier descriptions in, a) acknowledging the theoretical assumptions underlying the method; b) recognising the way in which researchers using the method draw on both concepts and explanatory theory, and c) distinguishing the different reliability and validity of different types of research data gained by using the method.

Such developments in methodology are necessary to meet legitimate criticisms [Whittington and Bellaby (1977)] and to establish the ways in which both social-analytic and action research can contribute to social science theory [Øvretveit (1984)]. Previous descriptions of the method are presented in Jaques (1947), (1951), (1965), (1976) and (1982);Rowbottom (1977), and in Øvretveit (1984)(M.Phil. thesis).

Social analysis is a method for the collaborative analysis of organisational problems and possible solutions. The purpose of the method is both to help to devise and test improvements to organisation and to develop scientific knowledge about organisational structure and processes which can be generalised to other situations. This combination of practical and theoretical aims situates social analysis as one of a number of action research approaches, which aim both to solve practical problems and to develop social scientific knowledge, and which holds to the view that, "To understand a social system and how it works, one must study how to change it". [Lewin (1947)].

Definition

Social analysis can broadly be defined as:

1) a collaborative, problem-focused method for
2) making explicit the current and future social context of individual behaviour, and
3) developing a scientific understanding of the relationship between social structures and individual behaviour and characteristics.

THE MAIN FEATURES OF THE METHOD

The main features of the method are described below.

1: Client Invitation

A prerequisite for collaborative working is that there is a "client" within the organisation who invites the researcher to investigate one or more organisational issues of concern to the client. Usually the researcher works directly with the client (an individual or group) who asks for help, and for as long as the client finds the help of the researcher useful. Under certain conditions the researcher will work with people nominated by the client, as long as they perceive there to be a problem which they wish to explore further. (The client does not always finance the research).

2: Client Problems

The starting point and the touchstone of the method is the organisational problem(s) of concern to the client. The researcher only works on problems which the client wishes to explore and to find some solution to, rather than on problems which are of concern to others or of research interest. It is this, and client invitation which assures, as far as is possible, that the client will be motivated to work towards describing and specifying organisation.

3: Client Confidentiality

It is a condition of the research that the researcher maintains strict client confidentiality. Discussions with and reports to clients are confidential. However, when material has been worked through with clients, it is usual that they give permission for it to be passed to others, or even published. Even when such "clearance" is given it is usually not necessary to identify individuals, and the researcher aims to report general principles and concepts which are of relevance elsewhere. Projects are never undertaken unless the principle of client confidentiality is recognised and accepted by sponsors, and no covert verbal or written reports are made.

4: Client Responsibility

The method aims to affirm and strengthen clients' responsibility for owning and resolving their own problems. The researcher has no executive power to propose or introduce changes, and any future action has to be taken by the client. The researcher does not make recommendations or give advice. The aim is to help the client to clarify the nature of the problem and its possible causes, to conceptualise future possible forms of organisation, and to explore the advantages and disadvantages of each alternative.

5: Researcher Independence

A basic condition for the researcher to be able to provide help is to maintain an emotional and practical independence from the problems and the organisation. The researcher has nothing to gain or lose by any particular outcome, is able to put the problem in perspective, and is often more able to perceive the logical features of the situation and future possibilities.

6: Analysis and Conceptualisation

An important feature of the method is that the researcher helps the clients by enabling them to achieve a better conceptualisation of the problem and possible solutions. The researcher helps the client to focus on central features of the problem (sometimes using existing concepts and/or theories), to conceptualise key features of current organisation, and to conceptualise alternative forms of organisation. By making organisation explicit and by providing concepts to allow discussion of certain features, the researcher and client are able consciously to review and explore different possibilities.

It is in this aspect of raising awareness about social organisation to enable conscious development that the method shares features of a tradition of social research and criticism which can be traced from Hegel, through Hegelian Marxism [Lukacs (1971)] to the Frankfurt school [Marcuse (1960), Habermas (1972)]. This analytic and conceptual explication not only helps one person to understand and explore possibilities, but also forms a basis for developing a common language and understanding amongst a group of people, who are then better able to explore and agree new forms of organisation.

7: Theory and Concepts of Social Structure

The method is based on assumptions about social structure and about the nature of individual's and of organisational problems. The assumptions are that certain common organisational problems arise because of uncertainty and lack of agreement amongst staff concerning key aspects of social structure and process (responsibilities, authority, etc). The assumptions are that improvements to organisation can be achieved by clarifying and agreeing these key aspects of structure and process.

In addition to these assumptions there is now a body of knowledge developed through research in many organisations which can be drawn on by the researcher where relevant [Rowbottom et al (1973) Jaques (1976) and Jaques, ed (1978)]. Thus a feature of the method is that the researcher is able to draw on already established concepts and theories, where these are relevant, to help clients to understand problems and develop new arrangements.

8: Social Process for Refining and Agreeing Future Organisation

A further feature of the method is a process through which individuals, after clarifying their views, discuss and agree possibilities with each other, and group reports are produced. The researcher will sometimes act as a "broker" in this process to clarify, in increasingly larger groups, the possible forms of organisation to be adopted. At each stage it is the group which agrees and decides further action, but the analyst often facilitates and accelerates this process.

9: Evaluation and Testing

Where new forms of organisation are agreed and adopted it is possible to test in practice the ideas which were developed, to discover subsequent problems which occur and to find out if the new organisation does indeed overcome the problems. Because the researcher produces a clear specification of new organisation it is possible to evaluate the change by finding out to what extent the change was introduced, and by noting divergencies from the original specification.

Not all social analytic projects follow the full sequence from individual discussion to group agreements and then official implementation and evaluation. As a result ideas and concepts produced in one project may have a lower validity and reliability than those produced in another project where the ideas have been fully refined and tested and put through the full process.

The following describes the full social-analytic process before then considering the reliability and validity of the different types of research material produced in social-analytic research.

The Social-Analytic Process

The process starts with organisational members' perceptions of a problem or a series of problems. Typically the situation is best described as a "mess", or as disorganised, and the various problems are presented as exemplifying or illustrating the breakdown on organisation. Usually it is senior members of the organisation who are in some way responsible for dealing with the situation who initially define the problem and contact the researcher for assistance.

The first stage of the process involves the researcher in helping various members to clarify their perception of the problem, and to formulate a joint analysis of causes and possible solutions, usually in discussion with individuals. Reports are fed back to individuals and

groups for revision to check that the researcher's formulation accords with clients' views, and to help the client to develop their ideas further. It is usually at this stage that key concepts need to be defined and agreed.

The second stage is when individuals' definitions and analyses of the problem are brought together, and a group meeting is held to develop shared conceptions and to examine alternative models. Further revisions may be carried out before the third stage of the process, which usually involves workshops attended by individuals from other organisations and sites with an interest in the problem and alternative models. This enables further revision of concepts and models and makes it possible to identify the conditions under which certain concepts and models are relevant or representative. Larger workshops thus help to identify the situations where the concepts and models can be applied, and the extent to which they may be generalised to other organisations.

Once the new organisation has been subjected to thorough and widespread discussion-testing, criticism and revision, it can be submitted by the relevant group to a higher authority which is empowered to introduce the change. The changes are then officially implemented and the researcher is available to help with problems of implementation or which arise subsequently. It is of note that underlying this process are assumptions about the importance of shared perceptions and common purpose to social organisation,and about how these may be developed.

The practical test of validity of a concept or model, using the idea of "validity" which underlies the process, is whether the original problems are resolved and the new form of organisation is effective over a number of years. It is not always possible, however, to follow through the full process to implementation and review. Higher authorities sometimes do not agree to implementation, and the researcher is not always invited back to review the operation of new organisation, especially if it is successful in resolving the initial problems. The following table summarises some of the differences between traditional research methods and the social-analytic method.

	Traditional Research	Social-Analytic Research
Research initiative:	Researcher requests interview.	Client invitation.
Focus of interview:	Researcher's questions and interests, directed by theoretical issues or gaps in knowledge.	Client's problem and possible solutions.
Purpose of interview:	For the researcher to gather information.	Joint analysis and conceptualisation: For the client to clarify organisational problems and solutions and the researcher to gather descriptions of organisation and processes.
Discussion of concepts and theory:	Rarely. Concepts and theory developed by researcher from interview data, usually by induction.	Concepts and theory offered by researcher where relevant to help joint analysis.
Independence:	Ideally,complete researcher independence.	A "disinterested concern" to help to improve organisation.
Cross-checking interview information with other	Always. analytic process.	Rarely systematically under-taken outside of the social- sources:

Table 5.1: Dimensions for Comparison of Social-Analytic and Traditional Research Methods for Investigating Organisation.

Research Limitations and Advantages

The above description of the types of data produced by the method and of the overall process is a development of earlier descriptions (based on Øvretveit (1984)(M.Phil.). This development is necessary to establish how data produced by the method can be drawn on to contribute to social scientific knowledge, and to show the appropriateness of the method for investigating the subject of the thesis. From a social scientific research perspective there are limitations as well as advantages to the method when compared with other methods for research into social organisation.

Validity

One limitation of the method is that the descriptions rely on reports by staff members about situations or of ways of working: the researcher does not typically directly observe actions or situations as they would using participant observation methods. Traditional research methods also tend to rely on reports ,but with social analysis, although the researcher is frequently involved in the everyday life of the organisation in meetings and visits, the method deliberately focuses on staff perceptions and interpretations. Descriptions built up from direct observation are of higher validity in one respect, but the researcher would need to be present for long periods of time, leaving less time for comparisons between sites.

The method produces descriptions of existing organisation and of future organisation.The latter descriptions are intentional statements or "social contracts" adopted by members and sanctioned by their employing organisation: they are agreements which members have been concerned to establish, and have invested their time and energy in specifying correctly, and have chosen to be bound by. The way in which members are involved in creating these descriptions through the social-analytic process results in data of a different nature to direct observation data, or to interview or questionnaire response data.

The validity of the explanatory theories developed in parallel with these descriptions is a separate matter, and the methods for generating and testing such theories are here the same as for any social scientific theory [Øvretveit (1984)]. Thus the researcher may develop insights, hunches and finally formulate hypotheses as a result of being involved in the process, but the process itself rarely allows for the rigorous and systematic testing of explanatory theory. An example is the explanatory theory of pyramidal hierarchical organisation structure [Jaques (1976)] which was developed over a series of research projects. The method of discussion-testing and other aspects of the process do make it possible to seek out disconfirming instances, but these methods are not designed to test the explanatory theory,although they are designed to rigorously refine and test concepts and models.

The validity of descriptions of organisation (termed category "B" data) is therefore judged according to:

- whether all who take part in, or who follow the organisational procedures and policies described are involved in formulating the descriptions;

- the way in which they are involved, i.e. that they invite the researcher to help them to describe the organisation, in confidence, individually and then in groups, and during the latter stages using concepts common to the group as a whole;

- the extent and nature of discussion-testing, using examples to test whether the concepts are being used in a common and consistent way, and whether staff do, or will do, what they said;

- direct observation (rarely systematically undertaken in social-analytic research);

- cross-checking with disinterested observers.

One criticism of the validity of the description is that it is not clear whether, or how, the researcher influences the way specifications are made of existing and future organisation [Whittington and Bellaby (1977)]. In previous reports (e.g.Jaques, ed. (1978) some descriptions have been reported in a way in which others are not able to tell whether the description is of existing organisation or of a future model. Where organisation is implemented this is clear, but a further criticism is then that the researcher has introduced prescriptive theories (e.g. levels of work, individual work capacity) which have influenced members to adopt a particular form of organisation.

One of the purposes of collaborative research is for the researcher to help the client, and this inevitably and intentionally involves influencing the client. The question is how the researcher influences the client, and how previously developed concepts and theories are used in defining organisation. The guiding principles are, (a) the researcher only introduces such concepts and theories where they are directly relevant and likely to help to clarify the situation, and, (b) the client decides whether the concepts and theories are relevant and helpful.

The client and the problem-centred approach also leads to certain research limitations which have already been mentioned. The researcher cannot choose the subject of investigation, and is not able to direct the investigation towards their areas of research interest. This disadvantage

counterbalances some of the advantages of access to, and within the organisation, and staff motivation and involvement in accurate specification.

A further criticism is that problems are often defined and chosen by higher management, or that a one-sided managerial description and perspective about the organisation can be developed. However, a requirement of research is for free access to the researcher by all members for confidential discussions. The researcher assumes a responsibility for making themselves available to all members of the organisation, and for explaining the kind of help that they can provide. In addition, that changes in organisation are discussed and agreed by all concerned before implementation.

Access

One advantage of the method is that the researcher is able to gain easy access to members of the organisation. The problem-focused and confidential approach can result in greater cooperation and trust than with other methods. This makes it possible not only to gain descriptions of organisation, but also to gain members' views about the "real" motives and factors behind certain forms of organisation, and to be part of the free discussions amongst members about the advantages to them of adopting certain arrangements (e.g. if a professional group chooses 'x' model, they are more likely to gain an extra post in 'y' site and avoid coming under the management of 'z'). This is data of a different order to description, and was data used by the author to develop explanatory hypotheses.

Confidentiality

The use of the accurate and rich data gained as a result of easy access, can be limited by the principle of client confidentiality. A criticism of the method is that only the descriptions and matters mentioned in confidential discussions, which members then agree to being widely reported ("cleared"), can be used in research publications.

Confidentiality is a necessary condition for the research, and there are cases where members have refused to allow publication. However, the main research experience is that refusals usually arise because there are flaws in the descriptions, and that alterations and changes to ensure anonymity make it possible to publish descriptions. It is less easy, however, to report motives and political strategies which are discussed and which can be used as evidence to support explanatory hypotheses.

Summary

The main research method used provided a way of both directly contributing to resolving practical organisational problems and of developing knowledge which could be generalised to other sites. The distinctive features of the method are: a focus on client's organisational problems, at the client's invitation and in a confidential setting; that analysis and conceptualisation are provided to help clients to clarify the nature of their problem and future possible organisation; that a conceptual framework can be drawn on where it is relevant to assist the analysis, and that the analyst facilitates an organisational process for clarifying, agreeing and implementing changes.

The method produces different types of research data with different validity and reliability (described in ch 5 as Category "B" data): (1) a public statement of existing organisation; (2) an individual's perception of organisation; (3) an individual's and researcher's joint description; (4) a description of organisation agreed by a group, and (5) data on new organisation which was implemented and reviewed.

APPENDIX 3 : ORGANISING PROFESSIONALS AND THEIR WORK : A REVIEW OF THEORIES AND RESEARCH

"It can even be laid down as a general rule that the less authority presides over the division of labour inside society, the more the division of labour develops inside the workshop, and the more it is subjected to the authority of a single person. Thus authority in the workshop and authority in society, in relation to the division of labour, are in inverse ratio to each other."

Marx (1847), "The Poverty of Philosophy".

PART 1: INTRODUCTION

Chapter 3 proposed that an examination of professional management structures could contribute to an understanding of institutionalised professional autonomy and control, and to an understanding of the nature of professions. The review presented in this appendix was undertaken to consider perspectives which could be used to study autonomy and work organisation,and to identify theories of and explanations for different types of management structure and work autonomy . Chapter 7 drew on the research reviewed below to develop an explanation for the differences and changes in autonomy and management structures which were discovered in the research.

The appendix first considers different general theoretical approaches to the study of organisation, paying particular attention to the way in which organisational structure has been conceptualised and explained, because this aspect of work organisation is important for investigating institutionalised professional autonomy and control. The discussion notes the particular research questions raised within, and across perspectives, and the aspects of organisation which are emphasised and ignored by each approach. The purpose of the initial review of perspectives is to provide a context within which the empirical research to be reviewed in Parts 3 and 4 of the appendix can be understood, and to begin to identify different possible explanatory accounts and hypotheses for the variations in structure which were discovered in the author's research .

Following the discussion of perspectives, the appendix reviews research into professionals in organisations (Part 3). It considers the findings of research into whether, or how, organisational

structure affects professional autonomy and control. Part 4 turns to research into the structures of work organisation established specifically by, or for professionals, and considers the typologies which were proposed by researchers to describe the different forms of organisation which were discovered. Part 5 considers more recent research which found compatibilities between bureaucracy and professions, and examines the development of theoretical debate in this area.

Two considerations run through the following brief review of perspectives on organisation. Firstly, the subject of the thesis is five professions whose members are mostly salaried employees of state welfare bureaucracies. They are formally employed to carry out the policies of democratically-elected parliaments and local authorities. The organisations with which the thesis is concerned are state bureaucracies, with a political character and a public accountability. The theoretical perspectives will be reviewed in terms of their ability to conceptualise and explain the structures and processes within such organisations.

Secondly, the thesis focuses on work organisation at "local" levels and on how services and departments are organised. Consequently the review will also judge how a particular perspective illuminates, and obscures, certain features of work organisation, and its usefulness for describing and explaining professional autonomy and control at the work place.

The aim is not to review the entire fields of organisation theory, organisational sociology, and of administrative and political studies. Rather the aim is to consider theoretical perspectives which can, or have been used to describe and explain the structure of work organisations, because it is that aspect of organisation which is of interest in pursuing an investigation of institutionalised autonomy and control. Accordingly the review will draw attention to the definitions of "formal structure" provided by researchers working within particular perspectives.

PART 2: THEORETICAL PERSPECTIVES ON ORGANISATION

Marx's view of State Bureaucracy

Marx did not develop a "perspective on organisation" as such, but his writings about the state and about bureaucracy are of relevance to this thesis. His general perspective was developed and applied by later neo-Marxists to understand modern capitalist and socialist organisations. For Marx the state and state bureaucracy did not represent the "general interest" in opposition to the "particular interests" of both the professions and the corporations of civil society, as Hegel had proposed. Rather the state represented the particular interests of the dominant class, itself part

of civil society. The state bureaucracy operated to maintain the interests of the dominant class, staffed by bureaucrats whose interests were linked to those of the dominant class. The state bureaucracy had a certain independence, but its existence ultimately depended on its effectiveness in maintaining the social order which benefited the dominant class.

From this point of view state bureaucracy had an important role to play when class polarisation and conflict increased: as a tool of the dominant class the bureaucracy perpetuated the objective conditions which enabled that class to exploit others, as well as obscuring the relations of exploitation. A corollary was that in capitalist society the overthrow of the dominant capitalist class by the first "universal" class in history would lead to a communist society and to the withering away of both the state and of state bureaucracy.

Marx's views on the state were later developed by practising Marxists to establish communist and socialist administrations (Lenin, Trotsky) and to understand aspects of class conflict in modern capitalism (Lukacs, Poulantzas). Some of their ideas are considered in Chapter 8 in developing an explanation of the role of the state and of professions in welfare services. From this perspective the class allegiance of professionals employed in state bureaucracies, and their potential political role is an important question: are they to be viewed as "para-bureaucrats" upholding the interests of the dominant class, as transforming state bureaucracies in the interests of the working class,or as a distinct and coherent class in their own right?

Marx did not develop a framework for analysing work organisation beyond his analysis of alienation and of the underlying economic relations of exploitation. Later Marxist sociologists have examined processes and structures of modern work organisations in terms of worker alienation and as mechanisms of exploitation [Braverman (1973)] as well as arenas for class conflict and as institutions within and through which inequalities in society are reproduced.

Weber's Bureaucratic Ideal Type

Weber was primarily concerned with state bureaucracies, rather than with industrial or commercial work organisation, and his writings on the subject need to be placed in the context of his overall historical analyses of society and of social change. In Weber (1947) bureaucracy is analysed as part of a general discussion of economic systems of domination and of types of authority. The following considers his analysis because it formed the basis of many later studies into a variety of organisations, and informs the perspective of this thesis.

In considering order in social groups, Weber distinguished "authority" as a special instance of "power" (where a person could enforce their will over others, despite resistance). Three "ideal" types of authority were defined in terms of the basis for the legitimation of authority,

> "according to the kind of legitimacy which is claimed, the type of obedience, the kind of administrative staff developed to guarantee it, and the mode of exercising authority will all differ fundamentally." (p 325).

Social orders as systems of domination were distinguished in terms of the basis for legitimation of authority. "Charismatic domination" was where a leader justified their domination by extraordinary capacities and actions, and where followers accepted the leader's domination because of their faith in him. "Traditional domination" was where legitimation rested in a belief in the "rightness" of tradition and where the leader commanded by virtue of inherited status. ("Obedience is owed to the person of the chief, who occupies the traditionally sanctioned position of authority and who is (within its sphere) bound by tradition." (p 328)). "Rational-legal domination" was where there was a belief in the legitimacy of impersonal rules and laws, usually because the process for establishing and enforcing the rules is agreed to be correct, and a belief in ,"the right of those elevated to authority under such rules to issue commands."

Weber proposed that the usefulness of the classification, "can only be judged by its results in promoting systematic analysis", and went on to consider rational-legal authority in a bureaucracy. He proposed that the effectiveness of rational-legal authority rested on the acceptance of five mutually dependent ideas, and showed how these ideas lead to the, "fundamental categories of rational legal authority:

> 1) A continuous organisation of official functions bound by rules; 2) A specified sphere of competence. This involves (a) a sphere of obligations to perform functions which has been marked off as a systematic division of labour, (b) the provision of the incumbent with the necessary authority to carry out these functions, (c) that the necessary means of compulsion are clearly defined and their use is subject to definite conditions .....; 3) The organisation of offices follows the principles of hierarchy; 4) The rules which regulate the conduct of an office may be technical rules or norms. In both cases, if their application is to be fully rational, specialised training is required.....; 5) .....the members of the administrative staff should be completely separated from ownership of the means of production or administration.....; 6)..... a complete absence of appropriation of his official position by the incumbent.....; 7)

Administrative acts, decisions and rules are formulated and recorded in writing.....; 8) Legal authority can be exercised in a wide variety of different forms .....". (p 333).

The Bureaucratic Ideal Type

Weber then described the purest type of exercise of legal authority as being "that which employs a bureaucratic administrative staff", and described the "criteria under which officials are appointed and function", which are,

"1) They are personally free and subject to authority only with respect to their impersonal official obligations; 2) They are organised in a clearly defined hierarchy of offices; 3) Each office has a clearly defined sphere of competence in the legal sense; 4) The office is filled by a free contractual relationship.....; 5) Candidates are selected on the basis of technical qualification; 6) They are remunerated by fixed salaries in money..... primarily graded according to rank in the hierarchy; 7) The office is treated as the sole, or at least the primary, occupation of the incumbent; 8) It constitutes a career. There is a system of "promotion" .....; 9) The official works entirely separated from ownership of the means of administration; 10) He is subject to strict and systematic discipline and control in the conduct of the office." (pp 333-334).

Weber attributed the superiority of bureaucratic administration to the way in which it enabled the deployment of "technical knowledge", and noted the power which this places in the hands of professional-administrators and the potential for their subverting democratic processes.

The "criteria under which officials are appointed and function" were adopted by later social scientists as the first systematic "definition of formal structure". It has been noted, however, that both the "ideal types" of authority and of bureaucracy were intended as analytic devices to advance a general theory of social change. They were not intended as descriptions of social phenomena but as caricatures emphasising important tendencies. Their truth, falsity or accuracy can only be assessed in relation to both Weber's theory of history and social change ,and his general theoretical problematic.

However, as analytic devices the ideal types of authority are useful, for example, in comparing the authority of different professions in relation to clients. The various combinations of legal, charismatic and traditional elements in such "systems of domination" can be identified and the reasons for discrepancies between the ideal type and reality considered. Similarly, a comparison

of the ideal type of bureaucracy with actual structures of professional organisation suggests possible explanations which can then be tested.

This thesis notes also that institutionalised autonomy can be viewed as the obverse or mirror image of "rational-legal authority". It is the ability to resist direction by a superior or by rules, which is institutionalised and legitimated by a bureaucracy. As authority is a special instance of power, so institutionalised autonomy is a special instance of freedom. Chapter 8 develops these points further.

Weber suggested that the historical existence of organisations which approximated to the "pure type" described could be found in a wide variety of fields, and he used this approach to demonstrate a more general thesis of the increasing rationalisation of the western world. He suggested that organisations displaying these characteristics were, "capable of attaining the highest degree of efficiency and are in this sense formally the most rational known means of carrying out imperative control over human beings". For Weber this type of organisation involved the final stages of depersonalisation, and an inter-linking "machinery" which provided maximum rationality, "the methodical attainment of a definitely given and practical end by means of an increasingly precise calculation of means".

In the context of Weber's overall theory, the increasing "bureaucratisation" of social organisation is not a product of capitalism, indeed in Weber's view it is inescapable and just as pervasive in communist societies. Rather bureaucratisation is an inevitable aspect of any complex industrial society,

> "When those subject to bureaucratic control seek to escape the influence of an existing bureaucratic apparatus, this is normally possible only by creating an organisation of their own which is equally subject to the process of bureaucratisation."

The bureaucratic ideal type is efficiency and rationality epitomised in social structure. At times it appears that Weber is suggesting that a functional imperative towards efficiency and rationality operates in all cases which drive most forms of social organisation towards the ideal type. It is certainly the case that later theorists have mistaken Weber's ideal type for a prescription for efficient organisation, and have made much of the "dysfunctions" and variations which were found.

In summary, the ideal types of domination provide one way of analysing the authority of professionals employed in state bureaucracies; the Weberian perspective highlights the significance of shared values and belief in the legitimation of authority, rather than objective

conflicts and mystification (Marx); and the bureaucratic ideal type was, for Weber, an heuristic device for analysing empirical examples, deployed in a cross-cultural analysis to distinguish various types of domination and their corresponding forms of administration. Torn from the Weberian theoretical problematic it becomes both a poor description and an apparent prescription for "efficient organisation". Finally, bureaucracies can threaten democratic processes, one reason being the importance of specialist knowledge held by bureaucrats which provides a separate power base. Where bureaucrats are professionals, who believe that they are acting in the public interest, the potential for conflict and subversion of democratic policies delegated to the bureaucracy to carry out is greater.

Weber's ideal type provided one starting point for later research into the internal structures of a variety of work organisations. In addition , both his and Durkheim's general theories of social order and change provided the basis for later structural-functionalist and structural-comparative theories of organisation. The chapter now turns to a discussion of these perspectives, considering how each conceives of organisational structure and goals.

The fundamental feature of all societies and of social life is organisation, in the sense that recurring and regular patterns of activity are to be found in all societies. Most early social scientists distinguished institutions and associations from other social forms as being established, at least initially, for specific purposes, and as having a formal structure for coordinating individual actions to achieve these purposes. Different perspectives can be distinguished in terms of their conceptualisation and explanation of both "organisational goals" and "formal structure".

The Structural-Functionalist-Systems Perspective

Gouldner's (1964) and Blau's (1963) studies (published in 1954 and 1956 respectively) both aimed to develop a social systems understanding of bureaucracy through empirical research. Gouldner's main question was "for whom, or for what, was bureaucracy functional?" Gouldner did not define "structure", but focused on an aspect of structure - bureaucratic rules - on the grounds that, a) this aspect was central to Weber's theory, b) it was "expedient" to do so, and c) that hypotheses about the function of rules would, "yield hypotheses ..... which are applicable to other bureaucratic characteristics." (p 158) His study drew on Merton's (1949) distinction between "manifest" and "latent" (unintended) functions and showed that bureaucratic rules were used by different interest groups for their own purposes.

Gouldner found three different "patterns of bureaucracy" in the industrial plant which he studied: the "mock", "representative" and "punishment- centred" patterns. In the first, rules were neither

enforced nor obeyed. In the last, when people in superordinate positions held to the rules, the rules were frequently evaded by subordinates and enforcement occurred through punishment, which was supported by the informal sentiments of the superordinate group. Tension and conflict was frequent. In "representative bureaucracy", rules were enforced and obeyed because there was joint support for them as a result of informal sentiments, mutual participation, and mutual "education" for both groups.

Gouldner proposed that, "representative bureaucracy in industrial settings operates in a "social space" whose contours, opportunities, and barriers are defined and shaped by punishment-centred bureaucracy". His research found that bureaucratic rules had both positive and negative effects, sometimes increased and sometimes decreased tensions, and produced both anticipated and unanticipated consequences.

Blau (1963) also drew on the ideas of Weber and Merton in his study of two government agencies. Criticising the Hawthorn studies view of "informal organisation" purely as failure to conform with formal prescriptions, Blau demonstrated that "informal" activities, "are not simply idiosyncratic deviations but form consistent patterns that are new elements of the organisation", and that there was a "dynamic" to bureaucracy. Although he did not define formal structure as such, his starting point was Weber's ideal type and it can be assumed that the study accepted these characteristics as "formal structure" and investigated other "informal" patterns of behaviour and their consequences.

Blau's study was guided by Merton's tenet to go beyond the origins of social phenomena to consider their consequences, in particular, "their contribution to and interference with adjustment or functioning in the social structure." Social action was viewed as functional or dysfunctional in terms of whether its consequences enhanced or reduced "the adaption or adjustment of the system". An example of this approach is Blau's description of the consequences of using performance records, which served as a new form of control, but also produced "dysfunctional" consequences. Workers aimed to maximise their performance "scores" which sometimes diverted them from organisational objectives, and the records also reduced cooperation and increased competitiveness. Records did not have these consequences in one group because the group had developed a culture of its own which stressed client service achievements rather than certain indexes of productivity.

Criticisms of the Perspective

Gouldner and Blau's studies both conceptualised organisations as social systems and investigated social action in terms of the function of action in enabling system adaption. A criticism of the approach exemplified in these two studies is that a particular conception of organisational goal is adopted against which rules and the consequences of behaviour are assessed. Blau too readily accepts managers' statements about the goals of the organisation, and does not treat managers as one of many interest groups. Gouldner, whilst emphasising the interests and goals of different groups, still uses a conception of function which refers to an overall system requirement (or "homeostatic condition").

A systems approach views organisations as a combination of interdependent parts. Consequently it is almost a tautology, and often not very illuminating, to show that a certain social pattern is functional or dysfunctional because it does, or does not, contribute to the maintenance of the system as a whole. Bureaucratic structure is assumed to be established for the function of efficiently pursuing "the goals of the organisation" and "informal patterns" are examined in relation to these goals. Other criticisms are that the biological analogy is inappropriate for social systems (human consciousness can change the nature of elements); an over-emphasis on conditions of stability, integration and maximum effectiveness (hence a conservative bias which concentrates on maintaining social order rather than highlighting contradictions and conflict), and an inability to conceptualise and explain social change.

The Structural-Comparative Perspective

Much research into organisational structure in the 1960s aimed to develop a structural-comparative approach to the study of organisations. The basis of this perspective lies in the studies of Blau and Scott (1963), Etzioni (1961), and of March and Simon (1967) (published 1958).

March and Simon viewed formal structures as arrangements for ensuring rational decision-making (selecting the best alternative for reaching a goal) and structure as consisting of, "those aspects of the pattern of behaviour in the organisation that are relatively stable and change only slowly". Included in this definition of structure are "programs", "switching rules" for programs and "procedures for developing, elaborating and revising programs" (pp 169-171). Their thesis was that the basic features of organisational structure and function derive from, "the characteristics of human problem-solving processes and rational human choice".

Scott (1961) defined structure as, "the logical relationships of functions in an organisation, arranged to accomplish the objectives of the company efficiently", and treated "division of labour" as a separate element of formal organisation. Blau and Scott's (1963) structural-comparative approach defined formal organisation as social organisation, "formally established for the explicit purpose of achieving certain goals", and structure as," rules and the status structure that defines relations between members (the organisation chart)" which have been "consciously designed to anticipate and guide interaction and activities."

Their perspective also considered networks of informal relations and informal norms, "since the formally instituted and the informally emerging patterns are inextricably intertwined," but, as noted earlier, only those aspects of informal organisation which are related to "organisational goals" were examined. Their typology for comparison suggests assumptions about determinants of structure: it is a classification based on which of four groups (members, owners, clients, the public) is the prime beneficiary: "mutual-benefit associations", "business concerns", "service organisations", and "commonwealth organisations".

Etzioni (1961) proposed an analytic typology based on modes of compliance and coercion. He viewed formal organisation as "one segment of organisational activities such as regulations and formal communications." (p xi).

Empirical research guided by this general perspective includes studies undertaken by Blau and Schoenherr (1971), and Pugh and Hickson (ed) (1976). Blau and Schoenherr (1971) defined formal organisation as "explicit procedures for mobilising and coordinating the efforts of men in the pursuit of given objectives", and related characteristics of structure such as size, levels, span of control, supervisory ratio, and regular staff meetings, to variables such as automation and environmental influences.

Pugh and Hickson (1968) viewed structure as, "regularities in activities such as task allocation, supervision and coordination", which are directed towards "given aims". They developed a continuum approach to comparing bureaucracies along the structural dimensions of specialisation, standardisation, formalisation, centralisation and configuration.

Hall (1968) also developed a "dimensional approach" to the concept of bureaucracy, which, "allows determination of the degree of bureaucratisation of an organisation in terms of the degree of bureaucratisation on each dimension". The dimensions proposed were, hierarchy of authority, division of labour, presence of rules, procedural specifications, impersonality and technical competence.

In general the studies within this perspective may be characterised, firstly as viewing organisations as legal or physical entities rather than as processes, secondly, as being constructed to pursue an identifiable goal, and thirdly, as focusing research on aspects of structure with the aim of identifying the sources and consequences of these aspects of structure. An "open-systems" approach (Hall (1972)) is usually adopted, which recognises the influence of external "environmental" influences on structure. Differences in structure such as variations in formalisation, task allocation and centralisation, are related to variables such as ownership, geography, technology, and market uncertainty. A common view is that relationships between structural characteristics are stable across organisations and societies. Thus Hickson et al. (1974) report, adopting this view as their central hypothesis, "implicitly rests on the theory that there are imperatives, or 'causal" relations ..... which take effect whatever the surrounding societal differences."

Few systematic studies of professional organisation have been undertaken using this perspective. A study using this approach, however, would relate formal structure to the goals of professional sub-organisation (e.g. plans, definitions of objectives of professional departments). Variations in vertical and other structural variables would be described and accounted for in terms of size of sub-organisation, technology, and certain features of the "environment" (e.g. the "type" of public employing authority and its policies, [c.f. Pugh et al (1969), Blau and Schoenherr (1971), March and Simon (1958)]. Studies within this tradition suggest a number of factors which might account for the differences in professional organisation found by the author (Chapters 6 and 7). Blau's (1963) work, in particular, suggests a number of associations between structural features and factors such as size, type of organisation and agency relations with clients, and is suggestive of ways of developing an analysis of professional organisation using the structural-comparative approach.

Contingency Theory

Some studies using the structural-comparative perspective have developed an approach termed "contingency theory". Kast and Rosenzweig (1973) proposed that contingency theory is, "ultimately directed towards suggesting organisational designs and managerial actions most appropriate for specific situations", and the general assumption is that the "performance" of an organisation depends on the "relevance" of the structures for the situational contingencies it faces. Three of the most important contingencies are organisational environment, size and technology. A study by Greenwood et al (1980) of local government is one of the few which attempts to relate national and local political factors to structure. The study noted Self's (1972) observation that the "relatively inchoate" political processes of public agencies rendered the

concepts and logic of organisational analysis of limited value, and critically applied the existing concepts of contingency theory to explain certain aspects of structure. They took the view that,

> "There is a process of mediation between organisation and environment in which actors seek to further their interests. Whether an authority responds to situational contingencies, to which contingencies it responds and in what manner is a function of the internal processes of struggle and mediation. But we would emphasise that the struggle is constrained by external contingencies." (p 171).

The contingency approach is less deterministic than some structural functionalist theories, and allows for human interpretation of "objective determinants" of structure.

Structural-Technical Perspectives

One category of studies undertaken within the terms of reference of the structural perspective emphasised the role of technology in influencing the structure of organisations. Woodward's (1958) research questioned whether there were basic principles of structure which were appropriate to all organisations - only firms which had similar technical methods (unit, mass, and process production) were found in her research to have similar organisational structures.

Thompson's (1967) study considered organisational strategies for coping with uncertainties resulting from technology and the environment. It examined patterns of organisational design and structure, methods of coordination, decision and control, in relation to the different types of technology of "long-linked" (e.g. assembly-line), "mediating" and "intensive" technologies.

Perrow (1967) held the view that Woodward's definition of technology was not, "strictly speaking technology, but is a mixture of production, size of production run, layout of work and type of customer order." He put forward a typology of technology based on two dimensions: the frequency with which the organisation faces exceptions, and the extent to which it utilises a knowledge base which provides for a precise analytical process in solving problems. Perrow suggested that structures which approximate to a professional model (allowing discretion, flexible, colleague working) would be found where an organisation faced many exceptions and lacked a precise body of knowledge from which solutions could be derived. Where there were few "exceptions", and analysable problems, a routinised hierarchical structure was likely. Perrow's typology suggests that conflict would only occur in situations where structural arrangements had been imposed which were inappropriate to the technology.

A less deterministic approach within this perspective was taken by Trist et al (1963) who viewed organisations as socio-technical systems. They assumed that both the precise technical form required to carry out tasks, and the social structure were variable and that choices were possible. For an organisation to achieve "the primary task", they took the view that it was necessary to design both technical and social components to optimise the two. Finally, it is of note that Hickson et al (1969) found that "operations technology" only influenced certain structural variables which were centred on the workflow.

There are problems in developing this approach to describe and explain professional management structures because of the open-ended conceptions of "structure" and "technology" which have been used, and the variety of technologies used by members of the same occupation who are organised within the same structure. Some concepts of "technology" developed within the perspective are only applicable to certain settings in public services and may not be an important aspect of many professionals' work. It is also questionable whether technology can be clearly distinguished from organisation and/or structure, in the same way that it is difficult to distinguish "means" from "ends". For action to be part of a technology, rather than some other form of behaviour, certain elements are necessary: (a) knowledge that actions will cause changes in specified circumstances; (b) some way of assessing the consequences of action; (c) a way of demonstrating that the actions work in the manner intended, and (d) the actions must be such that anyone could carry them out with the desired effect, providing they are adequately trained [Tuckett (1976)].

Only a loose definition of technology could subsume an entire therapeutic process or the "orientation" to professional practice of a practitioner. Chapter 2 suggested that it is often <u>because</u> there is not an established technology for certain problems that professionals and professional work is required. To define a whole approach to professional practice (e.g. assessment, planning, treatment and evaluation) as a "technology" is extending the concept beyond the bounds of usefulness. Thus there are problems in defining the unit of technology in professional work, but the approach does suggest possible explanations for detailed differences in structure.

Before turning to "interactionist" and "power" perspectives about organisation, two other approaches will be outlined which are suggestive of possible explanations for differences in occupational autonomy and organisation.

Exchange Theory

Homans (1961) and Blau (1961) both put forward frameworks for analysing social interaction and relationships in terms of the exchange of goods and services. This perspective could be developed to understand aspects of professional organisation, by conceiving professional organisation and professionals' relationships with clients as systems of rewards and sanctions. It may be possible to establish associations between the type of rewards and sanctions that an organisation applies to its staff, and the way in which the staff orientate themselves towards their tasks and carry them out. In professional organisation it would be expected that rewards intrinsic to the nature of the work itself might be emphasised more than extrinsic rewards which are part of the context or conditions of work. Different forms of professional organisation could be compared and explained in terms of differences in systems of rewards and in sanctions for staff, and clients. However, although such a perspective may suggest explanations for differences, it would not be suitable for developing as a framework for describing institutionalised autonomy.

Social-Psychological Perspectives

The pioneering social-psychological approach to organisational analysis was the Hawthorne study. The study emphasised a distinction between formal and informal structures and highlighted process of group control and organisation within formal structures. Some studies of institutions have drawn on this approach [Cumming (1956)], but few have applied a social-psychological perspective to describe and account for differences in professional organisation. This approach could be applied to reveal informal group processes and situations which maintain group cohesion, provide for the management of conflict within and between professions, and for the management of the stresses of professional work and relations with clients.

Menzies' (1961) study of nursing organisation drew on Kleinian Psycho-analytic concepts and Jaques' (1947) paper to analyse nursing organisation. The study revealed how nursing organisation and procedures served as a defence against the anxiety evoked by nursing work. Different forms of professional organisation could usefully be analysed in these terms to show how different structures and procedures in different forms of professional organisation protect and distance staff from anxieties and conflicts likely to be evoked by the particular type of work of the profession.

The review now considers the two other main perspectives which have informed research into organisation, before turning to studies about professionals in organisations.

Symbolic Interactionist and "Action" Perspectives

Chapter 2 outlined some of the characteristics of this perspective which developed in the USA in opposition to structural-functionalism. The perspective regards "organisational goals" as a reification, and structure as only existing in and through individual actions, as the outcome of the activities of many people with a multiplicity of goals.

Strauss et al (1963) applied the symbolic interactionist perspective in a study of a hospital and highlighted the way in which professionals maintained order in various settings, and how "profession is accomplished in interaction" [Dingwell (1976)].

Rather than viewing organisations as static structures, within this perspective routines are regarded as the continual creation of social interaction, and order as provisional and negotiated. Bucher and Stelling (1969) used this approach to describe professional organisation in terms of competition and conflict over resources, where integration was achieved through a political process with constantly shifting points of power, with continual internal differentiation, and role creation by members. More recent studies have applied this approach to examine professions in hospitals [Goldie (1978), Green (1974)] and in education [Noble and Pym (1970)].

Silverman (1970) was influenced by the symbolic interactionist perspective in proposing his "action" frame of reference for organisational analysis. He criticised previous studies for not recognising that organisations were social constructions, and that organisational processes and rules could not be understood without reference to their meanings for individuals. To view organisations as "systems" with "needs" for survival and to "behave" to adapt was, Silverman argued, to ignore the values and interests of people in the organisation and how they influenced structure and goals. Silverman held that it was only possible to conceive of an organisation as having a goal if it was assumed that there was "a consensus between members about the purposes of their interaction".

Faced with the problem of then distinguishing formal organisations from other social arrangements, Silverman emphasised: 1) an original goal and structure laid down by "founder(s)" which operated as a legitimating symbol to stimulate consensus; 2) a "patterning of relationships" which was "less taken-for-granted" by those controlled, and 3) the great attention paid in organisations to "regular discussion and execution of planned changes in social relations" - the "rules of the game". (p 14).

In reacting to the earlier functionalist role studies which reified social structure and minimised human agency, later studies using the interactionist perspective have tended to over-emphasise

the negotiable and changing nature of social structure [e.g. Goldie (1979)]. The result is that real and stable differences in structure have not been recognised, and a variety of factors which might account for the differences have not been explored. Whilst earlier functionalist studies have been criticised for confusing description with prescription, and ignoring conflict and the exercise of power in negotiating structures, the inter- actions approach can draw attention away from recognising the stable and enduring nature of certain structures, and that these structures are consciously established to achieve certain purposes. An approach is required which gives due weight to both the negotiable and other stable aspects of structure, and to the active element of human consciousness, as well as to the constraining aspects of structure.

Studies in the interactionist tradition have revealed much about the way structures are created and altered, but have little to say about the detail of structures which do exist over time and about the differences between professions. Although roles are negotiated and actors have to constantly "work at" creating and maintaining patterns of interaction, there are certain regular patterns which can be discerned and described and which constitute stable and institutionalised autonomy. Of particular importance are established structures of authority - their nature and the process through which they are established.

Power and Interest Group Perspectives

More recently a series of studies has developed and applied a power and interest group perspective to understand processes within organisations and to locate organisations more clearly within in a social and historical context [Benson (1973) (1977a)(1977b), Pfeffer (1978), Davies (1979), Watson (1980)]. This perspective can be distinguished from the symbolic-interactionist and "action" perspective because interests and values of organisational members are related to class differences in the wider society through neo-Marxist analyses.

Theorists adopting this perspective also criticised the way in which structural-functionalists accepted organisational goals as pre-given. Their approach may be distinguished by the view that there are a number of potential and actual goals for organisations to pursue, and that structures, like goals, are the locus of struggles between interest and power groups within the organisation. Even taking the simple "ultimate" goal of a business organisation to be to maximise profit, it becomes clear that there is a number of choices. Should the goal be short or long-term profit?, and who within and outside the organisation benefits from adopting different profit goals? In public services there are many more explicit and implicit goals which are the subject of public political debate.

Watson (1980), for example, argued that,

> "conflicting interests exist amongst members of the organisation ..... the structure and behavioral pattern of the organisation are as much an outcome of the initiatives and attempts at resistance on the parts of those not normally in control of the organisation, as they are a result of official corporate policies." (p 186).

Watson viewed work organisation as power structures with their "essential dynamic lying in the exercise of and resistance to power", and that the basis for this dynamic was to be found in the class struggles of the wider society. He suggested that organisational structures reflected and reproduced class patterns in society.

Benson (1977a) recognised that earlier theorists such as Crozier (1964), Hickson et al (1971), Strauss et al (1963), and Bucher (1970), provided insights into how certain groups are better able than others to extract advantages and privileges from the organisation, or to influence decisions affecting the direction of the organisation. He noted that Perrow (1972) too recognised that the organisation was a "tool in the hands of powerful actors". However, Benson argued that these theorists did not provide a framework for "analysing the struggle to control the tool"; rather they provided "a method of analysis to assess the effectiveness of organisational instruments for reaching specific objectives". Their critique remained at the level of the celebration of "informal" subversion. Benson (1977a) offered a Dialectical view of organisations as the outcome of internal struggles which also reflect the social relations, divisions and contradictions of the wider society.

Similarly, Pfeffer (1978), in asking "Who governs?", also explained structures and decisions as the outcome of competition between interest groups. Pfeffer developed an aspect of Cyert and March's (1963) view of organisations as coalitions to argue that the concept of "the organisation's goal" had little meaning. To assume that it was the goal of the owners was to assume an unlikely degree of control on the part of the owners and an unlikely acceptance of that control by the various interest groups inside and outside the organisation. Pfeffer considered dimensions of organisational structure to be the outcome of power struggles within the organisation, rather than being determined by rational criteria or variables such as size and technology.

The review now turns to research into professionals in organisations. The above presentation of perspectives followed a similar sequence to the presentation in Chapter 2, in order to emphasise some of the similarities in the way in which both professions and work organisation have been conceptualised, and a convergence of the two fields of study in recent years. In the study of organisation, as well as of professions, there has been a move from definitions of formal organisation and "trait" approaches, to continuum and comparative studies, a concern with the

question of increasing bureaucratisation, a study of organisation as achieved in interaction, and, more recently, a power process and interest group perspective.This convergence is most apparent in the bureaucratisation/ professionalisation debate, and in the study of "bureaucratic-professional conflict", to which Part 3 now turns in a review of studies of professionals in organisations.

PART 3: PROFESSIONALS IN ORGANISATIONS - RESEARCH TOPICS AND PRACTICAL PROBLEMS

The review now turns from general perspectives used to analyse work organisation, to particular studies of professionals in organisations. The two questions guiding the review are: has social scientific research found that organisational structure affects professional autonomy and control, and, if so, exactly which aspects of structure affect autonomy and control and what are the consequences?

Initial Assumptions about "Bureaucracy" and "Profession"

Early studies started from the premise that organisations had goals and were structured in a way which was designed to achieve goals. Weber's ideal type provided a conception of bureaucracy compatible with this view, which was juxtaposed against the then prevalent "trait" conception of profession. It was predicted that the organisation's structure was incompatible with the values and actions of professionals and that conflicts would occur between bureaucrats upholding the rules, and professionals who were subject to them.

A second theoretical debate conditioned by these conceptions was whether "bureaucratisation" impeded or accelerated "professionalisation". "Bureaucratisation" was viewed as, (a) more social institutions assuming bureaucratic features (e.g. voluntary agencies), (b) more professionals employed in bureaucracies, and, (c) professionals increasingly adopting aspects of bureaucratic work organisation both in the organisation of their practices and in their professional associations.

Research into the Impact of Bureaucracy on "The Professional Role"

A category of studies found that conflict did occur, but was not as acute as the theoretical models predicted. An important early study was undertaken by Kornhauser (1962), who considered

conflicts between the professional orientation of scientists and the requirements of industrial organisation. He noted conflicts between, (a) the professional's desire for autonomy and the bureaucracy's imperative for coordination; (b) professional norms of colleges control and organisational norms of hierarchical control (professional claims to judge competence and achievement are undermined if the organisation can hire, fire and promote personnel); (c) "expert authority" and "formal authority"; and (d) split loyalty to a professional association and to the employing organisation. The four areas of conflict can be summarised as, conflict over goals (professional standards may conflict with commercial requirements), controls (colleague/ hierarchy), incentives (rewards for managerial responsibilities rather than professional achievements), and influence (expertise/authority of formal position).

Research into the impact of bureaucracy on "the professional role" is considered below in terms of the sources identified as the main cause of conflict: role conflict, conflict of authority, supervision and evaluation, and conflict between bureaucratic regulations and professional autonomy.

Role Conflict

Some studies of the various role conflicts experienced by professionals have already been reviewed in Chapter 2. Conflicts arising as a direct result of bureaucratic organisation were listed by Scott (1965). He suggested four areas of role conflict for professionals in bureaucracies which resulted from the professional's, (a) resistance to bureaucratic rules, (b) rejection of bureaucratic standards, (c) resistance to bureaucratic supervision, and (d) conditional loyalty to the bureaucracy. Merton (1968) also considered the "bureaucratic-professional conflict" in terms of role conflict, showing the problems of adjustment faced by an employee socialised into a professional role, who then had to meet role expectations in a bureaucracy. Studies exploring this subject include those by Corwin (1961) (nurse students face the reality of their "bureaucratic role"), and Toren (1969).

Conflict of Authority

To account for typical conflicts which were predicted and found, studies located the source of conflict in the different types of authority of professionals and bureaucrats. It was held that formal organisational structure delegated authority to the bureaucrat, who legitimated their decisions on the basis of the compatibility of decisions with the formal policies and aims of the organisation. It is proposed that ,in contrast ,the professional draws on specialist expertise and knowledge to justify decisions which may be incompatible with current organisational policies and aims.

Crozier (1964) proposed that technical expertise represented a power base from which experts ("those who can control the remaining areas of uncertainty") could resist the bureaucratic hierarchy. Janowitz (1959) also argued that technical expertise "weakened" hierarchical authority, and Dalton's (1950) early study also accounted for conflicts of interests between management and staff "experts" in similar terms.

Blau and Scott (1963) in discussing "the second dilemma" of bureaucracy, argued that Weber failed to distinguish the principles that governed bureaucratic organisation from professional principles. They noted that both sets of principles have in common universal standards independent of personal considerations, impersonal orientations to facilitate rational judgment, specialised competence based on technical training which limit authority to a specialised area, and status by achievement. However, for Blau and Scott the differences were more important: a) the bureaucrat's responsibility was to, "represent and promote the interests of the organisation", whereas the professional was bound by a norm of service and a code of conduct to represent the interests of his clients; b) the bureaucrat's authority over "clients" rested on "a legal contract backed by formal sanctions", whereas the professional's was based on technical expertise; c) the bureaucrat's decisions were expected to be governed by "disciplined compliance with directives from superiors", whereas the professional's, by "internalised professional standards"; and finally, d) the last court of appeal against a bureaucratic decision was management, and for the professional it was a colleague group.

Smith's (1955) analysis of hospitals and "their problems" noted two main lines of authority - "lay and professional" - and "hybrid areas" in which the authority of both may overlap (e.g. pharmacy and pathology). He suggested that the "duality of controls" was a result of "bureaucratic" and "charismatic" principles of authority, which produced conflicting status systems, and involved "dual value systems".

Gross' (1967) research also led her to emphasise the difference between professional and bureaucratic authority, but her analysis disagreed with Smith (1955) about the source of that conflict,

> "A strong sense of competence is important because authority rests on it. The professional in the last analysis has nothing else on which to base his authority. His authority is not charismatic, not based on tradition, nor on the occupancy of a formal position."
>
> [Etzioni (1969) p 152]

The thesis argues that these studies misinterpreted Weber's ideal types of authority, and that their theoretical conceptions of bureaucracy and of profession led them to emphasise conflict and to lose sight of the overall compatibilities, which, paradoxically were recognised by the power and interest group perspectives. The following, however, considers a specific area of conflict which was found in many studies.

Conflict over Supervision and Evaluation

One of the particular areas of conflict discovered in most studies was the resistance of professionals to routine review and evaluation of work, a conventional control mechanism in bureaucracies for maintaining standards and for ensuring that employees' actions are in pursuit of organisational goals. Goss's research is the most extensive and most detailed on this subject, and as it relates to one of the professions studied in the thesis research it will be considered in detail.

Goss (1961) considered structural mechanisms in hospitals which minimised strain between "apparently incompatible" bureaucratic standards and the professional norms of doctors. In common with most studies of the time her research started from the incompatibilities suggested by juxtaposing Weber's ideal type and Carr- Saunders' characterisation of the professional: the prediction was that bureaucratic standards and hierarchical authority would conflict with professional norms which emphasise self-governance and practitioner autonomy; rules which applied to all would not allow for the exceptional case which professionals were likely to encounter.

However, Goss proposed that the theoretical and empirical research suggested that, "there may be more room for mutual adjustment of norms and standards than was supposed". She noted that research had not investigated this possibility because it had concentrated either on the professional or on the organisational structure. Consequently her study focused on organisational arrangements where doctors supervised and coordinated other doctors. Her thesis was that, "professional norms and values set distinct limits on how organisational needs for policy-making, coordination and supervision will be met, and thus markedly affects definition of the organisational roles of the physicians involved." (p 175).

The research undertaken involved a five-year participant observation study, and a questionnaire and document analysis study of 500 doctors in a large teaching hospital [Goss (1961)]. The research discovered that there was no apparent conflict between doctors in superordinate positions and other doctors. Such doctors would be expected to commonly subject other doctors' decisions to, "direction, review and possible revision", "in the interests of the

organisation as a whole", and this would be expected to conflict with the norm of personal responsibility. Goss found, however, that individual authority in making professional decisions was not curtailed because the role relationship involved "two types of control relationships that varied according to whether the work was professional or administrative in nature".

In the realm of administration there was a set of "formal authority relationships" with which the subordinate had to comply, but in professional work there were "advisory relationships, the right to give advice that subordinates are obliged to take under critical review, but not necessarily to follow". The formal sanctions were promotion or dismissal, but anticipated informal praise or criticism appeared to have a stronger force.

Goss described this arrangement as a "dual control system within a single hierarchy of positions" which reconciled bureaucratic requirements and professional norms - but only under certain conditions. Because the supervisor's advice was often unsolicited, doctors were likely to interpret it as a criticism, unless they viewed the supervisor as being at least as competent. Commanding respect as a supervisor also required that the formal rank was higher, and that the supervisor had access to appropriate information about the case. The second arrangement discovered was for doctors to work as part-time administrators.

Reflecting on these arrangements, Goss considered how best to characterise the arrangements as a type of formal organisation, and asked why it did not always occur amongst doctors, or amongst other professionals working in organisations. She noted that the arrangements were neither a "pure" case of bureaucracy nor a "company of equals", and suggested that Gouldner's "representative" pattern of bureaucracy would be prevalent amongst professions, but also that what she termed an "advisory" pattern should be recognised. The latter, unlike any of Gouldner's three patterns, did not involve "rules" which were "enforced", but "specific technical knowledge and guiding principles for the application of that knowledge" as the "content focus" of the "advisory bureaucracy". In addition, there was the formal obligation to give advice based on technical knowledge (rather than enforce the authority of the role), and an obligation to take advice under critical review when making "professional decisions". Punishment or "further education" would not be applied if decisions contrary to advice could be justified by reference to technical knowledge.

Goss suggested, however, that the advisory pattern was "bureaucratic" in being impersonal and entailing a formal hierarchy of positions. It was similar to a "representative" bureaucracy in terms of factors which minimised conflict: superiors and subordinates shared technical know ledge, principles and values:the advisory relationship did not violate values; deviance was correctable through education, not punishment; and conformity to principles maintained the status of both.

She concluded with the suggestion that, "comparative studies of organised professional staffs are clearly necessary, and inquiry concerning functional and dysfunctional consequences of the pattern for professionals, non-professional work associates, clients and for the overall organisation in which they work is particularly desirable". This thesis provides one such study.

Goss also suggested that comparative studies were necessary to determine, "whether one or another type of organisational pattern will prevail among physicians as well as among other professionals". She proposed that factors influencing organisation roles included, relative number, formal power position, informal bargaining power, economic need, prestige, indispensability, degree of professionalisation, and potential or actual alternative careers all influence differences, but that, "how these and other factors - such as organisational objectives, incentives, sanctions and recruitment policies - may combine dynamically to produce role differences and types of bureaucratic patterns is not at all clear".

Goss's study was one of a series which started from a hypothesis of conflict derived from structural-functional conceptions of bureaucracy and profession, and found that conflict was not as prevalent or acute as predicted. The study identified specific areas of conflict and described the "modifications" to bureaucratic structure which existed. Theoretical reformulation took the form of a description of a "pattern of bureaucracy" but the basic theoretical terms of reference remained unchanged.

Other studies which investigated different types of supervision and evaluation include those by Freidson and Rhea (1965) (information about performance for medical self-regulation was not made available by colleagues), Scott (1965) ("professionally-orientated" social workers were critical of routine systems of "supervision"), and Toren (1969) (supervision in social work performs a number of functions, some of which were welcomed by practitioners). Important issues in such studies were the formal and informal sanctions available to supervisors, the nature of "supervision" (advisory, therapeutic, regulatory), and criteria for evaluation (profess ional, bureaucratic).

This thesis conceptualises these issues as a question of the legitimation of the power of professional managers by practitioners . The thesis takes the view that conflict in this area is a particular form of a general problem of control and coordination in organisations, and is not qualitatively different in the case of professions. This view is borne out by the findings of the next category of studies.

Formalisation and Alienation

Supervision was found to be a problematic area in a category of studies which investigated the relationship between formalisation and alienation. Research into formalisation is relevant to the subject of practitioner autonomy,because such research provides evidence of various limits to practitioner autonomy.

Miller's (1967) study of scientists and engineers in a large aerospace corporation found that they reported that they "felt more alienation" when their supervisor used directive rather than participative or laissez-faire supervisory practices, and less when they could control decisions affecting their work. Length of training was found to be positively associated with felt alienation, and professionals in the basic research laboratory experience less alienation than those in production units. Miller proposed that organisational structure was related to degree of alienation from work.

Aiken and Hage (1966) "measured" alienation in part of their study of sixteen social welfare agencies. They investigated alienation from work, as well as "alienation from expressive relations" (If a professional worker was not satisfied with superiors and co-workers, they were said to be "alienated from expressive relations"). Where work was rigidly structured, and where rules were strongly enforced, professionals were "alienated from work" (dissatisfied), and "alienated from expressive relations", but less so of the latter than the former.

Rather than enter into a discussion of the meaning of "formalisation" and "alienation", and of methodological difficulties of research in this area, this review simply notes that these findings are similar to those of studies of non-professionals, and that professionals' perceptions are likely to be conditioned by professional ideals and ideologies.

In his study of a variety of professions Hall (1968) used a continuum of "bureaucratisation" which covered similar areas to operational definitions of "formalisation". He found that "bureaucratisation" was inversely related to "professionalisation", but also that, "the presence of a relatively rigid hierarchy may not adversely affect the work of professionals if the hierarchy is recognised as legitimate". His research was an advance over other general studies of formalisation and alienation because his detailed comparative examination of associations between aspects of bureaucracy and of professionalism enabled the research to identify particular areas of conflict.

Many studies treat "supervision" as one of the features of "hierarchical formal bureaucracy" which restricts "professionals' autonomy". Few recognise that superiors may apply professional criteria

and regulations in supervision as well as, or instead of, bureaucratic rules and policies. Even though there may be a bureaucratic hierarchy of authority, a bureaucratic requirement for regular supervision, and a set of bureaucratic rules, it does not necessarily follow that supervision conducted by professionals will involve the application of these rules rather than professional criteria, or that bureaucratic rules will conflict with professional standards. The author's research found that conflict also resulted when professional superiors required professionals to follow professional regulations and codes of ethics, and to actually observe professed ideals. Resentment may be due to subordinates feeling that professional superiors should know better than to take professional standards seriously.

Consequently there is a need to distinguish other bureaucratic regulations apart from the "regulation" that there will be routine supervision, and to consider how these regulations impinge on professionals' autonomy.

Conflict between Autonomy and Bureaucratic Regulations

Some studies account for the professional-bureaucratic conflict which they found in terms of the "requirement" for professional autonomy in bureaucracies. The view taken in many of the above studies was that the professional is employed to perform tasks which are not routine. The situations dealt with by the professional are not subject to standardisation, and the professional is said to require a large degree of freedom in order to apply his skills and judgment. It is proposed that these requirements of professional work are not easily accommodated within a formalised hierarchy. However, as Engel (1970) notes, "much of the literature is anecdotal and general", and often reflects the arguments and ideology of professionals and of aspiring professions rather than empirical findings.

Engel's (1970)study is one of the few which have explored this subject in detail. Although Engel's study set out to, "determine empirically whether bureaucratic organisation does limit individual professional autonomy", the study actually compared autonomy as perceived by professionals in settings of various degrees of bureaucracy. The study treated "degree of bureaucracy" as the independent variable, as indexed by, (a) the number of hierarchical levels in different settings, (b) the degree to which rules and regulations were utilised and (c), the presence or absence of a physical setting in which work could be performed in teams or groups.

Three settings were studied: "non-bureaucratic" (solo practice), "moderately bureaucratic" (privately-owned organisations), and "highly bureaucratic" (governmentally-associated organisations). The dependent variable "degree of professional autonomy" was defined in terms

of professionals' perceptions of: (a) responsibility (determination of the use to which the professional's work is put, not subordinate to those less knowledgeable, defined own work goals, and permitted to think and act without interference); (b) communication (access to all vital information, could communicate without interference or obstacles, and participate in democratically-organised discussions), and (c) innovation (instigation of changes related to work tasks, responsible for initiation/origination, alteration of established work methods, and produced novel ideas and/or methods).

The overall findings of the questionnaire survey were that professionals in the "moderate bureaucracy" perceived themselves as having more autonomy than those in either the "non-bureaucratic" or the "highly bureaucratic" setting. Research autonomy was perceived to be greater in the highly-bureaucratic setting [Engel (1970)].

Although Engel's research is limited to perceived autonomy, it provides further evidence which questions the accuracy of the simple professional-bureaucratic conflict theory. In this respect her findings are typical of empirical research on professional-bureaucratic conflict. Many studies start from the assumption that the authority and control structures of bureaucracies are more rigid and confining than the authority and control structures of the professions, hence if a professional works in a bureaucracy he/she could undergo a loss of autonomy. Starting from this assumption most studies do reveal areas of conflict, but they also show that conflict is not as acute or pervasive as the theoretical models would suggest.

Forsyth and Danisiewicz (1985) also studied perceived autonomy and found differences between professions. Working within the "power" perspective they distinguished between "profession", a social process between practitioners and clients, and "professional organisation", the formal organisation of an occupation. They examined the power exercised by individual members through the use of Hall's concept of autonomy, "the feeling that the practitioner ought to be allowed to make decisions without external pressures from clients, from others who are not members of his profession, or from his employing organisation". [Hall (1969) p 82].

Their main assumptions were that, 1) "the perceptions or attitudes of practitioners that they are free of decisional constraints are likely to be indicative of their power", 2) "an examination of several types of work-related attitudinal autonomy will reveal patterns differing by occupations", and 3) "levels of attitudinal autonomy might well provide a means to index professionalisation of occupations".

Hall's (1968) measure of attitudinal autonomy was not used because it only measured autonomy from employing organisation. For the latter dimension, eleven questions explored "submission to

organisational administration, perceived importance of organisational loyalty, and willingness to bend organisation rules". Eleven other questions operationalised client autonomy in terms of "decisional independence from clients and conviction of own knowledge".The sample was 1000 students from eight professions, a further assumption being of "anticipatory socialisation". The researchers cited Chapell and Colwill's (1981) study as evidence that students' attitudes are reliable indications of those of practitioners.

Analysis of variance procedures was used to compare autonomy averages. The findings were that, 1) law and medicine together scored above average on both client and organisational autonomy, and 2) semi-professions (as defined by Etzioni (1969)) scored above average on one dimension , education being "client-autonomous" and nursing and social work being "organisation-autonomous". The research findings were used to support a three-stage model of professionalisation which suggested that "true professions" were autonomous on both dimensions.

The main limitations of the study were that it only investigated students' perceptions of autonomy, was based on assumptions of a direct relationship between power and autonomy, and was preoccupied with distinguishing "true professions" from other occupations, with looking for differences already assumed, and completely ignored the organisational context of practice. However, the study did suggest a useful model of the process of professionalisation, and sought to investigate causes of variation on the dimensions of autonomy, and did attempt to explain the differences.

A focus on conflict as perceived by professionals tends to support the bureaucratic-professional conflict thesis. A review of the studies so far suggests that the source of the conflict may be more the professionals' image of the ideal work situation, and of professional ideals, than ordinary conflicts which occur at work and which are similar for any worker. The next category of studies found evidence of individual adaptation, and less conflict than those reported in the studies reviewed above.

Individual Adaptation

A number of studies have described how individual professionals adapt to organisational requirements and cope with role conflict. Wilensky (1964) suggested professionals used a variety of styles or orientations to role behaviour to balance bureaucratic and professional requirements.

Abrahamson (1969) described the "resocialisation" experience of academic scientists starting work for industrial laboratories. Initial conflicts, "pivoted around the new scientists' demand for immediate autonomy", but over time conflict diminished as a result of the industry "resocialising" the scientist towards product development. In time demands for autonomy became weaker, and as the scientist "proved himself", greater autonomy was allowed.

Organ and Greene's (1981) study found that rather than producing conflict between administrative imperatives and professional norms, the "net effect of formalisation was to reduce alienation". This finding was predicted by previous organisational theorists such as Brown (1960) and, by Jaques (1976). Organ and Greene concluded that, whilst formalisation may produce role conflict, it also reduces role ambiguity and enhances identification with the organisation. This qualified the previously held general view that bureaucratic rules and procedures lead to alienation in professionals (i.e. a sense of powerlessness, meaninglessness, normlessness and isolation, and self-enstrangement). Certain forms of structure were found to be valued by professionals, and it was proposed that, "the professionalisation of the work force neither presages unmanageable tensions nor dooms the bureaucratic structure to extinction".

Ben-David's (1955) study is of interest because it showed how doctors came to terms with the untypical situation of bureaucratised medicine in Israel in the early 1950s. In order to service a shifting immigrant population a centrally-organised and supervised network of public clinics was established, where doctors on fixed salaries had a set quota of patients, and case responsibility rested with the organisation. The doctor (GP or specialist) was, "independent of his patient, which enables him to act according to his professional conscience only, and is supposed to make him, for the same reason, a more trusted figure than the private practitioner".

Ben-David questioned whether the doctor-client relationship was in fact more trustful because it was "untainted by economic considerations", or whether it produced "a rigid impersonal contact characteristic of bureaucracies". In an interview study (n = 78 doctors) he found widespread resentment about loss of authority and autonomy, and a feeling on the part of doctors that patients "came for no good reason". However, the study also found that "state doctors" were much more interested in "scientific progress on the job" than private practitioners, and felt that there were more opportunities for research in a large organisation.

In general, the category of studies reviewed above concluded that features of bureaucracies were antithetical to key features of professions. Their findings suggest that elements of bureaucratic and professional structure can only be combined with difficulty, and introducing elements of "professional structure" in bureaucracies was seen to seriously disrupt "normal" administrative processes.

The Impact of Professionals on Bureaucracy

With the increasing employment of professionals in bureaucracies, social scientists began to find that professionals and professions were modifying bureaucratic structures and processes, and a variety of individual and structural modes of accommodation of conflict were discovered.

Barber (1963) described specialised roles or departments which helped to preserve professional "needs for autonomy" but which created new problems for the professional, "the professional must be all the more active in transmitting his professional knowledge and skills to other differentiated subgroups in his employing organisation. He has to be forceful in promoting his ideas, because of lack of knowledge of what he can do and because of structural resistance." The second structural arrangement noted by Barber was a "specialised authority structure" which accommodated both the "organisation's need" for superordinate control and the professional's need for the "colleague control pattern of authority" by way of a "professional-administrator". Problems here were difficulty in finding professionals who "combine the proper mixture", and the strains involved in the role. The third arrangement described was "a differentiated reward structure" where organisations provided opportunities for professionals to achieve professional rewards and to pursue professional interests, and where two career channels were established, although monetary rewards in the professional channels were usually lower.

Structural features of organisations which accommodated or minimised conflict were also described by Brown (1954) and Foulkes (1970). These were processes for consultation with, and involvement of, the profession in organisational decision making. Kaplan's (1959) study of research administrators also recognised the important role played by professional supervisors who mediated between the profession and administration. He described two types of supervisor; those who believe professional freedom in work was best achieved by rigid adherence to the organisation's rules, and those who regarded their role as a necessary evil which could protect the profession from certain organisational regulations. Kaplan found that direction of professionals by such supervisors was more acceptable than direction by a non-professional. Other structures for mediating conflict have been described by Evans (1965) (appeal systems), and processes for continually adjusting structure to avoid the build-up of conflict are examined by Lawrence and Lorsch (1969) and Lynton (1969).

Other mechanisms found were to organisationally separate bureaucratic and professional elements [Goss (1961), Litwak (1961), Kornhauser (1962), La Porte (1965)], or to structure in a sphere of autonomy for professionals within the organisation [La Porte (1965), Katz (1968)]. Montagna (1968) noted the high degree of centralisation and few administrative personnel in large accounting firms which was made possible by certain types of "external rules". He observed

that such rules were a fusion of bureaucratic rules and professional norms which avoided the need for frequent direct supervision, and limited "dysfunctions" of bureaucratisation by enhancing the autonomy of the professional.

Other studies have examined ways in which professional expertise can be structured into organisations to serve "organisational goals" with minimum disruption. Experts could be organisationally separated, physically segregated from the main chain of command, or could be used on a consultancy basis. Structures for staff organisation (advisory roles) [Walker and Lorsch (1970)], matrix organisation, task forces, and product teams have been examined. The "dual career ladder" was also considered by Kornhauser (1962) and Gouldner and Ritti (1967). Kornhauser (1962) refers to "pluralist bureaucracies" which accommodate occupational expectations by differentiating occupational career structures and reward systems from those of administrative hierarchy.

Noble and Pym (1970) described how conflict between professional autonomy and bureaucracy was accommodated by a system of committee control which was "able to exploit the uncertainties of collegiate authority without destroying it". They described decision making in a large public sector service organisation in terms of a "receding locus of power". The combination of many professions in this organisation produced a variety of committees with unclear decision-making powers. They describe the diffusion of responsibility and authority as a mechanism which minimised overt conflict and maximised either the pretence or reality of professional autonomy. The type of organisation they describe appears as a federation of professional departments which evolved to accommodate the work of many professions.

Most of the above studies found particular mechanisms and processes operating within, but not fundamentally affecting the overall bureaucratic structure. A separate category of studies reviewed below found distinct forms of professional work organisation involving entire structures of single or groups of professions with a variety of novel characteristics.

Blau and Scott (1963) argued that the presence of a large body of professionals in an organisation undermines the possibility of a rigid hierarchy of control. However, they questioned the assumption that a hierarchy of authority was essential for coordination in complex organisations. Michels (1959), in considering political organisation, proposed that the emergence of a hierarchy of control and the concentration of power was inevitable, and his argument suggested that this would occur even in organisations with large numbers of professionals.

A question which arises from the findings so far is, although professionalisation and bureaucratisation appear to be incompatible in certain respects, does grouping of large numbers

of professionals in organisations necessarily lead to "bureaucratic-type" structures, and how are conflicts accommodated in these situations? To explore these questions more precise definitions and descriptions of organisational forms are required. The review now considers studies which qualified or revised the "professional-bureaucratic conflict theory" by proposing distinct forms of "professional" or "semi-professional" work organisation.

PART 4: DISTINCT FORMS OF PROFESSIONAL WORK ORGANISATION

Important developments in the Bureaucratic-Professional conflict debate were a recognition that the degree and nature of conflict varied according to, a) the profession involved, and, b) the work and organisation setting. Research into these subjects discovered variations from the bureaucratic ideal type and some theoretical revisions took the form of proposed typologies of professional work organisation. The review first considers Weber's discussion of, "collegiality and the separation of powers", before reviewing the typologies which were proposed.

The Principle of Collegiality in Limiting Monocratic Authority

Weber considered collegiality in a discussion of how specific social relationships and groups limited traditional or rational authority [Weber (1947) pp 392-407)]. He considered how the principle of collegiality may deprive any type of authority of, "its monocratic character, which binds it to a single person", by examining four principle types, a) other monocratic authorities, b) unanimity or majority decision bodies, c) a collegiality of monocratic officials each with veto, and d) where the acts of a monocratic "primus inter pares" were subject to consultation with formally equal members. Four types of "advisory" collegiate were then considered.

Weber noted that, "collegiality almost inevitably involves obstacles to precise clear, and above all, rapid decision .....", that, "where collegiate bodies have had executive authority the tendency has been for the leading member to become substantively and even formally preeminent .....", and that, "those enjoying positive privileges" rather than "negatively privileged groups" try to establish collegiums to limit monocratic leadership and the possible loss of privilege.

Weber's discussion outlined and began to explore a variety of collegiate arrangements, but always in relation to his more general thesis of the inexorable rise of bureaucracy.

Parsons noted that when professional services were carried out in "complex organisations", there were "strong tendencies" for professionals to develop "a different sort of structure" from the bureaucratic hierarchy,

> "Instead of a rigid hierarchy of status and authority there tends to be what is roughly, in formal status, a "company of equals", an equalisation of status which ignores the inevitable gradation of distinction and achievement to be found in any considerable group of technically competent persons. Perhaps the best example of this tendency ..... is to be found in universities, hospitals and law firms."

He suggested that Weber "overlooked" the importance of such structures.

Scott (1965) developed his description of professional work organisation by drawing on another distinction made by Weber,

> "A corporate group may be either autonomous or heteronomous, ... Autonomy means that the order governing the group has been established by its own members on their own authority ..... in the case of heteronomy, it has been imposed by an outside agency." [Weber (1947) p 148]

Scott (1965) distinguished between "bureaucratic", "autonomous" and "heteronomous" types of professional organisation. In the "autonomous" type,

> "organizational officials delegate to the group of professional employees considerable responsibility for defining and implementing the goals, for setting performance standards, and for seeing to it that standards are maintained." (p 66).

In the "heteronomous" type, "professional employees are clearly subordinated to an administrative framework, and the amount of autonomy granted to professional employees is relatively small. An elaborate set of rules and a system of routine supervision controls many, if not most, aspects of the tasks performed, so that it is often difficult, if not impossible, to locate or define an arena of activity for which the professional group is responsible individually or collectively."

It is of significance that Scott uses the term "heteronomous" to refer both to a form of work organisation and to a type of profession. Chapter 8, argueds that this combination suggests the key to an understanding of the semi-professions: semi-professions were created by bureaucracies, the conditions for the formation of such occupational groups were created by

bureaucratic organisation, and such occupations were then in a position to organise outside bureaucracies, to develop specialist knowledge and to claim autonomy on the model of the traditional professions.

However, as regards Scott's typology, the terms "heteronomous profession" and "semi-profession" are not synonymous and confuse features of work organisation and of professions. In Scott's analysis "heteronomous professional organisation" refers to guidance and control of members of the profession by a combination of internalised professional norms, professional associations and expert knowledge, and by administrative rules and superiors. "Semi-professionalism", however, refers to aspects of a profession such as a short training, no exclusive skills or monopoly, no firm theoretical knowledge base, and less clearly defined function and area of competence than the established professions. Although related, a close association between "semi-professionalism" and "heteronomy", and "full professionalism" and "autonomy" is not always the case. It is also of significance that most studies use the term "professional organisation" in a number of senses. The ambiguity of the term "professional organisation" is that it can be used to describe both how a profession organises and controls work and its members, and how an employing organisation organises professionals and their work. Many studies do not make this basic distinction.

Toren (1969) noted the specific areas of autonomy in semi-professions and "differential zoning of control", for example, that the teacher was more autonomous vis-a-vis a school head with regard to in-class matters than in respect to administrative matters such as record keeping. This finding was also reported by Øvretveit (1985) in the "semi-profession" of physiotherapy. Toren concluded,

> "This is not to deny the greater autonomy of the established professions, e.g. medicine and law, but to emphasize that instead of labelling any profession as heteronomous, autonomous or otherwise, we would ask: Which aspects of the professional's daily conduct are controlled, by whom, and how? If this is specified, the description of any profession becomes more complex and realistic and less ideal-typical."
>
> [Etzioni, ed (1969) p 153]

Etzioni (1961) as part of his comparative typology of organisation, defined professional organisations according to two characteristics, their goals and, "the rank at which professionals are employed. Their chief goals are professional goals, such as therapy, research and teaching, and most of their performers are professionals." (p 51).

He differentiated two major types of professional organisation on the basis that "professionals constitute the middle ranks of the organisation, e.g. hospitals, universities and schools" or, "where lower participants are professionals (e.g. research organisations, architects, law firms, and editorial wings of newspapers)".

Etzioni's later typology (1964) is more frequently used, and, like Scott, it is to be noted that he also combined an analysis of types of profession with an analysis of work organisation. Viewing the basic principle of administrative authority to be, "quite incompatible" with, "the most basic principle of authority based on knowledge or professional authority", he suggested that the fundamental question was, "how to create and use knowledge without undermining the organisation", and outlined, "three basic ways in which knowledge is handled within organisations."

The first was where organisations were established for the purposes of "producing, applying, preserving or communicating knowledge". He termed these "professional organisations", characterised not only be their "professional goals", but also by over 50% staffing by professionals, and by professionals having, "superior authority over major goal activities".

"For certain purposes it is useful to distinguish between those organisations employing professionals whose training is long (5 years or more), and those employing professionals where training is shorter (less than 5 years). The former we call full-fledged professional organisations; the latter semi-professional organisations." (p 78).

The second "way in which knowledge was handled" was to provide professionals with "the instruments, facilities, and auxiliary staff required for their work" and such organisations were termed service organisations. ("The professionals however are not employed by the organisation nor subordinated to its administration.")

Thirdly, professionals, "may be employed by organisations whose goals are non-professional (industry, military). Here professionals are often assigned to special divisions or positions, which to one degree or another take into account their special needs."

This typology laid the basis for Etzioni's discussion of how the "two authority principles" conflicted and were reconciled in each type of organisation. In non-professional organisations professional orientations threatened to "displace" the "primary profit goal" and professionals dealing with "the means" were placed in "staff" positions in relation to "line" administrators, sometimes with authority in relation to specific matters. In "full-fledged" professional organisations this distinction

was reversed, and administrators in "staff" positions were responsible for administering "the means" to the major activities carried out by professionals.

Etzioni notes that in "semi-professional organisations", although there was less autonomy, much of the supervision was done by people who were themselves semi-professionals or professionals. In addition, and significantly, that, "Not all the differences between professional and semi-professional organisations can be traced to the differences in the nature of professional authority. Part of the problem is due to the fact that the typical professional is a male, whereas the typical semi-professional is a female ....." (p 89).

Etzioni does not discuss the "deeper reasons" for, "the fact that the professional and administrative authority are here related in a different way from professional organisations".

It is of significance that both Scott and Etzioni relate a category of professions to a type of work organisation. This thesis takes the view that this is not a terminological convenience but a reflection of a fundamental dynamic : that semi-professions are defined by work organisation and vice versa in a very real sense, not only in analytic categories.

Concluding the review of typologies of work organisation, it is also relevant to note Freidson's (1970) continuum of medical practice organisation. The continuum ranged from, 1) client-dependent practice, usually a solo practice where the client was in control because of his ability to leave or choose others at will, to 2) a practice where patients were referred to the doctor by his colleagues, to 3) solo practice of a group of doctors (GPs and specialists) who worked in the same place and shared rent but not profits, to 4) a medical partnership of a group of doctors with the same speciialty, with shared profits, to 5) a true group practice, where a large group of different specialists practised as an organisation and shared profits and expenses. The latter was a "colleague-dependent" type. Freidson's continuum was based on the division of labour within the profession and aimed to distinguish features of practice determining the source and content of control in order to judge the degree to which they were amenable to colleague control.

The thesis holds that the typologies reviewed above reflect social changes in work organisation and in professions. Underlying the typologies, however, are assumptions about salient features of organisation, and their purpose is usually to advance investigation of underlying theories. The typologies need therefore to be assessed in relation to the theoretical problematics and assumptions which generated them.

The typologies are useful insofar as they move away from the simple conception of bureaucracy and "professional collegiate" and recognise different types of professional work organisation and

begin to grapple with the practical and theoretical issues arising when professionals work together and/or are employees. However for the purposes of advancing the line of enquiry adopted by this thesis the above typologies and concepts used are limited in a number of respects. How, for example, are we to characterise multi-professional organisations such as the NHS, or a DHA, or even a small NHS hospital? The descriptive concepts are limited for this purpose, and explanatory theories are virtually absent. Why, for example, are "professionals" (e.g. doctors) more "qualified" to supervise "semi-professionals" than "lay administrators"?

PART 5: COMPATIBILITIES AND THEORETICAL REVISIONS

Compatibilities rather than Conflict

By the nineteen sixties most professions had accepted that the future lay in employment in bureaucracies, and set about exploiting the possibilities. Social science research began to find compatibilities rather than conflict, and it became recognised that "the problem of accommodation" was more a problem of reconciling incompatible theoretical models than a practical problem specific to professionals in organisations.

Rather than assuming conflict and describing modes of accommodation, a series of studies questioned whether there was inevitable conflict between professionals and bureaucrats, between professional and bureaucratic structures, or between professionalisation and bureaucratisation.

At the structural level it was noted that professional organisation exhibited features of bureaucracy such as hierarchy and rule following. The reivew has already considered Blau and Scotts (1963) discussion of similarities between professional and bureaucratic authority. Wardwell (1955) described bureaucratic pressures in professions with the proliferation of senior partners, chairmen and presidents. Harries-Jenkins (1970) also drew attention to the common elements of universal standards, specific expertise and affective neutrality. Hall (1968) noted that technical competence and a highly developed division of labour characterise both bureaucracy and professions. Studies also reported the successful combination of seemingly incompatible structural patterns and of professional and bureaucratic elements. Goss's (1961) study of an out-patient clinic was one of the first of these studies, followed by studies on nursing [Corwin (1961)], education [Clark (1963)], various occupations [Katz (1968], accountancy [Montagna (1968)] school-teachers [Lortie (1969)], and other occupations [Katz (1968) Holland and Lawler (1970)].

At the individual level many research subjects in different studies did not report difficulty in combining professional and bureaucratic roles [Glaser (1964), Wilensky (1964), Engel (1969) and (1970), and Thornton (1970)]. Some studies discovered a group of professionals who were "organisational men". Gouldner and Ritti (1967) concluded that, "from the start of their business careers many engineers have personal goals that coincide with the business goals of the corporations.". These studies specified more precisely the particular circumstances under which conflict was experienced. It was reported that professionals themselves often recognised that a bureaucracy provided resources which allowed them to do more for their clients than would otherwise be possible, as well as more freedom to pursue research and professional interests.

Some studies also noted that,at the individual level, professionals and bureaucrats increasingly have more in common and share similar values [Taquiri (1965)], especially a service orientation and commitment to clients in human service agencies. Bureaucrats are increasingly becoming professionalised, acquiring professional training outside of the employing organisation and do not tie loyalty and career to one organisation.

Green (1975) used Kornhauser's (1962) findings of areas of conflict as a basis for his study of the position of the medical profession in the Scottish hospital service. The picture which emerges from Green's and other health services studies is of administration mediating conflicts between professional groups or between interest groups within a profession. The study did not suggest that administration was neutral, or did not at times align with one faction or another. It did show, however, that often what appears to be a professional-bureaucrat conflict is caused by differences in perspectives and competition within and between professions. Green also (1975) criticised the usefulness and assumptions of the professional/bureaucratic conflict theory. He noted some of the points already made in this chapter. First that there are similarities in bureaucratic and professional work and organisation [Harries Jenkins (1970), Hall (1968), Wardwell (1955)]. Secondly that professions are not unitary groupings [Parsons (1968), Hall (1968), Bucher and Strauss (1961)]. Thirdly, the individual independent practitioner is the exception.

As early as 1955 Ben-David drew attention to the possibilities for research created by state mediation. This countered the conventional view that bureaucracy always stultified innovation, a view which frequently reflected professional ideologies rather than empirical findings. The discussion of state regulation in Chapter 3 showed that regulations applying to an individual professional in private practice are mainly those of the professional association, and are certainly far fewer than those encountered when practising in a large organisation. However, there are different constraints to autonomy in private practice: having to earn a living from client fees may restrict ability to make professional contributions or to do research, client income may be

unpredictable, there may be less freedom to turn down clients for various reasons, and administering and managing the practice both restricts and allows autonomy in different areas.

Johnson (1972) argued that state mediation reduced professionals' dependence on consumers by guaranteeing a clientele, and by creating an organisational context which further reduced dependence. He suggested that this may lead to greater autonomy, "The organisational man may pick his problems if not his clients." Where there were competing norms of "science" and "service", state mediation of the practitioner-client relationship lead to a variety of organisational contexts where a "science" orientation is more likely to prevail over a conflicting "service" orientation. However, Johnson cautioned against confusing structural conditions conducive to research and innovation, and conditions conducive to the implementation of research. He suggested that where state-mediation created service agencies, most technical advance would not be by practitioners but by full-time research institutions.

Thus private practice may offer increased autonomy in some areas and decreased autonomy in others . Some professionals choose to practise in large organisations because it allows work freedoms which they value more than those work freedoms which are restricted. Of major importance is access to extra resources which would not be so easily accessible in private practice, and an "insulation" from client demands and dependency on clients.

However, for many professionals private practice is not a realistic option for various reasons. In these cases the conflict is rather between bureaucratic restrictions and the ideals of the profession instilled by socialisation, which are often based on the concept of the individual independent private practitioner. Chapter 2 proposed that this concept was more an ideological banner-image than an accurate description of current (or past) reality, and served to support and legitimise opposition to certain bureaucratic requirements. As such the concept plays an important function, especially if shared by administrators, and is real in its consequences.

Theoretical Reorientations

Later studies, informed by different conceptions of bureaucracy and of profession, did not explain conflict either in terms of the application of rules and procedures to ensure that professionals' behaviour and decisions were geared to achieving organisational objectives, or professionals' resistance as a result of their pursuing "professional objectives". Rather, these studies noted that there were common objectives, values and interests, and that where conflict occurred it was more frequently a result of managers and professionals pursuing their own economic power and status interests, rather than those of "the organisation", or "the profession".

More recent research into professional organisation, especially within the interactionist and power perspectives, has tended not to categorise types of organisation but to concentrate on processes of change and of power interaction. These perspectives questioned the unitary notion of "organisational goal" and regarded alliances between professionals and bureaucrats within and across divisions as just as likely as conflict between them.

Albrow (1968) [in Salaman and Thompson (1973)] questioned the usefulness of viewing organisations as goal-orientated collectivities and suggested that they might better be viewed as societies functioning through areas of agreement, alliance and rule imposition. One of the earliest proponents of the power perspective for the study of professionals in organisation was Benson (1973). Benson outlined a "dialectical" perspective for conceptualising bureaucracies and for studying bureaucratic-professional conflict. He proposed that future study should focus on contradictions in organisations which are based on opposing vested interests and ideological perspectives. From this perspective bureaucratic-professional conflict could be explained by analysing the underlying contradictions in the organisation, and by looking at the links and conditions which led to conflict. Conditions which affect the form of the conflict were proposed as combinations and oppositions of vested interests and perspectives, degree of commitment to idealised models (or "pure forms") of structure, and social processes of centralisation, domain definition, differentiation, technological innovation and rigidification. Benson suggested that such an approach could analyse the "ebb and flow of bureaucratic-professional conflict over time", and lead to generalisations about regularities of process, rather than about cross-sectional differences.

One study which was influenced by Benson's approach was that undertaken by Davies and Francis (1973). This study is of particular relevance to the thesis because of its subject matter (hospital structure)and because of the theoretical perspective which was adopted. Davies and Francis (1976) noted a lack of both empirical studies of variations in hospital structure, and of theories about determinants and consequences of variations, as well as a reliance on American research. The study noted that, "medical, nursing and administrative hierarchies are not integrated into a single pyramid ..... doctors are in a special position ..... Thirdly, within the nursing hierarchy lack of resources and manning by unqualified staff and undermanning in general render precise operation according to bureaucratic rules something of a fiction." In addition, that operating policies, which were rarely written down, were decided by various professions.

Davies and Francis aimed to build on more recent conceptualisations of bureaucracy to understand hospital organisation, proposing that,

> "All the dimensions of bureaucracy must be treated as variables, and the particular configuration on these dimensions taken up by any organisation will depend not only on such so-called external constraints as size and task but also on the way in which various aspects of the work situation, including technology, get defined in such a context. The objectives held by various actors and the power they have to attain them have also to be paid serious attention."

Their research also drew selectively on recent conceptions of professional organisation, at the same time showing, "a great deal of ambiguity and contradiction surrounding the concept". (Professional and bureaucratic organisation are not strict alternatives but display similar features). They suggested that the reconceptualisations did not offer plausible hypotheses concerning overall hospital organisation, and introduced assumptions about power and professionals' beliefs which should themselves be matters for empirical enquiry.

The research examined hypotheses about the tasks, structure and performance of specialities in general hospitals, mainly by questionnaires developed from other structural-comparative studies such as those of Aiken & Hage (1966) and Hall (1962). The four dimensions of "structure" investigated were, individual influence, standardisation of duties, clarity of authority relationships, and problem-solving communication. An analysis of doctors' and nurses' (n = 123) perceptions of structure in medical and surgical wards in three hospitals found, amongst other things, a, "striking similarity of the experience of all grades of nurses concerning the structuring of their work", involving high standardisation of duties and of authority.

Davies and Francis concluded that the "discipline and structure" found (N.B. as perceived), was "markedly at variance with the professional model of work organisation". In fact they argued that nurses opted for structure and discipline in order to *increase* professional status. They also questioned the appropriateness of the "negotiated order" perspectives stressing that, "power play takes place within a broader structure which cannot be ignored".

The study also suggested that the task characteristics proposed by Abell & Mathew (1973) and Kovner (1967) (novelty, classifiability of inputs, certainty of application of techniques), acted in medical and surgical specialities as constraints to, rather than determinants of, structure.

Davies and Francis' (1976) study therefore proposed a process of, "professionalisation without, via bureaucratisation within" which questioned previous theories of professions and of professional organisation. It raised the paradoxical possibility that self-imposed constraints on practitioner autonomy could assist professionalisation, but failed to note that this perhaps was the only route available to nurses within a structure dominated by medicine. Their study was also

limited in being confined to perceptions of structure, and to the interdependent occupations of nursing and medicine, in the particular context of three hospital medical and surgical wards.

One conclusion from recent research ,then , is that there are many compatibilities between professionals and bureaucracies, that professionalisation and bureaucratisation can be mutually-reinforcing, and that conflict is not as prevalent as it once was, or was thought to be. Furthermore that power concepts and perspectives for understanding organisations can also be applied to understand professions as ways of "organising" specialist knowledge in modern society.

The findings of recent research can be explained by two developments. Firstly, changes in modern society, mainly the employment by organisations of increasing numbers of professionals, increasing professionalisation, and professionals increasingly organising themselves in combined practices for economic reasons. Even if there were conflict, the requirement to organise, and the pressures to organise bureaucratically "forced" a variety of "accommodations", and professions and professionals began to make the most of the situation.

This thesis, however, takes the view that "bureaucracy" and "profession" never were incompatible, that the problems experienced by professionals and managers were essentially no different than for any employed workers and managers, and that the conflict was more theoretical than actual. It takes the view that the second reason why compatibilities, not conflict, were found by more recent studies is that the studies adopted and developed different theoretical conceptions of "bureaucracy' and of "profession" as a result of applying the theoretical perspectives of symbolic interactionism and of power and interest group analysis. The thesis locates the basis of the theoretical conflict debate in a particular interpretation of Weber's ideal type.

Chapter 6 develops this argument by returning to a discussion of Weber's ideal type of rational-legal authority. It draws on Weber's concept of authority to put forward a view of a process by which power is legitimated in authority. Using a particular concept of authority the thesis argues that the source of professional authority is not specialist expertise per se, but expertise is one aspect of the power of professions used by them to acquire authority and institutionalised autonomy.

PART 6: SUMMARY AND CONCLUSIONS

Chapter 3 argued that Freidson's theory of professional autonomy and medical dominance offered the most promising approach for developing new knowledge about professions and about their relations with the state. When applied to "state welfare professions" in the UK, however, the theory was found to exaggerate the degree of autonomy and control granted by the state to the medical and to other professions. The thesis proposed that there was a need to distinguish different types and degrees of institutionalised autonomy, each with different consequences for the profession and for clients. In particular,that, in the UK, local management structures established by state employing authorities were of crucial significance to professions. It was suggested, that these management structures institutionalise practitioner and management autonomy, and that the structural position and authority of head profession-managers was critical for the future of each profession and in defining the work to be carried out.

This appendix reviewed theories and research on organisation structure for the purposes of examining perspectives and concepts which could be used to develop knowledge about professional management structures, about how structures impinge on and institutionalise forms of autonomy, and about how structures were established and changed.

The review considered how each perspective conceptualised organisation structure and goals, the variables which were viewed as determining structure, and noted the importance of Weber's ideal type to later research into structure. It noted that the structural-functionalist perspective had tended to accept organisational goals as given or unproblematic, and, partially because of their level of analysis, had minimised human agency, meaning and choice in the creation of structure. In contrast, symbolic interactionist perspectives, focusing on individual action and negotiation, had tended to assume that the only rules and regularities to action were those which individuals chose to perpetuate and accept as meaningful. Recent power and interest group perspectives had recognised structures and determinants of action in organisation, but had also been able to conceptualise structures in relation to the meanings, interests, and values shared by groups within organisations. This perspective has been used in recent studies investigating professionals in organisations which considered organisational processes and structure in relation to coalitions and alliances between groups in organisations.

Having suggested that these perspectives set the terms of reference for research into structure, the review then considered the findings of empirical research into professionals in organisation and into forms of professional work organisation. Early studies, influenced by contrasting concepts of bureaucracy and of profession, found areas of conflict, but the conflict was not as extensive or acute as the theory predicted.

Studies also found ways in which conflict was minimised and accommodated, at the psychological level and in different patterns of organisation for professionals. One theoretical reformulation, which corresponded to developments in society, was to outline typologies of "professional bureaucracies". These studies (notably Scott (1965) and Etzioni (1964)) accepted the basic terms of reference of the bureaucratic-professional conflict theory, but drew on and contributed to, on the one hand, a "theory" of bureaucracy as a continuum of ideal-typical bureaucratic features, and on the other hand, a "theory" of professions as varying in degree along a continuum of "professionalisation".

More recent studies found many compatibilities between professions and bureaucracies and a similarity of interests and orientations between professionals and bureaucrats. These findings were paralleled by theoretical developments which questioned the way in which professions and bureaucracies had been conceptualised. This second line of theoretical development was mainly within the symbolic-interactionist perspective, or using neo-Weberian or Marxist power perspectives. Studies challenging the "professional-bureaucratic conflict theory" showed the complicity of interests between both bureaucrats and professionals, and state bureaucracies and professions. These studies examined processes of negotiation between professionals, bureaucrats and clients by using analytic frameworks to compare these processes with the strategies of other workers and occupations.

Freidson's and Johnson's studies (Chapter 3) are examples of this approach, and a variety of historical case studies of occupational development have been undertaken using the "power/process" perspective [Parry and Parry (1976) (Medicine), Larkin (1983) (Paramedics), and Davies (1980) (Nursing)]. One "historical" study proposed that the processes of professionalisation and bureaucratisation are similar, compatible and mutually reinforcing [Ritzer (1974)]. This thesis adopts a similar power perspective, by using a particular conception of power and authority, it also focuses on structures of authority in a comparative study of the organisation of five professions.

Conclusions

The main conclusions of the review are:

1) There is a lack of knowledge about the details of professional management structures in UK welfare services, and about the effect of these structures on professional autonomy and control, and few comparative studies into professional structures.

2) It is not possible to develop Freidson's theories of institutionalised autonomy and of medical dominance in the context of the UK by reference to previously published research findings.

3) The use of similar terms ("semi-profession", "heteronomous profession") to describe both types of profession, and types of work organisation, is compatible with the thesis argument that an understanding of work organisation is crucial to an understanding of the nature and characteristics of professions.

4) More recent "power" and "process" perspectives suggest new ways of conceptualising both bureaucracies and professions, and of understanding the significance of interests, values and meaning in the formation and change of structure.

APPENDIX 4 : A TYPOLOGY OF PROFESSION - MANAGEMENT STRUCTURES

A variety of management structures was found in the research which can be summarised in terms of the three broad types described below. The two variables with the greatest effect on professional autonomy were found to be:

1. The level up to which the profession exercised management control (e.g. whether one profession-head managed heads of department who themselves managed practitioners, or whether the highest level of profession-management was one or more heads of department, each accountable to a different general manager);
2. The nature and authority of profession-management roles (e.g. fully-managerial, joint-manager, or advisory role, etc).

TYPE 1: AUTONOMOUS PROFESSIONAL MANAGERIAL STRUCTURES

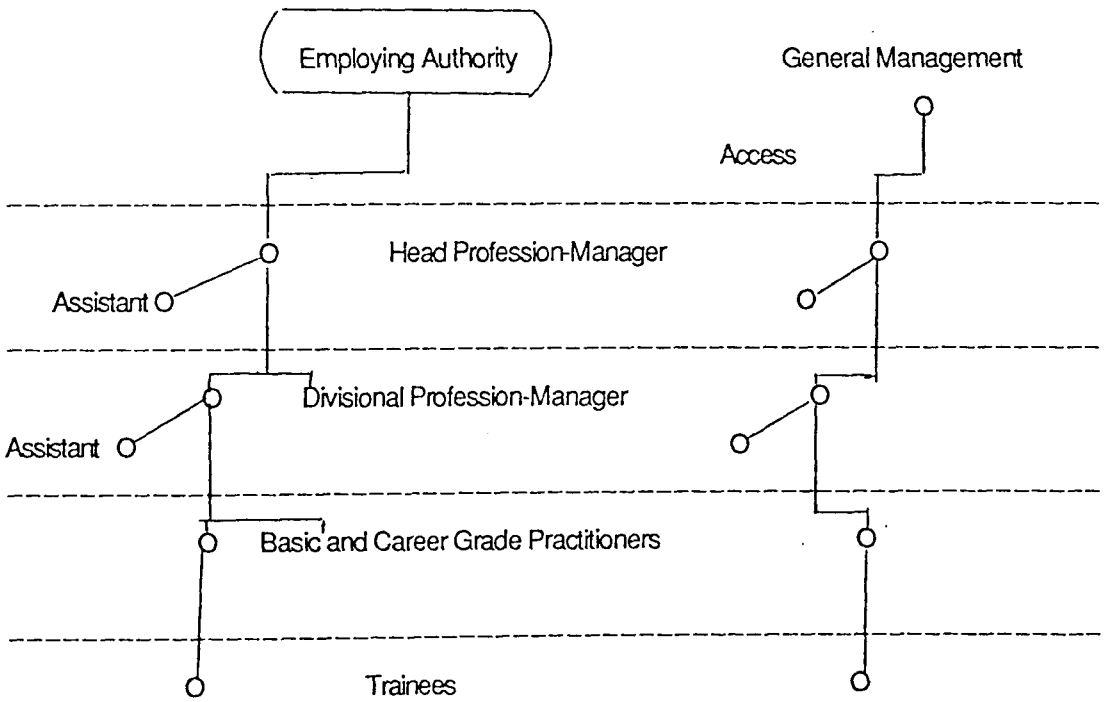


Diagram Key ○ Managerial Relationship

Variant A: Fully Autonomous Managerial Structure

(e.g. Nursing 1974-1985)

Variant B: Partially Autonomous Managerial Structure

(e.g. Some Physiotherapy Structures 1978)

Level of Profession-Management Control

In these "Type 1"structures all members of the profession employed by the authority were organised within one managerial structure for the profession, headed by one profession-manager. Variant "A "was where the head profession-manager was directly accountable to the employing authority, and no other manager had authority to make or override management decisions affecting the profession.

Variant "B" was where the head profession-manager was accountable to a general manager (or management group), who in turn was accountable to the employing authority for managing the profession. The profession-manager had right of access to the employing authority to directly present their case in decisions of importance to the profession.

Nature of Management Control

Within this Type 1 structure, profession-managers at each level were fully accountable for the actions and decisions of their subordinates, and had managerial authority in relation to managers and practitioners below them. Both Basic Grade and Career Grade practitioners were accountable to a profession-manager who had authority to,

- decide place and types of work;
- decide allocation of cases, and assign detailed tasks;
- review and override case decisions;
- appraise performance and decide training;
- initiate disciplinary action.

The overall structure is similar to a typical managerial hierarchy in manufacturing and service industries, and many government agencies. It is often described as a traditional bureaucratic hierarchy, and provides for maximum accountability through managerial roles with authority to assign and review subordinates' work in detail. It is different from structures in industry and commerce in three respects, which are related to three types of occupational autonomy.

Firstly, all members of the occupation employed by the organisation are managed by members of the occupation and are grouped within one or more occupational hierarchies. A degree of individual and group autonomy thus arises as a result of "group management".

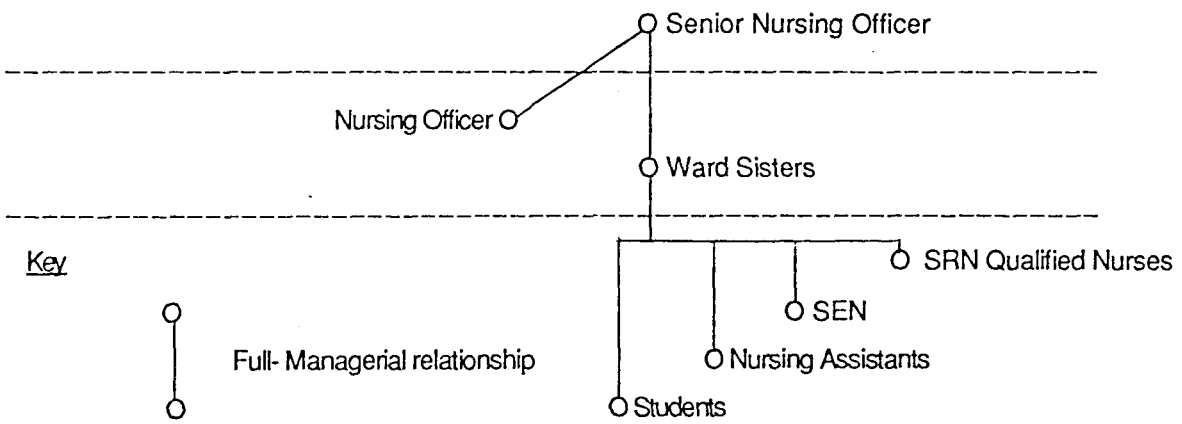
Secondly, the head profession-manager has the right of direct access to the employing authority, irrespective of whether they are themselves accountable to a manager between them and the authority. The profession- manager has the authority to represent their case directly to the

authority, and may be called by the authority to account for actions of any member of the occupation employed by the authority.

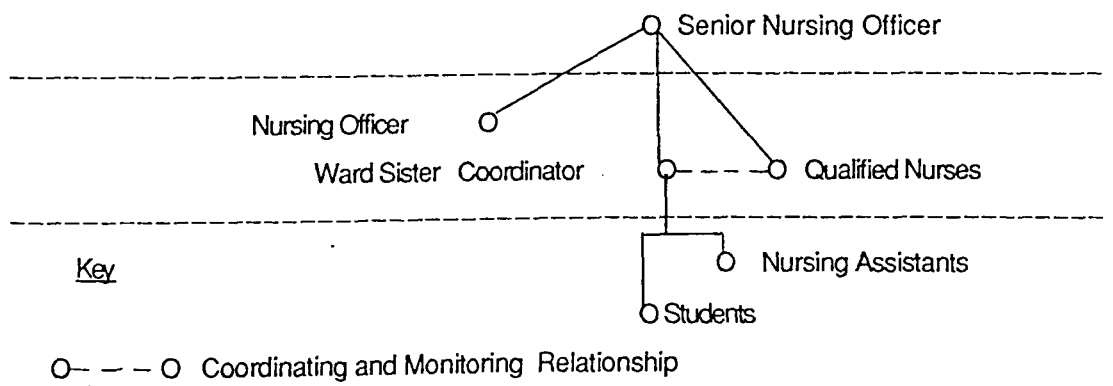
Thirdly, many members of the occupation are usually either state registered or members of a professional association. Thus managers cannot assign tasks which infringe state registration requirements, and face resistance if they give instructions which infringe the code of the professional association. (Managers, as members of the occupation, are in any case reluctant or refuse,to do so. Having been socialised in the values of the occupation they frequently retain a commitment to the occupation and its values).

At the practice level, two variations are common: the first (Model A) is a more detailed version of the simple model above; the second (Model B) involves a ward or team leader coordinator. In each a variety of advisory staff and supervisory support roles to the manager is usually involved, with different types of authority in relation to the manager's subordinates.

Model A: Managerial Hierarchy



Model B: Managerial Hierarchy/Ward Coordinator

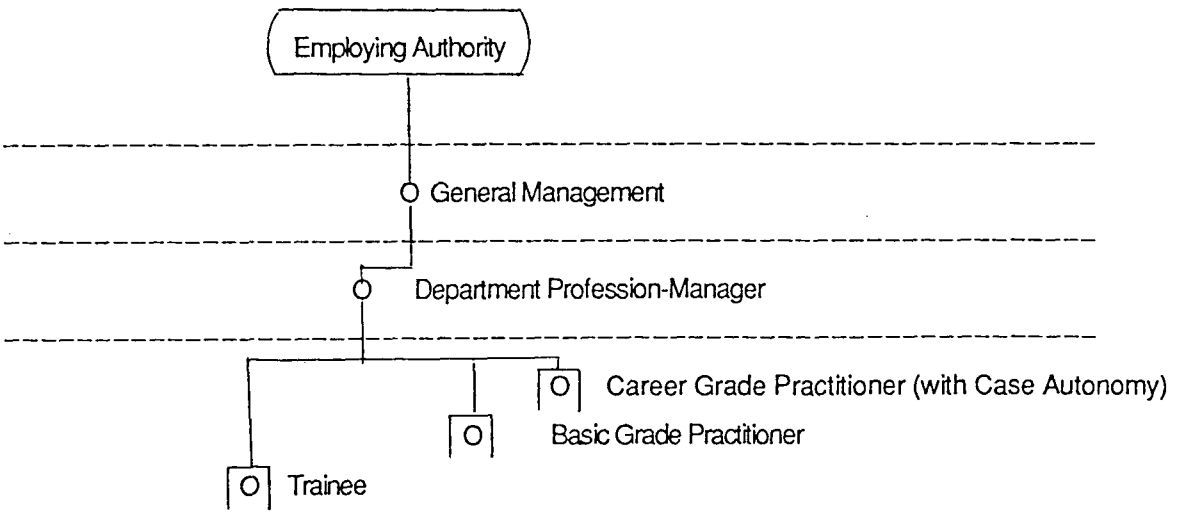


TYPE 2:AUTONOMOUS DEPARTMENTS AND PRACTITIONER AUTONOMY

In these structures practitioners were organised into divisions (e.g. Clinical Psychology Specialities ,Physiotherapy Departments, or Medical Consultant Firms), and had Case and/or Practice Autonomy.

The first variant of the "Autonomous Department" structure (Variant A) was where practitioners and trainees were organised into departments under heads of department, but where heads did not have Practice Autonomy.

Variant A: Managerial Structure with Case Autonomy (e.g. Physiotherapy 1977-1985)

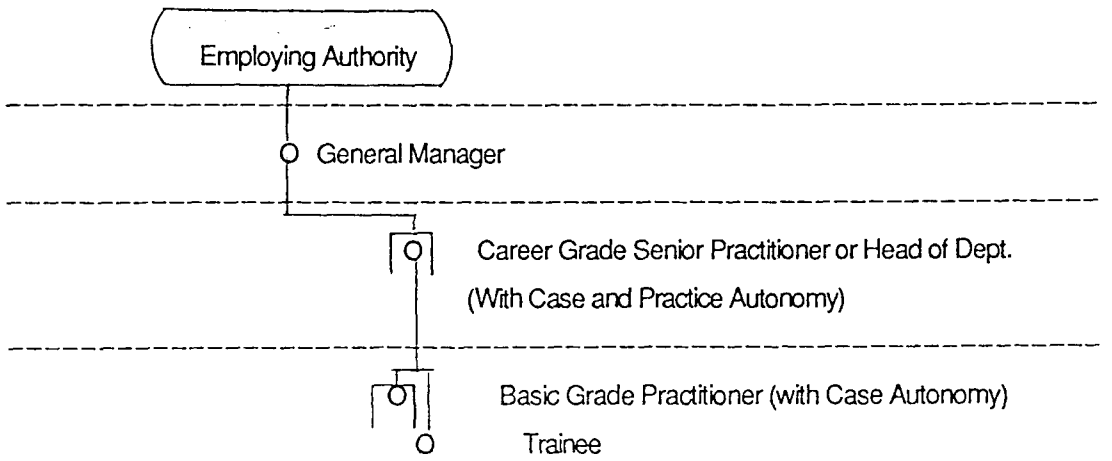


Department Heads had Case Autonomy but were fully-accountable for the running of the department to a general manager. The general manager, who was not a member of the profession, had full-managerial authority to review and instruct the head over aspects of the management of the department which were not related to individual case decisions.

Only senior practitioners had Case Autonomy, but heads of department did have authority to allocate cases, assign administrative and other tasks, and set general treatment and practice policies. This structure was common in physiotherapy between 1977 and 1987.

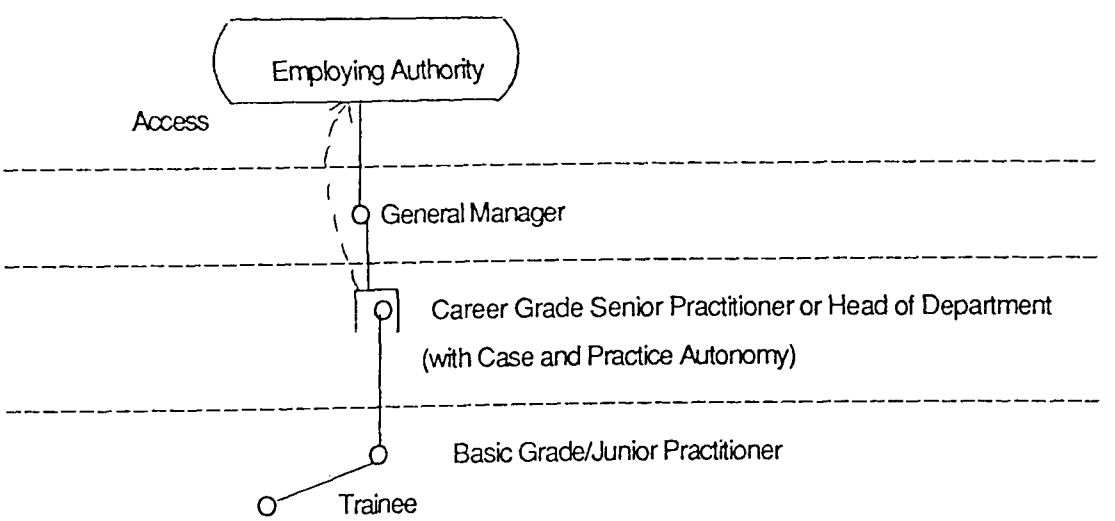
In the second variant (Variant B) the department profession-manager had Practise as well as Case Autonomy.

Variant B: Case and Practice Autonomy Structure (e.g. Some Psychology, 1977;1985)



In Variant B, a career grade senior practitioner with Case and Practice Autonomy managed basic grade practitioners with Case Autonomy and was the full-manager of trainees. In this structure heads of department were accountable to general managers for providing a defined service with the resources allocated. General managers did not have authority to review or instruct them over details of the management of the practice, but did have authority to set resource and other limits to Practice Autonomy, after negotiation. Heads of department had authority to set policies and limits to the Case Autonomy of practitioners, and had full-managerial authority over trainees, as in Type 1. The next variant of the Type 2 structure was Variant C below.

Variant C: Practice Autonomy Managerial Structure (e.g. A Medical "Firm")

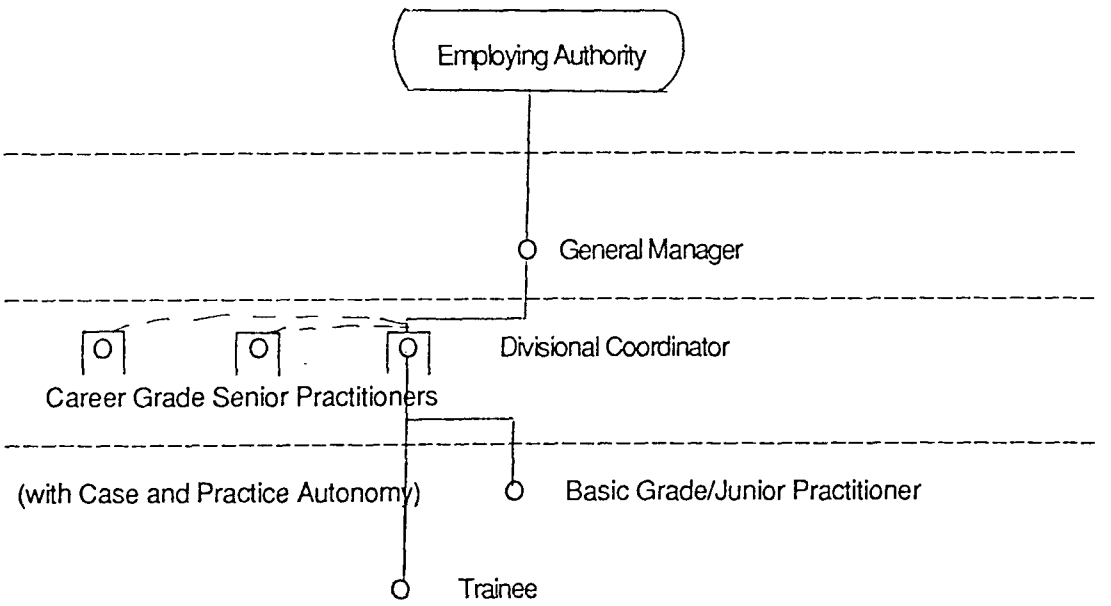


In this structure junior practitioners who were at various stages of training were fully-managed by career grade senior practitioners (often referred to as Head of Department), who were accountable

for juniors' work and case decisions. The two main differences from the Type 1 structure described above are that the professional divisions are far smaller (1 - 8 junior practitioners), and the career grade senior practitioner is not fully-managed by a general manager: they have autonomy within certain limits in relation to case-work and practice (or department management) decisions. They also often had right of access to the employing authority.

A variation of this structure was the "departmental collegiate". In the departmental collegiate there were few, if any, junior practitioners, and a group of senior practitioners with Case and Practice autonomy was coordinated by a profession leader, who sometimes also managed junior staff. Some psychology departments were organised in this way.

Departmental Collegiate

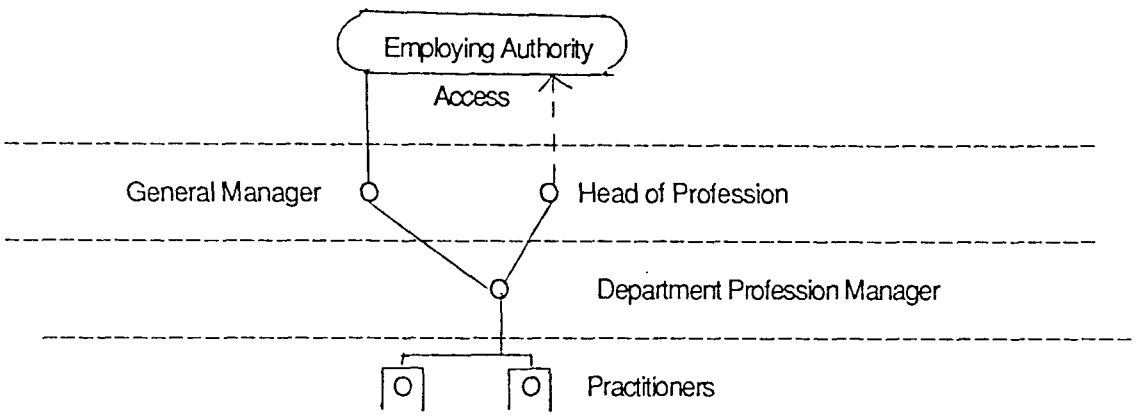


TYPE 3: JOINT-MANAGEMENT STRUCTURES

Structures categorised within Types 1 and 2 above were where all full and trainee members of the profession were found to be organised solely within departments (Type 2) or complete hierarchies (Type 1). The third type of structure below was found where practitioners and/or heads of department were jointly-managed by a general manager and a professional superior. Joint management, where both superiors were members of the same profession, has been a common arrangement for some time(e.g. where Superintendent physiotherapists managed Basic grade staff who were supervised "on a day-to-day basis" by Senior grade staff. However, following Unit

management in the NHS in 1982, and the development of community multidisciplinary teams, practitioners and professional managers were increasingly placed under the management of both a general manager and their professional superior.

Variant A: Joint Management of Department Profession Managers

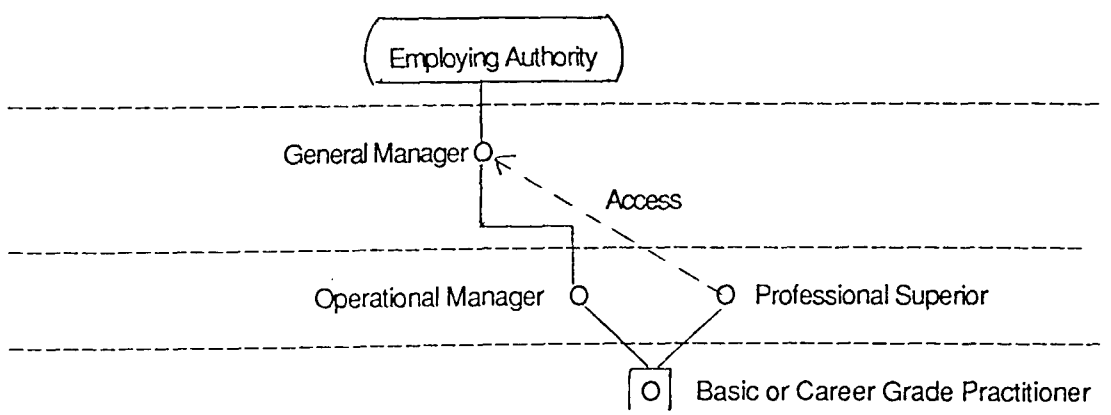


In Variant A of Type 3 each department profession-manager was "managerially accountable" to a general manager and "professionally accountable" to the authority's head of profession. The head coordinated department managers and monitored professional standards, and the general manager monitored the management of the department.

The management autonomy of the profession was less in this type of structure than in Types 1 and 2, and the nature of the authority of the general manager and of the head of profession was a focus of uncertainty, disagreement, and sometimes conflict.

The management autonomy of the profession is even less in Variant B below, where practitioners were jointly managed by an operational manager (or team leader) and a professional superior.

Variant B: Joint Management of Practitioners



Practitioners were frequently allocated part or whole-time to multi-disciplinary teams, where they came under the authority of operational managers or team leaders. The professional superior provided technical and professional advice to practitioners in teams. Sometimes the professional superior headed a department where practitioners were not working full-time in teams, and provided a district professional service separate from the team services.

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APPENDIX 5 : DETAILS OF THE AUTHOR'S FIELD RESEARCH

This appendix provides details of the author's field research into professional organisation over the period 1980-1988 , in the order in which the projects are reported in CH 5. The appendix lists,A) the title of the project,B) the project start and finish dates, details of ,C) the interviews and ,D) the workshops undertaken,and E) notes other researchers who were engaged on the same project where the research was undertaken in a research team. Further details of the field research are listed in Appendix 1(research documentation and sources),and in CH 5.

Psychology Organisation

A)Project Title:Northumberland Psychology District Service Organisation
B)Dates: March 1984(3 days),C).Interviews: District Psychologist,followed by, D).Workshop: 2 days,on site,attended by all members of the department(12),E).Other researchers involved:None.

A)Project Title:North Manchester Psychology District Service Organisation
B)Dates: January 1985(3 days),C) Interviews: District Psychologist,followed by, D).Workshop: 2 days,on site,attended by all members of the department(14) E).Other researchers involved:None.

A)Project Title:Eastbourne Psychology District Service Organisation
B)Dates: February 1985(3 days),C) Interviews: District Psychologist,followed by, D).Workshop: 2 days,on site,attended by all members of the department(13) E).Other researchers involved:None.

A)Project Title:Macclesfield Psychology District Service Organisation
B)Dates: March 1986(3 days),C) Interviews: District Psychologist,followed by, D).Workshop: 2 days,on site,attended by all members of the department(9) E).Other researchers involved:None.

A)Project Title:Dudley Psychology District Service Organisation

B)Dates: March 1986(3 days),C) Interviews: District Psychologist,followed by, D).Workshop: 2 days,on site,attended by all members of the Dudley department(9), two unit general managers and 6 members from the Bromsgrove and Reddich department, E).Other researchers involved:None.

A)Project Title:Oxford Psychology District Service Organisation
B)Dates: July 1986(2 days),C) Interviews: District Psychologist,followed by, D).Workshop: 1 day,on site,attended by all members of the department(27) E).Other researchers involved:None.

A)Project Title:St. Helens and Knowsley District Service Organisation
B)Dates: October 1986(3 days),C) Interviews: District Psychologist,followed by, D).Workshop: 2 days,on site,attended by all members of the department(12) E).Other researchers involved:None.
A)Project Title:Gwynedd Psychology District Service Organisation
B)Dates: Jan 1987 (3 days),C) Interviews: District Psychologist,followed by, D).Workshop: 2 days on site,attended by all members of the department(9)and 2 unit General managers E).Other researchers involved:None

Other Research Reported

Interview with District Psychologist,Bexley Department (April1983 and July 1984)
A)Project Title:Nottingham 1982 Trail Project.Psychology organisation sub-project.
B)Dates:November1981,C).Interview: District Administrator and Disstrict Psychologist,E).Other researchers involved: Professor Ralph Robottom (BIOSS).

Regional Workshops(Chaired by the researcher alone)

(Sept 1984), West Midlands Region Workshop,22 attended .
(June 1986), Northern Region Workshop ,19 attended.
(March 1987), West Midlands Region Workshop ,23 attended.

Brunel Workshops(Chaired by the researcher alone)

23/24 Nov 1983, 18 attended,13/14 Feb 1984,16 attended,23/24 Feb1984,19 attended,13/14 Sept 1984 15 attended,27/28 Sept 1984,16 attended,30/31 Oct 1984 ,14 attended,31 Jan/1 Feb 1985,16 attended,13/14 Feb 1985 ,13 attended,3/4 Oct 1985,17 attended,15/16 Oct 1985,18 attended,4/5 March 1986,9 attended,22/23 April 1986,16 attended,30/31 July 1986,14 attended,3/4 Dec 1986 (Specialist Health Professions),14 attended,15/16 Dec 1986,14 attended,31 March/1 April 1987,11attended.

Other Conferences/Seminars where concepts and organisation presented by the author,

10 May 1982, "Regional Representative Structures", King's Fund Centre, London.

1984, "Grading and Organisation", King's Fund Centre, London.

1984, "Organising District Psychology",

1984 , S-E Thames Region, David Solomans House.

1984, "Planning Organisational Structure", Oxford Region Seminar,Warneford Hospital.

Physiotherapy Organisation

A)Project Title: Chartered Society of Physiotherapy Organisation Project
B)Dates:Phase 1 Jan 1980-June 1980,C).Interviews: 14 District Physiotherapists ,17 senior physiotherapists in Enland and Scotland,E).Other researchers involved:Dr. Warren Kinston (BIOSS).

B)Phase 2 July 1980-July 1982,(role of senior physiotherapsists) C).D).Workshops: 1 day,on site,attended by senior members of all departments in each region,conducted by the researcher alone,
North-West Thames (19/1/82)17 attended,South-West Thames (10/2/82),19 attended, South-Western (26/2/82),22 attended,North-Eastern (11/3/82),18 attended,Oxford (31/3/82),23 attended,Wessex (15/6/82),19 attended,Trent workshop (6/6/81),21 attended.

Other Workshops,chaired with Dr. Warren Kinston.
"Integrating Education and Clinical Services",3/4 Feb 1982, 9/10 March 1982, and 17/18 March 1982.
"Senior Practitioner and Superintendent Workshop",June1984(attended by 27 staff from Nottingham and Norwich departments).

Brunel Workshops,chaired with Dr.Warren Kinston.
"Managing Physiotherapy in the New Districts" (20/21 Sept 1984).
"Managing Physiotherapy in the New Districts" (1/2 Nov 1984).

Nursing Organisation

A)Project Title:North-West Thames Nursing project
B)Dates: Phase 1: March 1980-August 1982.Phase 2: January 1984-July 1984..
C)Interviews: Phase 1 : Northwick Park Hospital,interviews with 13 ward sisters,and 8 other nursing staff,followed by, D).Workshops: Ward sisters from Northwick Park 14th May 1981(24),Ward sisters from Barnet DGH 18th May 1981(21),Ward sisters from St.Marys Paddington 12th June 1981(26),Ward sisters from all sites,at Brunel,29th June 1981 ,Senior Nursing staff from all sites at Brunel,14th,15th,21st and 22nd July 1981(39),E).Other researchers involved: Ian Macdonald(BIOSS) at Northwick Park,Anne Melia (BIOSS)at Barnet,Stephen Cang (BIOSS)at St. Mary's Paddington.

B)Dates: Phase 2: Jan 1984-July 1984.
C).Interviews: Phase 2 : St.Mary's,interviews with Personnel officer,Nursing Officer and 3 Ward sisters.E)Other researchers involved:Stephen Cang (BIOSS).

A)Project Title:Nottingham 1982 Trail Project.Nursing organisation sub-project.
B)Dates:October 1980-July 1982,C).Interviews: 16 senior nurses from all specialities,E).Other researchers involved: Professor Ralph Robottom (BIOSS).

A)Project Title:St. Ebbas Mental Handicap Hospital Organisation,Nursing organisation sub-project.
B)Dates:September 1984-September 1987,C) Interviews: 14 Ward sisters and Charge Nurses,5 Nursing Officers, followed by D)Workshop: 1 day,on site,attended by all senior nurses(8)(April 1986) and 1 day,on site,attended by 17 Ward Sisters and Charge Nurses(July 1986).Other researchers involved :Ian Macdonald (BIOSS).

A)Project Title:Rhondda Vanguard Organisation,Nursing organisation sub-project.
B)Dates: March 1986-April 1988,C) Interviews: 4 community mental handicap nurses,4 nurse managers,followed by D).Workshop: 1 day,on site,attended by all senior nurse members of Mid-Glamorgon(13)(October 1987) E).Other researchers involved:None on the nursing organisation sub-project,but overall project was jointly conducted with Ian Macdonald(BIOSS).

Other Brunel National Workshops,Chaired with Stephen Cang,Ralph Robottom and Warren Kinston,
"Organising Nursing Services in the New Districts and Units" (1983),22/23 Sept. DNOs and Dr. NS 17 attended,11/12 Oct. DNOs and Dr. NS 16 attended.
"Accountable Management of Nursing in the Post-Griffiths NHS" (1984),1/2 Feb. DNOs and Dr. NS 16 attended,10/11 April DNOs and Dr. NS 19 attended.

Social Work

A)Project Title: Organisation of Residential Social Work,B)Dates: November 1983,March 1984,D) Workshops : 2 workshops held at Brunel ,attended by 11 and 13 social services managers from different English Social Services Departments ,E).Other researchers involved: David Billis (BIOSS).

A)Project Title: Improving Social Work Records and Practice ,British Association of Social Work project. B)Dates: Phase 1 : October 1984-October 1986, C) Interviews: with social workers and managers mainly in Oldham,Surrey,Hillingdon,Liverpool,Kent,Sussex,and Coventry social service depatments, E).Other researchers involved:None.

Phase 2: October 1986-October 1988
D) Workshops:On-site workshops with practitioners and managers on case recording, case management and accountability,all chaired by the researcher alone: Bexley SSD (4/4/85), Oldham SSD (9/5/85), DHSS (Brighton Conference) (22/6/85), DHSS (Scarborough Conference) (22/7/85), Merton SSD (11/9/85 and 20/11/85),(1986), South Glamorgan SSD (5/2/86), DHSS (Kensington Conference) (21/3/86), Kent SSD (7/3/86), Greenwich SSD (4 workshops, March/April 1986), Kirklees SSD (24/7/86 and 25/7/86), Grampian Region SSD (3/10/86), Croydon SSD (14/10/86), Borders Region SSD (28/1/87), Social Work Services Group (2 workshops, 29 and 30/1/87), Dorset SSD (27/2/87), Islington SSD (3/3/87), Lewisham SSD (8 workshops during March, April and May 1987),Coventry SSD (2 workshops and team visits July-Nov 1987),Essex SSD June(1988),Westminster SSD (Sept.1988).

Brunel Workshops:"Social Work Records and Practice", 9 workshops during 1985, 1986 and 1987, attended by approx. 160 social workers from England, Wales and Scotland,chaired by the researcher alone.

Medicine

A)Project Title:St. Ebbas Mental Handicap Hospital Organisation,Medical organisation sub-project.B)Dates:September 1984-September 1987,C) Interviews: 5 Hospital Consultants,3 Junior Doctors.E).Other researchers involved in the overall project :Ian

Macdonald (BIOSS).

A)Project Title: Multidisciplinary Community Team and Service Organisation.

B)Dates: 1984-1988

D).Workshops: Programme of 2 day on-site workshops for practitioners and managers to specify organisation,involved consultant psychiatrists and junior doctors,and other professions.(all workshops were chaired by the researcher alone):

Psychotherapy Unit, Doncaster (1984).Child Development Centre,(Clywd), (July 1985). Child Guidance Centre (Wrexham), (Nov 1985).Southern Derbyshire Mental Health Team Workshop (April 1986).Sunderland Mental Health Team (June 1986).Doncaster Mental Health Team (June 1986).Berkshire Specialist Community Services Team (July 1986).North Derbyshire Bolsover Community Mental Health Team (Aug 1986)Greenwich Terminal Illness Support Team (Aug 1986).Macclesfield Mental Health Teams (Oct 1986).North Derbyshire, Chesterfield Mental Health Team (March 1987).Sunderland Mental Health Team(follow-up,Jan.1987).South Birmingham Psychologists from teams(March 1987).Wrexham Mental Health Resettlement Team (March 1987).Barking and Havering Mental Handicap Team (May 1987).Lincoln Mental Health Teams(June 1987).Lincoln Mental Handicap Teams(June 1987).South Birmingham Mental Handicap Teams(June 1987).South Birmingham Mental Health Teams(Sept.1987).North East Derbyshire Mental Health Team(Nov.1987).Southern H&SSB,Northern Ireland Mental Handicap Teams[Jan.1988].Swindon SSD/DHA ,Child Guidance Team[Jan.1988] .Lincoln DHA/SSD (South) ,Mental Handicap Teams. [Jan.1988].Kettering DHA/SSD,Mental Health Teams and Services[May 1988].Forth Valley Health Board,Mental Handicap Services and Teams[May 1988].Bexley DHA/SSD Services and Teams for the Elderly [June 1988].Aylesbury DHA/SSD Mental Health Teams and Services [July 1988].Leeds DHA/SSD Mental Health Teams [Sept 1988].Ayre Health Board Mental Handicap Services and Teams [October].Essex DHA/SSD Mental Handicap Teams(Nov.1988)

National Workshops at Brunel on Multidisciplinary Team Organisation

30,31 January, 27,28 June, 15,16 July,1986,9,10th April ,5,6th May ,29,30 September,23,24 November 198716,17th May 1988,27,28th September 1988,7,8th December 1988.

Other Workshops on Team organisation

Mental Health Teams, King's Fund Conference, (June 1985).

Mental Health Teams, King's Fund Conference (Dec 1985).

Rhondda Vanguard Mental Handicap Service (May 1985 Workshop).

Rhondda Vanguard Mental Handicap Service (Oct & Nov 1985 Workshops)

St Ebba's Behavioural Team Organisation (1985 Interview project).

Padington Mental Health Teams (Dec 88)