Exploring the impact of clinical governance on the professional autonomy of general practitioners in a primary care trust in the North West of England

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Abstract

Employing a single-site exploratory case study research methodology, this study seeks to paint a rich and detailed picture of managerial and professional perspectives of the impact of clinical governance on the professional autonomy and self-regulation of general practitioners (GPs) in a Primary Care Trust (referred to as the Utopian PCT), in the North West of England. The study defines clinical governance in the context of general practice; identifies the requirements for and barriers to its implementation; explores the role of GP Medical Advisers to the PCT and determines whether clinical governance is contributing to the deprofessionalisation (Haug 1973; 1975; 1977; 1988), proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997) or restratification of general practice (Friedson 1975; 1983; 1984; 1985; 1986).

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There are a small number of existing studies examining the impact of clinical governance on the professional autonomy and self-regulation of GPs (Sheaff et al 2002; 2003; 2004; Locock et al 2004). This study focuses on the *whole* process of clinical governance whilst others focus on the implementation of National Service Frameworks. This is the only study employing a single-site exploratory case study methodology seeking to 'particularise' rather than to 'generalise' and to paint a rich and detailed picture of the 'human-side' of the Utopian PCT and the associated general practices. Whilst never intending to be generalisable, the results of the study add to the growing body of evidence that the restratification of general practice has begun in England through GP Professional Representatives (referred to as GP Medical Advisers at Utopian PCT), employed in

hybrid advisory/supervisory roles within PCTs. My study also supports Sheaff et al's (2004) findings, suggesting that in the case of general practice, restratification does not divide the profession into separate occupational groups (Friedson 1984). Instead, knowledge management, supervision and general practice are different aspects of the same role (Sheaff et al 2004; Courpasson 2000). The study demonstrates that despite the structural constraints imposed by clinical governance on general practice GPs are by no means helpless victims of government policy. Where possible they use clinical governance to their own advantage and to the advantage of their patients. They unenthusiastically implement those aspects of clinical governance they dislike but cannot avoid. The GPs participating in the study objected to what they perceived to be the managerial interference embodied in clinical governance and continued to adhere to a professional rather than a 'neo-bureaucratic' culture. The study suggests that in the future the new General Medical Services Contract (2004) will be influential in reinforcing the implementation of clinical governance in general practice.

This study identifies areas for future investigation including the comparison of the GP Medical Adviser's role in Primary Care Trusts with that of Clinical Directors in Hospital Trusts; the longer-term impact of the new GMS Contract (2004) on the implementation of clinical governance; the changing role of the Practice Manager resulting from the implementation of clinical governance and the new GMS Contract (2004); the contradictions apparent in subsuming risk management into the wider clinical governance agenda; the longer term impact of the use of National Service Frameworks (NSFs) and National Institute of Excellence (NICE) guidance and the associated training of GPs, on the clinical performance of GPs and finally, the impact of direct employment with a PCT for GPs on their professional autonomy and self-regulation.

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Chapter One

Introduction

> ***'I have no doubt that we shall have at least as many physicians in 2020 as we have now....but will those physicians be professionals in the way we understand the term at present? Will they have the same values or will medicine have become a business, its practitioners tradesmen, and healthcare just another service industry? ....Yet, it is upon them (the medical profession) that the future of medicine rests. If their sense of calling is not destroyed, they will be doing their best for sick people in the dark hours when the hostile critics of the profession are chattering away at their dinner parties or safely tucked up in bed' (Tallis 2004:241, 3)***

The Department of Health (1998b:33) defines clinical governance as,

> 'A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.

Since the introduction of the NHS in England in 1948, successive governments, in their attempts to deliver efficient and high quality healthcare services to the whole population have challenged the professional autonomy and self-regulation of the medical profession. This has become more overt since the implementation of the Griffiths Report proposals in 1983, which was a signal for the continued application of managerial techniques derived from the private sector. The internal market followed in 1991, and the implementation of the Labour Government's 'third way' since 1997 has continued this trend (Harrison and Ahmed 2000; Flynn 2002; Harrison and Smith 2003; Harrison and McDonald 2003).

Clinical governance has emerged against a backdrop of highly publicised medical failures or malpractice including, the Bristol Heart Surgery Inquiry, the unauthorised use of children's organs at Alder Hey hospital, mistaken diagnosis in breast cancer screening services at Canterbury Hospital and the murder of numerous patients by GP

Harold Shipman. Clinical governance incorporates the setting of national standards of care through 'National Service Frameworks' (NSFs) via the National Institute for Clinical Excellence (NICE); continuous quality improvements, based on clinical standards and evidence-based practice; risk management, and the monitoring of progress, through the Commission for Healthcare Audit and Inspection (CHAI), a survey of patient and user experience, and a system of modernised professional self-regulation, involving GP performance appraisal, continuous professional development (CPD) and the five yearly revalidation of medical practitioners (DofH 1998b; 1999).

There is an ongoing debate about the impact of clinical governance on the professional autonomy and self-regulation of the medical profession including general practitioners. The debate centres around whether clinical governance is contributing to a decline in professional autonomy of GPs, conceptualised by two overlapping theories of deprofessionalisation (Haug 1973; 1975; 1977; 1988) and proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997) or whether it is leading to a redistribution of power within the profession, referred to as restratification (Friedson 1975; 1983; 1984; 1985; 1986). It is to this body of knowledge that I am seeking to contribute with my thesis.

1.1 Aim and Objectives of the Research

The aim of this study is to examine the impact of clinical governance on the professional autonomy and self-regulation of general practitioners (GPs) in a Primary Care Trust (PCT) in the Northwest of England from the perspectives of Primary Care Trust directors and managers, and medical healthcare professionals working in general practice.

The objectives of this research are:

- To explore clinical governance in the context of general practice and to identify the requirements for and the barriers to its implementation.

- To examine the role of GP Medical Representatives on the Primary Care Trust (PCT) Board and Professional Executive Committee (PEC) in the implementation of clinical governance in general practice.
- To analyse the impact of clinical governance on the professional autonomy and self-regulation of GPs to determine whether this is contributing to the deprofessionalisation, proletarianisation or restratification of general practice.

1.2 Background to the Research.

My interest in quality assurance developed whilst I was studying for my MBA degree during the late 1980s. For my action research based dissertation I was asked by my employer to design a quality assurance system. During this process I located the literature on New Public Management and became interested in the issues surrounding the transferability of private sector management techniques to public sector services. After graduating I was employed by a former Polytechnic as a Senior Lecturer in a Business School, and over the years started to experience first hand the impact of increasingly managerialist approaches in higher education on my own work as a lecturer, feeling considerably constrained by this.

After the election of the Labour government in 1997 and the introduction of clinical governance as a quality assurance system in the 'New NHS' (DoH 1998), and at the same time, whilst supervising the MBA dissertation of a senior manager in a newly formed Primary Care Group (PCG), I recognised parallel issues in relation to challenges to professional autonomy in the health and higher education services. General practitioners were continually cited by my MBA student as individuals who were blocking the progress of the implementation of clinical governance in primary care. I wondered if GPs might be starting to feel as I had been over the previous few years.

After doing some initial reading I realised that whilst there was a wealth of publications about quality assurance issues in secondary care, there was considerably less in relation to primary care and general practice in particular. At the same time I started to read the

literature on the sociology of the professions, which identified the medical profession as one of the 'true' professions with a monopoly of specialist knowledge giving control over the content of work, leading to professional autonomy and self-regulation. (Johnson1972; Friedson 1983). It appeared to me that clinical governance presented a direct challenge to the professional autonomy of the medical profession, and in the context of my own particular interest, general medical practitioners (GPs).

Having secured access to a Primary Care Trust (PCT) in the Northwest of England as a research site (from here on referred to as the Utopian PCT) through my MBA student, I planned to examine the impact of clinical governance on the professional autonomy of GPs, this forming the central inquiry of my research study. I already had a brief insight into a PCT manager's perception as a result of supervising my student's dissertation. I decided to explore this further, and to contrast this with the professional perspective of GPs themselves and other healthcare professionals working with them in general practice. I started to form my research questions,

- How do PCT managers and GPs in the Utopian area define clinical governance in the context of general practice?

- What do PCT managers and GPs perceive to be the requirements for and the barriers to the effective implementation of clinical governance in general practice?

- What are the perceptions of PCT managers and GPs of the impact of clinical governance on GP's professional autonomy?

I understood from my initial literature review that the impact of successive government policies on the autonomy of the medical profession is an established field of inquiry (Salter 2002; Flynn 2002; Harrison and Ahmed 2000; Harrison and Smith 2003). Interpretations vary according to the author's theoretical approach. Neo-Marxist analysts like Johnson (1972); Haug (1973; 1975; 1988); Mckinlay and Arches (1985); Mckinlay and Stoeckle (1988) and Coburn (1992) suggest that the medical profession is

slowly succumbing to 'deprofessionalisation' and 'proletarianisation' as in the case of other workers in advanced capitalist societies.

Friedson (1984; 1986) rooted in a Neo-Weberian tradition, takes issue with these 'professional decline' theorists, arguing that rather than the medical profession losing overall control of its work it has experienced a restratification within the profession. 'Rank and file' professionals may lose control to knowledge management and supervisory elites emerging within the profession, but the profession does not lose control overall. This raises the question,

- Has general practice experienced a professional decline as a result of the implementation of clinical governance, or is it experiencing a restratification?

This question was posed by Mahmood (2001) who argued that GPs occupying managerial positions on PCG/T Boards and senior committees could be interpreted as a form of restratification in general practice. No firm conclusion was however reached. In 2002, Harrison and Dowswell examined how government policy along with its governance arrangements impacted on the professional autonomy of forty-nine GPs in Northern England, it was concluded that the use of GPs on PCG/T Boards does represent a form of restratification. Sheaff et al (2002; 2003) after examining the role of GP Clinical Governance Leads in implementing clinical governance in general practice also reported that restratification of general practice is starting to occur in England. Other studies however, suggest that there is inconclusive evidence of restratification in general practice (Lockwood et al 2004; Armstrong 2003).

The debate about whether or not restratification is occurring in general practice in England appears set to continue for a long time. Having identified this, I determined to contribute to this ongoing debate.

- What is the role of GP representatives on the PCT Board and Professional Executive Committees?

- Are these GPs principally medical representatives (Friedson 1986) or do they become primarily PCT managers, co-opted to pursue a governmental and managerial agenda ?

From these six research questions I was able to define precisely the aim and objectives of my research study as outlined at the start of this chapter.

1.3 Outline of the Thesis.

Chapter One - Introductory chapter.

Chapter Two – New Public Management, the National Health Service (NHS) and General Practice.

This chapter is the first of two chapters providing contextual material in support of my study. The chapter discusses the emergence of New Public Management (NPM) in the National Health Service (NHS) with a focus on general practice. It details the events surrounding the emergence of the NHS and outlines the approaches of successive governments to the management of the service. The purpose of the chapter in the context of the aim and objectives of my research is to explore the shift from traditional bureaucratic management of public services in general and the NHS in particular. Clinical governance with its roots in Total Quality Management (TQM) has been described as the latest manifestation of NPM in the National Health Service (Flynn 2002). This chapter focuses on the impact of NPM on the professional autonomy and self regulation of the medical profession with an emphasis on general practitioners, whilst the following chapter provides a detailed account of clinical governance.

Chapter Three – Clinical Governance.

This chapter is the second of two contextual chapters. It explores in detail the concept of clinical governance, reviews existing medical attitudes to clinical governance, considers the potential impact of clinical governance on the autonomy and self-regulation of the

medical profession and examines the new General Medical Services (GMS) contract as a mechanism for reinforcing the implementation of clinical governance in general practice. Along with chapter two, the aim of this chapter is to provide contextual information and to support the analysis and discussion of the results of my study which are presented in chapters six and seven of this thesis.

Chapter Four – The Professions and Professional Autonomy.

Chapter four presents the literature review underpinning my study. The chapter firstly explores the literature relating to the nature and development of the professions as a distinct occupational group and identifies professional autonomy and self-regulation as the defining characteristic of a profession. The chapter continues with a review of the theories of deprofessionalisation and proletarianisation as explanations of the impact of recent healthcare policy on the medical profession. These theories suggest that the result has been a decline in professional autonomy. The alternative explanation of restratification is then reviewed, which argues that the medical profession has not experienced a decline in professional autonomy but merely a redistribution of power and autonomy within the profession. The final section of the literature review presents an account of the relatively few existing studies of the impact of clinical governance on the professional autonomy and self-regulation of general practitioners in England and demonstrates how my study seeks to add to this body of knowledge.

Chapter Five – Methodology.

Chapter five outlines and justifies the methodological framework of my thesis and presents the research design.

Chapter Six – Results.

Chapter six presents the results of my study and takes the form of a comparative presentation of the managerial and professional perspectives of the concept of clinical governance in general practice, the requirements for and the barriers to its effective

implementation, the role of GP Medical Advisers to the PCT in relation to the implementation of clinical governance in general practice and the impact of clinical governance on the professional autonomy of GPs.

Chapter Seven – Discussion: Clinical Governance in General Practice

Chapter seven discusses the results of my study in the context of the existing literature on the impact of clinical governance on the professional autonomy and self-regulation of GPs reviewed in chapter four. The discussion also draws on the contextual material on NPM and clinical governance outlined in chapters two and three of the thesis.

Chapter Eight – Conclusions.

The final chapter presents the conclusions flowing from the discussion presented in chapter seven of my thesis. The chapter outlines the contribution of my study to the existing body of knowledge, identifies the limitations of the study, defines areas for future research, and concludes with an outline of the personal development I have experienced as a result of undertaking the research.

Chapter Two

New Public Management, the National Health Service and General Practice

'Better management provides a label under which private-sector disciplines can be introduced to the public services, political control can be strengthened, budgets trimmed, professional autonomy reduced, public service unions weakened and a quasi competitive framework erected to flush out the natural 'inefficiencies' of bureaucracy'. (Pollitt 1990:49)

2.1 Introduction.

This chapter is the first of two chapters providing the contextual backdrop to my study. The purpose of the chapter in the context of the aim and objectives of my research is to explore the shift from the traditional bureaucratic management of public services in general, and the NHS in particular, to 'New Public Management' (NPM). Clinical governance with its roots in Total Quality Management (TQM) has been described as the latest manifestation of NPM in the National Health Service (Flynn 2002). This chapter explores the concept of NPM, outlines the events leading to the establishment of the NHS, and traces the various approaches to the management of healthcare services including the application of NPM techniques in more recent decades. Throughout the chapter the focus is on the impact of healthcare management on the autonomy and self-regulation of the medical profession, particularly general practitioners (GPs). The second contextual chapter provides a detailed account of the concept of clinical governance.

2.2 New Public Management and 'Managerialism'.

New Public Management (NPM) according to Pollitt (1990) quoted above, is a 'label' representing the transfer of private sector management practices to public services. Its aim is to improve the quality and efficiency of services and to curb the power of professional groups delivering them. Dunleavy and Hood (1994:9) suggests that (NPM) is,

> 'a handy shorthand, a summary description of a way of reorganising public sector bodies to bring their reporting, and accounting approaches closer to (a particular perception of) business methods.'

NPM has no conceptual foundation of its own but stems from 'public choice theory' and 'managerialism' (Barselay 1992). Growing out of 'new right' ideology (McLaughlin et al 2002) NPM is an international trend in public administration designed to slow down the expansion of public spending and to encourage private-sector provision of services previously provided only by the public sector (Hood 1991; 1995a; 1995b; Newman and Clark 1994).

The Public Management Committee of the OECD defined NPM as,

'A new paradigm for public management..... aimed at fostering a performance-oriented culture in a less centralised public sector.' (OECD, Public Management Service 1995, quoted in Mathiasen 1999).

The characteristics of NPM have been defined by various commentators and include a focus on output measurement in terms of efficiency, effectiveness and quality of service; the replacement of centralised structures with decentralised 'management environments' where decisions on resource allocation and service are made closer to the point of delivery, and which seek feedback from clients and other stakeholders; a search for alternative more cost effective sources of service provision to direct public provision and regulation; and a focus on the flexible response to external changes at the least cost. (Aucoin 1990; Osborne and Gaebler 1993; Mathiasen 1999; Holmes and Shand 1995; Dunleavy and Hood 1994).

Drawing on the work of other authors, Hood (1991) identified seven doctrines of NPM including 'hands-on' entrepreneurial management as opposed to traditional bureaucratic public administration (Clarke and Newman 1993); the use of explicit standards and measures of performance (Osborne et al 1995); an emphasis on managerial output controls (Boyne 1999); the disaggregation and decentralisation of public services (Pollitt 1990); the promotion of competition in the provision of public services (Walshe 1995); the use of private sector styles of management (Wilcox and Harrow 1992); and the disciplined allocation and use of resources (Metcalfe and Richards 1990)

Barzelay (1992) observes that NPM does not have a conceptual foundation and a set of internally consistent propositions. Various disciplines are useful however, in understanding and analysing NPM. Microeconomics provides the tools for policy analysis and is used as the basis for determining 'rational' management practices. 'Law and regulation' provides the framework for managerial action. The most significant contribution to understanding NPM is perceived to be 'organisation theory' which suggests how the culture of bureaucracy shapes the behaviour of individuals and groups, which in turn influences the way public sector organisations function. Barzelay (1992:132) identifies the management practices adopted within the framework of NPM as,

> '....exercising leadership, creating an uplifting mission and organisation culture, strategic planning, managing without direct authority, pathfinding, problem setting, identifying customers, groping along, reflection-in-action, coaching, structuring incentives, championing products, instilling a commitment to quality, creating a climate for innovation, building teams, redesigning work, investing in people, negotiating mandates, and managing by walking around.'

Whilst few would argue with the sentiment of improving the quality and efficiency of public services, the suitability of this approach to the management of public sector organisations has been questioned. Aucoin (1990) suggests there is theoretical contradiction in the concept of NPM leading to cross-pressure and confusion for managers and contradiction in organisational designs with competing rationales. Rhodes (1994) observes that NPM is responsible for the erosion of the British State through privatisation, the loss of functions by local and central government to alternative delivery systems, the loss of functions by British government to the European Union

and reducing the discretion of public servants and the professions. These are believed to lead to a 'hollowing out of the state'.

Hood (1991) suggests that NPM is like the 'Emperor's new clothes'. New managerialism has changed nothing apart from the language used in management circles, the basic problems associated with public services remain. Secondly, Hood (1991) argues that NPM has not achieved its main aim which was to lower the unit cost of services, instead it has damaged public services and has resulted in the 'aggrandisement of management', and has produced a 'performance indicator industry'. Hood (1991) argues that the practices of 'top-slicing' and creative accounting have destabilised the necessary bureaucracy of public services and has redirected resources away from the 'frontline' of service delivery. It suggests that the main beneficiaries of NPM are an elite group of 'new managers' whose careers have been built on its implementation.

Not least of all the criticisms is that public organisations are different forms of organisation with different objectives and purposes than private sector profit orientated business organisations (Newman and Clark 1994). Success for private sector organisations depends on the ability of managers to maximise financial performance, they must be profitable and economically efficient to survive in the market place. Ultimately, private sector organisations are accountable to shareholders. On the other hand, public organisations are created by government for political purposes including the provision of public services. They are accountable to political representatives, the law, and ultimately, the general public for achieving their objectives. Measuring their success is more ambiguous than it is for private sector profit making business and cannot be reduced to 'bottom-line' profit or loss (Farnham and Horton 1996).

Dunsire (1973) observes that public organisations have to achieve a balance between resource efficiency and goal effectiveness. Policy tests imply a qualitative judgement about goals and their priority and it is politicians who decide on both the goals and the resources to be allocated to achieve them. There is no objective way of determining the right policies or the right amount of resources it is a political choice, in the private sector this is achieved by supply and demand and the price mechanism. Traditionally

public sector management systems have emerged out of administrative systems, whilst in the private sector the reverse is the case. These observations and criticisms raise the fundamental question, is NPM an appropriate vehicle for achieving the purpose and objectives of public services?

2.3 Managers, Professionals and Managerialism.

Farnham and Horton (1996) observe that 'managerialism' is an ideology which is directive and potentially authoritarian. It is not based on a philosophy of management by consent. It is an 'elitist' view of management emphasising the managers 'right to manage' in a sector where professional groups have traditionally dominated in the management of services. Newman and Clark (1994) observe that the ethic of public service depends on bureaucratic procedures and unquestioned professional expertise which are undermined by the new approaches to management.

Ackroyd, Hughes and Soothill (1989) observed that professionals resist the implementation of bureaucratic control strategies, preferring a 'custodial' or professionally determined line management. Mintzberg (1983) described the structure in which professional workers have traditionally dominated public services as a 'professional bureaucracy'. Work is complex and requires the application of expert specialist knowledge, skills and tacit judgement on a daily basis. Professionals have considerable control over their work and operate independently from their colleagues without direct managerial supervision. The 'professional bureaucracy' emphasises professional authority with standards for work set externally by independent professional bodies rather than internally by managers. This is set in sharp contrast to Mintzberg's (1983) 'machine bureaucracy', where work is more routine, procedures more formalised, where there are rules, regulations, formalised channels of communication, centralised decision making power and close supervision of work by managers.

NPM criticises the 'professional bureaucracy' on a number of counts. Public choice theorists are concerned about the monopoly power held be professional groups within the 'professional bureaucracy'. This is perceived to distort the market and to result in

'producer capture' where services promote the interests of professionals rather than service users. (Alaszewski 1995). Managerialist critics on the other hand highlight the failure of the 'professional bureaucracy' to deliver efficient services. Collegial forms of organisation are perceived as,

> '.....impediments to the development of rationalised managerial control.' (Ackroyd 1995:6)

Kitchener et al (2000) observe that 'professional bureaucracies' are also criticised for their focus on operational management rather than strategic management, and for their perceived failure to respond to change in the external organisational environment. Professional front-line staff are believed to exercise too much discretion without a necessary concern for budgeting constraints and other organisational priorities.

NPM with its emphasis on strategic management, human resource management, performance management, leadership and cultural control mechanisms directly challenges the approach of 'professional bureaucracies' to supervision. It also uses 'hybrid practitioner managers' to monitor and control professional work. (Exworthy and Halford 2002; Ferlie et al 1996; Kitchener et al 1999; Kitchener et al 2000). NPM presents a more bureaucratic form of control, similar to Mintzberg's (1983) 'machine bureaucracy' described above, placing greater emphasis on standardised practices and establishing clear measurable performance targets for individual professionals (Pollitt 1993; Hoggett 1996).

Exworthy and Halford (2002) suggest that it is to be expected that the result of the application of NPM techniques would be conflict between professionals and managers over power, status, authority and over how services should be run, although there is now evidence of greater co-operation and collaboration between these traditional antagonists. Three key lines of argument are present in the literature in relation to this. Firstly, that the professions are becoming 'deprofessionalised' as they lose their cultural authority in terms of prestige and trust (Haug 1973; 1975; Starr 1982). Secondly, the professions are becoming 'proletarianised' as they lose their independence and become increasingly subject to the rules of management (Mckinlay and Arches 1985 and Mckinlay and Stoeckle 1988). Finally, that the professions fragment internally as a result of greater

specialisation within professions, especially the separation of administrative professionals and 'rank and file' practitioners, and the bureaucratisation of professional bodies in an attempt to strengthen the credibility of professional self-regulation. The professions experience a form of internal 'restratification' (Friedson 1985; 1986). This debate is central to my thesis and is returned to as the main focus of the literature review in chapter four.

2.4 The National Health Service (NHS) and New Public Management.

The National Health Service (NHS) was established in 1948 to provide healthcare according to clinical need free at the point of use. It was to be funded by central government out of general taxation. Since that time this has resulted in a political tension between the desire to provide a high quality service and the need to constrain public expenditure. This is exacerbated by an unwillingness of governments to raise taxes, growing public expectations, scientific and technological advancements in medicine, and a rising proportion of elderly people in the population using medical services. In common with the experience of other OECD countries and other UK public services this has resulted in the application of NPM techniques in the NHS. In turn this has resulted in a tension between NHS managers and the medical profession exercising their professional autonomy. (Corby 1999)

2.4.1 Background to Establishment.

Ham (1999a) provides a detailed account of the lead up to the establishment of the NHS. Throughout this process a clear commitment to the continued professional autonomy of doctors was demonstrated by the government. The 1911 National Insurance Act had been a key part of the then Liberal government's programme of social reform. This provided groups of working people earning under £160 per year with free care from general practitioners (GPs). There were also sickness payments and unemployment pay made available. There had however been great opposition from the

medical profession, concerned about the potential this presented for the state to control its work. GPs only co-operated after an agreement was reached, that their payments would be based on a capitation system rather than a salary, thereby protecting GP independence. GPs were also offered a choice about whether or not to work for the NHS. Generous levels of payments were agreed for GPs and high-level earners in the population were excluded from the scheme, securing potential additional income for them. The main criticism of the scheme was that only insured people were covered and not their families and hospital care was not included.

Ham (1999a) reports that responsibility for the provision of healthcare services had increasingly been taken on by the state. The Dawson Committee set up by the Ministry of Health recommended the provision of a comprehensive system of primary care and hospital services. Reports from the Royal Commission on National Health Insurance in 1926, The Sankey Commission on Voluntary Hospitals in 1937 and the British Medical Association in 1930 and 1938 all criticised the existing services and made various suggestions for change. These included the greater need for the coordination of hospitals and the need for health insurance to cover additional groups of the population. The Royal Commission's report suggested that health service funding might be derived from general taxation instead of insurance. The BMA suggested that health insurance should be extended to cover the whole of the population and that insurance should also cover hospital services. The Beveridge Report on Social Insurance and Allied Services in 1942 proposed reform and extension of the social security system along with proposals for a National Health Service (NHS). In 1944 a white paper was published proposing a NHS. Harrison (in Exworthy and Halford 2002) observes that commitment to professional autonomy for the medical profession was a key feature of the white paper which stated,

> 'Whatever the organisation, the doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way they feel to be best.' (Ministry of Health 1944:26, quoted in Exworthy and Halford 2002:51))

The National Health Services Act was passed in 1946 and the National Health Service was established in 1948.

In the negotiations leading to the establishment of the NHS the medical profession worked hard to achieve its own objectives and achieved many concessions. Retention of independent contractor status for general practitioners (GPs), the option of private practice and access to pay beds in NHS hospitals for hospital consultants; distinction awards with related increases in salary for consultants and a leading role in the administration of the service. During the process of negotiation, Bevan divided the medical profession, winning the support of hospital consultants, who became employees of the service in return for high financial incentives. GPs were isolated but successful in maintaining their independent contractor status (Dopson 1997; Harrison in Exworthy and Halford 2002).

2.4.2 The NHS 1948-1979.

Harrison et al (1992) observed that in 1948 the NHS comprised a tripartite structure including general practitioners, dentists, pharmacists and opticians, who were self-employed practitioners contracting their services to the NHS; hospital services; and local government responsible for ambulances, health visiting and child welfare and preventative services.

The country was divided into 19 then 20 regions controlled by Regional Hospital Boards (RHB) responsible to the Health Minister. Reporting to the Health Minister were groups of hospitals managed by a Hospital Management Committee (HMC) of part time appointees many of whom were doctors (Harrison 1988). Doctors were not employed by HMCs, but by RHBs, thereby protecting their professional autonomy and freedom of speech from managerial challenge, and were the most powerful group from the outset. The contract included the right for consultants to engage in private practice and gave them a right of appeal to the Secretary of State against dismissal (Harrison et al 1992).

General practitioner, dental, and ophthalmic services were administered by Executive Councils (EC) appointed by Local Authorities (LA) and the Ministry of Health, and were also funded directly by the Ministry. Ham (1999a), highlighted that in no sense were ECs management bodies, but merely administered the contracts of family

practitioners, maintained lists of local practitioners and dealt with complaints by patients. In this way the professional autonomy of GPs as independent contractors was also protected. (Ham 1999a; Harrison et al 1992)

Lewis (1998) observes that in 1965 GPs demanded a new contract with the NHS, complaining about poor pay in relation to hospital consultants. They wanted the state to intervene to limit their hours of work and the services they offered by making some of them chargeable, and to provide more fringe benefits. They also highlighted that their existing contract provided no incentive to improve practice premises or to engage in continuing education. At the same time GPs firmly defended their status as independent contractors, on the grounds that they needed to safeguard their relationship with patients by limiting state interference. The state granted the GPs demands when they threatened to resign 'en masse' from the NHS.

Ham (1999a) reported that the next significant development in general practice occurred in the late 1960s with the growth in health centres and group practices and the emergence of the primary health care team. Another important development was the distribution of GPs between different parts of the country overseen by the Medical Practices Committee (MPC), set up under the 1946 National Health Service Act. The Committee had no power however, to insist that GPs work in specific locations. In 1966, Area Allowances were introduced as a financial incentive to attract doctors to less well provided areas. There were however still problems of quality and coverage of general practitioner services.

The NHS was restructured in 1974 removing the Local Government element of the NHS, and creating 14 'Regions' in England, divided into 90 'Areas'. Around half the 'Areas' were divided into two or more 'Districts' based on the location of a district general hospital. Regional Health Authorities (RHA) and Area Health Authorities (AHA) were set up as statutory corporate bodies, whilst district level was purely administrative. (Corby 1999).

At each level there were multidisciplinary management teams who were to make decisions by consensus, doctors, each with a power of veto held half of the membership in these teams (Harrison 1982; 1988). General practitioners maintained their independent contractor status, but were brought under family practitioner committees (FPC) accountable to the AHA. Community Health Councils were established in each district to represent the views of the local population. (Corby 1999).

Dopson (1997) suggests that this reorganisation had four aims, to unify health services under one authority, to provide better co-ordination between health authorities and related local government services, to improve the management of the NHS and to provide central control of expenditure to ensure 'value for money'.

Ham (1999a:21) reports that,

> 'Management Arrangements for the Reorganised NHS' (the Grey Book), set out the functions of each of the tiers in the new structure, and the medical profession was given a key role in the management system. There was to be 'maximum delegation downwards, matched by accountability upwards'.

Dopson (1997), drawing on the work of Draper, Grenholm and Best (1976) questioned how the new mechanistic command and control structure could accommodate the complex pressures on the provision of healthcare, and that the reorganisation represented a move away from the principles on which the NHS was founded towards a more authoritarian, top-down bureaucracy.

Harrison (in Exworthy and Halford 2002) observed that the commitment to the professional autonomy of the medical profession in the 1974 reorganisation was still present. The Labour government stated that,

> 'The service should provide full clinical freedom to the doctors working in it.' (DHSS 1970:29, quoted in Harrison 1999).

Whilst the Conservative government specified that,

> 'Professional workers will retain their full clinical freedom.....to do as they think best for their patients'. (DHSS 1972a:vii, quoted in Harrison 1999)

And then in a further document,

> 'Management plays only a subsidiary part....it can help or hinder the people who play the primary part.' (DHSS 1972b:9, quoted in Harrison 1999)

Arrangements for employing and organising medical staff remained free from subordination to management at local level. Hospital consultant's contracts continued to be held at a strategic rather than operational level, and they still had the right to engage in private practice and to appeal directly to the Secretary of State against dismissal. General practitioners remained self-employed contractors, and largely isolated from the rest of the NHS, their contracts being held by separate public bodies and only vaguely specifying their terms (Harrison and Smith 2003).

Harrison (1988) concludes NH services were created as an aggregate of individual clinical decisions. Managers were reluctant to question medical decisions in relation to the pattern of services or to propose changes to them.

> 'Managers neither were, nor were supposed to be influential with respect to doctors.... Managers in general worked to solve problems and to maintain their organisations rather than to secure major change.' (Harrison 1988:51).

2.4.3 The NHS 1979-1997.

A Conservative Government was elected in 1979 and challenged the existing Keynesian approach to the welfare state. It pursued a programme of privatisation of state owned enterprises, reductions in some taxes and introduced controls over public spending. It was perceived that public services, including the NHS, should be made more efficient

and that the best way to achieve this was to emphasise managerial priorities (Ham 1999a).

A reorganisation took place in 1982 when the 'Area' level was eliminated from the structure. 'Regions' were retained, and 190 District Health Authorities and 8 Special Health Authorities were created. In 1981 the Family Practitioner Committees were given the status of employing authorities in their own right. In 1983 performance indicators were introduced which facilitated the comparison of health authorities on the basis of value for money. 'Manpower' targets were also set for all staff. Health Authorities had to participate in competitive tendering for laundry, domestic and catering services (Corby 1999).

2.4.4 The Griffiths Report.

The most significant policy during this period was the introduction of general management resulting from the Griffiths Report published in 1983. In effect the Griffiths Report signalled the overt application of private-sector management techniques in the NHS. Roy Griffiths was deputy chairman and managing director of the supermarket chain, Sainsburys. Griffiths was asked to advise on the effective use of resources in the NHS. The five areas of alleged weakness identified by Griffiths and his team were a lack of strategic central direction, a lack of individual managerial responsibility, a failure to use objectives as a guide to managerial action, a neglect of performance and a neglect of the consumer (Hunter et al 1988; Dopson 1997)

The report recommended that general managers should be appointed at all levels in the NHS to provide leadership, motivation and continual improvement. The general manager was to become the final decision maker for decisions previously made by consensus teams to avoid the delay created in the past by failure of the teams to reach an agreement. Hospital doctors were to accept the management responsibility that went with their clinical freedom and professional autonomy, and to participate fully in decisions about priorities. Centrally, the NHS was to be strengthened by the establishment of a Health Services Supervisory Board and an NHS Management Board

with the chairperson being appointed from outside the NHS (Dopson 1997; Ham 1999a).

Harrison and Ahmed (2000:132) observe that the replacement of consensus management with general management represented a major defeat for the medical profession. They quote the BMA writing to the Secretary of State,

> ' It could be interpreted from the report (Griffiths) that a somewhat autocratic 'executive' manager would be appointed with significant delegated powers, who would – in the interests of 'good management' – be able to make major decisions against the advice of the profession .... it should be clearly understood that the profession would neither accept nor co-operate with any such arrangement- particularly where the interests of patients are concerned.' (BMJ 288, 14 January 1984:165).

Despite this, the recommendations of the Griffiths report were implemented. As well as the setting up of the Boards, and the appointment of general managers, budgeting systems, performance indicators, and structures relating to the management of clinical workloads were introduced. A number of the management posts were taken up part-time, by doctors (Dopson 1997; Packwood et al 1991; 1992).

Harrison et al (1992) suggest that a review of empirical work from 1984-1990 suggests that whilst medical professional domination had been challenged by Griffiths there was little loss of professional autonomy as a result. Packwood et al (1991; 1992) observed another effect of the Griffiths reforms, managers became more externally focused responding more to the government's agenda than to the professional agenda. Harrison et al (1992) conclude that by 1985 there was no longer any medical pressure to return to consensus management. General managers in the NHS had achieved legitimacy and substantial influence.

2.4.5 The Internal Market.

Against the backdrop of an increasing public funding crisis, the Griffiths report had laid the foundation for the introduction of the internal market in 1991.This was underpinned

by the rationale that private sector markets would lead to greater efficiency. Ham (1999a) argues that this was made easily possible because of the previous appointment of large numbers of Chief Executives in the NHS who were receptive to NPM policies, and the greater involvement of the medical profession in management. All Trusts were to have a medical director, and many had internal organisation structures built around 'clinical directorates' headed by consultants working closely with senior managers. Harrison and Pollitt (1994) state that this was an attempt to use doctors to 'manage' other doctors and to encourage them to think more in managerial terms, by placing budgetary constraints on them.

Many authors (Fitzgerald 1994; Llewellyn 2002) highlight the doctor/manager role as significant in the manager/professional relationship in the NHS. Llewellyn 2002 :594) argues that medical directors occupy a boundary role, and exhibit 'Janusian' thinking, 'they constructively join two sets of traditionally opposed ideas.' (2002:596). Clinical directors act as a channel of information to other medical professionals and have some control over how management ideas and priorities are communicated to them. Llewellyn (2002) also observes that managers do not have access to or are able to control ideas of medical professionals,

> 'Clinical directors straddle the whole organisation, whilst managers cannot comment on clinical matters or professional conduct' (2002:596).

Harrison (in Exworthy and Halford 2002) observes that the use of doctors as managers along with access to aggregate medical audit data made it easier for managers to challenge doctors over their use of resources and service priorities. Ham (1999a) suggests doctors are made more accountable for their performance by involving managers more in the management of clinical activity. Managers were also to take part in the appointment, and drawing up of job descriptions and the reward management for consultants. Disciplinary procedures were to be implemented for hospital doctors. Resource management was extended and there was to be greater use of clinical audit in hospitals. Doctor's contracts were now to be held locally by the Trust bringing consultants more within a traditional bureaucratic hierarchy and curtailing any public criticism they might make about the NHS. The right to appeal to the Secretary of State in relation to dismissal was also eventually lost.

The White Paper, 'Working for Patients' was published in 1989. This laid out the basis on which health services would be delivered. The market was based on a split between healthcare purchasing and providing organisations. Provision of services was the function of Trusts, independent of health authority control, in a contractual relationship for patients, with either the health authority or general practitioner fundholders(GPFH). In addition management arrangements were to be further strengthened at central and local levels. In the New Department of Health, the Supervisory and NHS Management Boards were to be replaced with a Policy Board and NHS Management Executive. Locally, managers were to sit as members of local authorities along with a small number of none executive directors appointed for their personal contribution not because they were drawn from designated organisations (Harrison and Ahmed 2000).

In the case of primary care, Family Health Practitioner Committees were to be replaced by Family Health Services Authorities. These were also to appoint general managers to sit as members of the authorities along with four members drawn from the health profession, five non-executive directors and a chairperson. Non-executive members of all these structures were to be paid in order to attract talented individuals to theses roles. (Haml999a). Warwicker (1998) suggests that these changes transformed the FHSA from an administrative body to a managerial authority to which for the first time in their history, GPs would become accountable.

Harrison and Pollitt (1994) report that GP Fundholding was introduced on a voluntary basis. By 1996 over 30% of general practices in England were involved. GP Fundholders were allocated a budget to purchase secondary care services from NHS Trusts of their choice or from the private sector. Under-spending could be retained for reinvestment in the practice. Harrison and Ahmed (2000) refer to the empirical work of Harrison and Choudhry (1996) which indicates that GP fundholders had been willing to move some specialist clinics into primary care, and that GP fundholding financial leverage had led to changed relationships with hospitals and hospital consultants. GP threats to re-allocate referrals had led to prompter pathology results, prompter patient discharge reporting, and the reduction of waiting lists. None of this had been the case for non-fundholding GPs. Glendinning (1999) argued that involving GPs in cost

containment strategies is particularly significant since they control access to and therefore in effect determine the levels of demand for expensive secondary care.

Glendinning (1999) reports that fundholding had provided the financial flexibility to allow GPs to develop the range of services offered by their practices. By the mid 1990s it had been extended to produce Multifunds and Total Purchasing Pilots. Multifunds allowed the collaboration of smaller practices enabling them to share management costs. Total Purchasing Pilots enabled GPs to manage budgets for the full range of community and hospital services, thus expanding services into new areas.

North and Peckham (2001) suggest that GP fundholding significantly changed the relative power base of GPs and hospital consultants. Fundholding meant that hospital clinicians could be accountable for their performance by their peers, but within a managerial rather than a professional context. On the other hand, fundholders were required to control their purchasing of hospital and community health services, prescribing and practice costs within a fixed budget, with the incentive of being allowed to retain savings from cost efficiencies for re-investment in the practice.

Harrison (1999) reports that, as in the case of the Griffiths reforms, the government faced opposition from the BMA in relation to the proposed new internal market.

> '(The BMA) ..... does not believe that the changes proposed would achieve (the government's stated) aims. Indeed it is convinced that many of the proposals would cause serious damage to NHS patient care, lead to a fragmented service and destroy the comprehensive nature of the existing services. The government's main proposals would appear to contain and reduce the level of public expenditure devoted to health care. The proposals would undoubtedly increase substantially the administrative and accountancy costs of the service, and they ignore the rising costs of providing services for the elderly and of medical advances. In the absence of any additional funding the proposals would inevitably reduce the standards of NHS patient care (BMA 1989:2, quoted in Harrison 1999).

The government, as had been the case with the BMA's objections to the Griffiths proposals, pressed on with implementation. The BMA ended its campaign against the proposals in June 1992. Harrison and Pollitt (1994) and Harrison (1999) observe that the possibility (if not the event) of 'provider competition' within the internal market served to some extent to unify the professional managerial relationship within hospitals. The necessity to calculate the cost of services and general cost pressures made the activity of medical professionals more transparent. The mutual interests of organisational survival and growth ensured a degree of co-operation between the two groups.

In the case of primary care, the White Paper, 'Promoting Better Health' published in 1987 proposed a new contract for GPs and dentists. The contract for GPs was published at the same time as 'Working for Patients' and came into operation in 1990. The contract required health checks for new patients, three yearly checks for patients not otherwise seen by GPs, and annual checks of patients aged 75 and over. Targets were set for cervical cancer screening and vaccination immunisation, the provision of health promotion and chronic disease management clinics were encouraged along with the possibility of GPs engaging in the provision of minor surgery, GPs were also expected to become involved in child surveillance. There were extra payments offered for GPs agreeing to work in deprived areas, and additional money for the employment of practice staff and to improve practice premises. Practices were requested to produce annual reports of their activities and a practice leaflet for patients. Procedures for patients changing doctors were simplified. Income from capitation payments was increased from 46% to 60% to encourage GPs to provide the services demanded by patients. (Ham 1999a)

Warwicker (1998) observes that there were several modifications made by central government on the contractual obligations of GPs. In 1993 the health promotion clinics were discontinued on the basis that they had created a 'clinics industry', resulting in disproportionate payments going to some practices with little evidence of improvement in performance measures. Clinic fees were replaced with banding which in exchange for an annual fee required GPs to provide an annual programme of health promotion. A second modification was the removal of the obligation to carry out three yearly checks.

GPs had put increasing pressure on the government stating that these checks were expensive and not effective. In 1996 there was a third shift in government policy, the banding scheme was removed, GPs only being required at the start of each year to submit a description of their proposed health promotion activities to a Health Promotion Committee which would recommend to the Health Authority to approve the activities for payment. These changes represent a shift from GP obligation to provide services, to giving them more discretion, and from having to provide extensive data on the health of patients to only an indication of activities and minimal data on patients.

Warwicker (1998) states that the 1990 GP contract failed to 'manage' GPs. There was a lack of scientific evidence and rationality behind the required health promotion activities. The FHSA had not 'managed' and 'monitored' GPs to ensure they met their contractual obligations. GP professional autonomy and their independent contractor status did not fit well with the government's 'managerialist' model. Warwicker (1998) concluded that the contract failed because of incoherence of government policy. On the one hand there was a commitment to reduce public expenditure on primary care by imposing NPM strategies on GPs to subordinate them and make them more accountable. On the other hand, its commitment to market forces, minimal Government-intervention and entrepreneurship, had transformed GPs into entrepreneurial small business managers and they behaved accordingly.

The contract was also criticised for its failure to directly address inequalities in general practice and the integration of GP services with other community based health services. The contract contained minimum performance indicators and quality assurance mechanisms (Glendinning 1999). Nevertheless, Rivett (1998), suggests that the contract was an attempt to exert managerial accountability over the levels and quality of services offered by GPs, and introduced an element of performance related pay using specified screening and health promotion activities as performance indicators. The contract represented an attempt to 'manage' areas of clinical activity, challenging the professional autonomy of GPs.

Lewis (1998) notes some interesting contrasts between the circumstances of the 1965 and 1990 GP contracts. In 1965 GP morale was low, but they emerged successfully

from negotiations with their demands for higher pay and better working conditions met, and their professional autonomy endorsed by the government. In 1990, morale was high but the government succeeded in imposing a new contract on GPs increasing their accountability. In 1965 GPs saw their independent contractor status as a means of protecting their professional autonomy, but in 1990, it was the means by which the government secured more specific terms of service from GPs.

Harrison (1999) reports that during 1996 there were a series of Green Papers published (DoH 1996a; 1996b and 1996c) documenting a series of problems with the NHS. The 1990 GP contract had not assured quality and was difficult to enforce. The internal market had created inequalities of levels and quality of service provision geographically. Funding mechanisms were inflexible and unresponsive to variations in local healthcare needs. In particular the separation of the general medical services budget and the community health services budgets were problematic for purchasing or providing integrated services which crossed the GP/NHS Trust divide. The NHS (Primary Care) Bill received royal assent just before the May 1997 general election. The Act introduced an option for the introduction of salaried GPs to assist in attracting GPs to areas where services were poor. It was anticipated that salaried GPs would facilitate greater flexibility in the roles and responsibilities of different medical professionals. If GPs were salaried and had a common and equal status to nurses and other healthcare professionals as employees of a provider organisation it could be easier to substitute nurse run services for general medical services currently provided by GPs.

The Act also allowed for the pooling of the GMS and HCHS budgets providing greater flexibility to meet local needs. Three types of projects to implement these were operational from April 1998. Individual 'salaried GPs' employed by the Local Health Authority with a contract to provide a specified range of services. 'Personal Medical Services '(PMS), which was a contract between a practice and the Health Authority to improve the range and quality of services. 'PMS plus' projects, which were personal medical services and an extended range of medical services. Cash-

limited GMS and HCHS budgets were linked in a single contract to provide an additional range of services than GPs would provide under their individual GMS contracts. (Glendinning 1999).

Glendinning (1999) concludes that the 1997 Act marks a transition from general practice to primary health services. It provided the organisational and financial framework to facilitate coherent primary health services. It is recognised however, that the professional autonomy of GPs is challenged by providing the opportunity to build both clinical activities and performance targets into individual employment contracts or organisational service contracts. It also provides Health Authorities with managerial levers in the form of financial incentives and sanctions to control the range and quality of primary health services including those provided by GPs.

2.4.6 The NHS from 1997 'The Third Way'

In 1997 The Labour Government was elected and set about developing its own policies for the modernisation of the NHS. This was labelled 'the third way' because it was to be different to both the centralised planning implemented by previous Labour governments and the internal market implemented by the previous Conservative government. Less emphasis was to be placed on competition and more on partnership. There was a commitment to maintaining the separation of purchasers and providers with a focus on holding providers to account for their performance rather than as a means of promoting competition.

It was proposed to abolish GP fundholding because of its expense and inequity, and to replace it with GP commissioning. Annual contracts were to be replaced with longer term health care agreements. Variations in performance were to be reduced by new national service frameworks (NSFs) and a system of clinical governance. GPs and other primary healthcare staff were to be free to make resourcing decisions at the local level to improve services for patients. There were to be a wide range of incentives to increase efficiency and raise standards, and sanctions for poor performance. These proposals represented a ten year plan to modernise the NHS. The government committed to

continue to fund the NHS through taxation and to increase spending on the NHS in real terms every year. (Ham 1999a)

GPs were required to work within the framework of a Primary Care Group/ Trust (PCG/T) which was charged with co-ordinating local healthcare organisations, including general practice, in the provision of local primary healthcare services. 36000 GPs were organised into 481 PCGs in England, responsible for the commissioning of services and for working with Social Services to produce the Health Authorities Health Improvement Plan. Each PCG covered a local population of around 100,000 patients, and was accountable to the Health Authority (Horton and Farnham 1999).

McIntosh (2000) reports that initially GPs threatened to not co-operate with PCG/Ts, refusing to accept Boards of Directors similar to Health Authorities and Trusts, with lay members and chairs appointed by the government. Negotiations between the BMA and the Secretary of State followed, leading to concessions on the composition of the PCG Boards. GPs were allowed to make local decisions as to whether they wished to be in the majority on the Boards. They were also allowed to choose whether a GP would be the chair of the Board. In most cases they chose this to be the case. MCIntosh (2000) suggests that this was a major extension of professional power, and an opportunity to reclaim power from NHS managers. PCG Boards thus comprised four to seven GPs and one or two nurses selected by their colleagues, one social services representative, a non-executive director and a lay member appointed by the Health Authority. Other primary care professionals could also be co-opted onto the Board as non-voting members. McIntosh (1999:11) highlighted that the National Association of Primary Care Survey demonstrated that GPs felt threatened and unsupported by PCGs, and previous fundholders believed their independence had been reduced.

Sheaff et al (2003) note that as GPs continued to be protective of their independent status, and avoided the prospect of salaried employment, there was no possibility of these organisations being anything other than local professional networks. PCG/Ts lacked the governance structure of conventional bureaucracies. General practices remained organisationally independent of the PCG/T working under contract to the

Department of Health, and reimbursed by the PCG/T for most of their spending on staff and buildings

It was intended that PCGs would eventually be transformed into PCTs. The first seventeen PCTs were operational in April 2000, followed by a second group by October of the same year. All PCGs were to become PCTs by April 2002, although the initial transitions were to be voluntary (North et al 1999). PCTs are statutory bodies controlling around 80% of expenditure on local hospital and community health services. PCT are required to control access to and develop secondary services, community nursing and care of the elderly. PCTs can invest in premises, buy or construct community hospitals, purchase facilities and employ doctors directly. There is a Trust Board and a Professional Executive Committee (PEC). The Board's role includes determining the pay of executive members, preparing proposals for expenditure on general medical services (GMS), and is responsible for the overall performance of the Trust. There is a chair and five lay members appointed by the Health Secretary, and three professional members. This structure is different to the structure of the former PCGs. It attempts to balance the influence of managers and clinicians supervised by lay members. The PCT Chief Executive is appointed by the Board. The Chair of the Board is a lay person, whilst the chair of the Executive Committee is usually a GP. The PEC is responsible for setting priorities, investment plans, reviewing services and implementing decisions (McIntosh 1999).

Whilst transition from PCG to PCT status was at first voluntary, it was unlikely that this would be agreed without the support of the relevant GPs. The BMA suggested that GP support should be confirmed by a ballot. A minimum of 80% GPs should have voted, with two thirds supporting a transition before it should go ahead. The Royal College of GPs (RCGP) stressed PCG's interests should be justified by tangible benefits that would come from PCT status. There would be greater responsibilities for corporate and clinical governance increasing the pressure on PCT managers to ensure that individual practices and other teams within the PCT stayed within budget and were accountable for the standards of services provided. In reality, GPs have been unable to prevent transition (Beecham 1999). Furthermore, Glendinning (1999) observes that GPs will be unable to

hide behind a distant Health Authority for their prescribing and referral decisions and that they will be centrally involved in priority setting and resource allocation decisions.

Mahmood (2001) argues that PCTs are in effect an extension of management control over GPs because their status in a PCT is different to what it had been in a PCG, the medical majority on the Board having been removed. Fewer doctors on the Board reduce their ability to influence PCT decisions. This may not be an issue if there is agreement over objectives and how to achieve these.

The key observation of 'the third way's' impact on medical professional autonomy relate to the implementation of clinical governance and are discussed in the next chapter. Harrison (in Exworthy and Halford 2002) however, generally observes that 'third way' reforms will lead to a redistribution of autonomy within the medical profession with the advent of a primary care led NHS. Although it is possible to overstate the professional independence of GPs working in the NHS, because their terms and conditions of work are heavily regulated by the government, there is a belief that the shift in power to them represents a move away from the international trend of the 'corporatisation' and 'bureaucratisation' of medicine. In April 2004 a further new General Medical Services (GMS) contract was implemented. This is also discussed in the next chapter.

The discussion in this chapter demonstrates that the relationship between medical professionals and NHS managers has been a dynamic one during successive reorganisations of the NHS. Overall, Kitchener et al (2000) evaluating the consequences of the application of NPM in the NHS suggest that the service has become more financially driven, transparent and accountable. There is a greater emphasis on assessing the cost of services and rationing of services on this basis. Performance management systems and clinical audit have increased the ability of managers to monitor and control the work of 'front-line' professional workers. The medical profession has suffered significant defeats, particularly in relation to the Griffiths proposals and the introduction of the internal market.

Kitchener et al (2000) observe however, that in spite of the defeats professional workers have continued to exercise a high degree of tacit control over service delivery. Bureaucratic rules and regulations are not always implemented, performance management data is not always collected, and where it is, it is not always used systematically in the continuous improvement of services. Referring to the work of Ackroyd et al (1989), Kitchener (2000) suggests that 'custodial' (professionally determined) approached to service provision still retain a key influence in the NHS.

2.5 Conclusion.

This chapter has defined and explored the concept of New Public Management which is rooted in a combination of 'public choice theory' and 'new managerialism'. NPM does not have a conceptual foundation of its own but micro economics, law and organisation theory are useful disciplines for explaining the practices of NPM. The focus of NPM is to slow down the expansion of public spending and to encourage private sector investment in services previously provided only by the public sector. NPM uses private sector management philosophy and practices in an attempt to improve the quality and efficiency of public services, and to curb the power of professional workers within the services. NPM has been heavily criticised by many, particularly in relation to its relevance to the management of public sector organisations which have different purposes, goals and criteria for and measures of success than private sector business. The strategies, structures and culture of NPM present a clear challenge to 'professional bureaucracy' which has been the traditional means by which the professions have dominated public sector services.

The chapter has traced the emergence of the English NHS and the various approaches to the management of the service have been reviewed, including the application of NPM in the last three decades. Throughout, the focus has been on general practice and the impact of NPM on the autonomy of the medical profession. There is evidence to suggest that NPM practices have steadily eroded the autonomy of the medical profession (Haug 1973; 1975; 1993; Mckinlay and Arches 1985; Mckinlay and Stoeckle 1988). The employment of doctors in managerial type roles, suggests that there may have been a

restratifucation of professional autonomy within the medical profession rather than an overall decline in its power (Friedson 1985; 1896).

Clinical governance with its roots in TQM has been described as the most recent manifestation of NPM in the National Health Service (Flynn 2002). The next chapter provides a detailed account of clinical governance to support the analysis and discussion of the results of my research presented in chapters six and seven of this thesis.

Chapter Three

Clinical Governance

'The introduction of clinical governance in the National Health Service in England represents a fundamental shift in the relationship between the state and the medical profession.....It is also a response by the state to the increasing problems with the regulation of expertise in an era of heightened consumer awareness of risk.' (Flynn 2002:155)

3.1 Introduction.

This chapter is the second of two chapters providing the contextual backdrop to my study. It explores the concept of clinical governance, reviews existing medical attitudes to clinical governance, considers the potential impact of clinical governance on the autonomy and self-regulation of the medical profession and examines the new General Medical Services (GMS) contract as a means of reinforcing the implementation of clinical governance in general practice.

Clinical governance has been described as the latest phase of managerialism in the National Health Service, and represents a potentially significant increase in managerial control of the medical profession (Flynn 2002). It is not an entirely new concept but combines a range of existing processes of healthcare management. These include multi-professional clinical audit, evidence-based practice, clinical supervision, management learning from complaints and adverse incidents, continuing professional development, patient/user feedback systems, clinical performance management and the collection and analysis of data for monitoring clinical care. In addition, clinical governance requires a complete change in organisation culture, systems and staff behaviour (Swage 2000).

Clinical governance has emerged against a backdrop of highly publicised medical failures or malpractice including, the Bristol Heart Surgery Inquiry, the unauthorised

use of children's organs at Alder Hey hospital, mistaken diagnosis in breast cancer screening services at Canterbury Hospital and the murder of numerous patients by GP Harold Shipman. Clinical governance represents the state's response to public concerns and is a clear attempt to regulate the work of the medical profession presenting a direct challenge to medical professional autonomy (Flynn 2002)

Clinical governance incorporates the setting of national standards of care through 'National Service Frameworks' (NSFs) via a new organisation, the National Institute for Clinical Excellence (NICE); continuous quality improvements based on clinical standards and evidence-based practice; monitoring of progress through another new organisation, the Commission for Healthcare, Audit and Inspection (CHAI); a new survey of patient and user experience; and a system of modernised professional self-regulation, involving performance appraisal, life-long learning and the periodic revalidation of medical practitioners. This has been supported in primary care by the implementation of a new contract for general practitioners implemented in April 2004. These reforms have been referred to as 'neo-bureaucracy (Harrison 1999); as a form of 'soft governance' (Courpasson 2000) of the medical profession (Dent 2005); and as the most recent manifestation of New Public Management in the NHS (Flynn 2002).

3.2 What is Clinical Governance?

The Department of Health (1998b:33) presented clinical governance as a process that provides NHS organisations and individual health professionals with a framework within which to build a single coherent local programme for quality improvement. It is formally defined as,

> 'A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'.

Penny (2000) observed that the term 'clinical governance' was first used by the World Health Organisation in 1983 to summarise high quality care on four dimensions, professional performance, resource allocation, risk management and patient satisfaction.

Chandra Vanu Som (2004) explores a range of definitions of clinical governance and concludes that common to them all is the concept of an integrated approach to care, incorporating the patient experience and the co-ordination of diagnosis and treatment in the context of the overall environment. Drawing on the work of Martin (1994), it is suggested that 'integration' extends to organisational integration; and the co-ordination, co-operation and communication between units of the organisation involved in delivering quality care. Thus, clinical governance is designed to integrate and consolidate previously fragmented approaches to quality improvement in NHS organisations.

Chandra Vanu Som (2004) takes the main principles of clinical governance and develops a definition which takes into account health care organisational inputs, structures, processes and outcomes. The main principles of clinical governance are identified as clear lines of responsibility and accountability for the overall quality of clinical care; a comprehensive programme of quality improvement systems including clinical audit, application of evidence-based practice, implementing clinical standards and guidelines, workforce planning and development; education and training plans; risk management policies, and procedures for all professional groups to identify and address poor performance. Clinical governance is thus defined as,

> 'A governance system of health care organisations that promotes an integrated approach towards management of inputs, structures, and processes to improve the outcome of health care service delivery where health staff work in an environment of greater accountability for clinical quality' (Chandra Vanu Som 2004:89).

Flynn (2002) suggests that official NHS definitions of clinical governance are ambiguous and varied, but stress the necessity for improvements in quality and stronger mechanisms for professional self-regulation (DofH 1998: para 3.2). Flynn (2002:157) argues that clinical governance is,

> '.....a new model for marrying clinical judgement with national standards, in contrast both with previous central control of clinical judgement and patient needs of the late 1970s, and the laissez-faire system of competiton of the early 1990s.'

Hurst (2003) observes that clinical governance is based on a simple spiral model comprising the setting of quality standards, delivering quality standards, and the monitoring quality standards. The following three subsections explore these elements in more detail.

3.2.1 Setting Quality Standards.

'A First Class Service' (DoH 1998b:13) stated that high quality services for all, which would overcome previously unacceptable variations in the quality of care available to different NHS patients in different parts of the country, would be achieved through the development of national guidance based on reliable evidence of clinical and cost effectiveness. There were to be clear national standards set, defining what patients could expect to receive from the NHS. National Service Frameworks (NSFs) and clinical guidance would be developed through a new organisation, the National Institute for Clinical Excellence (NICE).

The National Institute for Clinical Excellence (NICE) was established in April 1999 with the status of a Special Health Authority (Harrison and Lim 2000). The remit of NICE was to promote clinical and cost effectiveness through guidance and audit. It would provide advice on best practice, on the use of existing treatment options and appraise new health interventions. This would result in the production of 'clinical guidelines' for the management of specific medical conditions, or recommendations to the Department of Health, that particular treatments should not be introduced without further trials. These clinical guidelines would feed into general practice and NHS computer information systems (DoH 1998b: 14-17). Whilst the application of NSFs and NICE guidance are optional for the medical profession, in the BMA News Review, (March 1999:16), the Chair of NICE advised clinicians to record the reasons for any non-compliance with guidelines in patient case notes.

National Service Frameworks (NSFs) would define pathways through primary, secondary and tertiary care which a particular type of patient might be expected to follow. Freedman (2002) observed that the aim of NSFs is to set out common standards across the UK and represents a positive attempt to implement continuous improvement of clinical care, reduce variations in clinical practice, improve patient access to services and to improve clinical outcomes.

'A First Class Service' (DoH 1998b:46-47) refers to 'modernised professional self-regulation' and encourages professional and statutory bodies to continue to set and monitor standards. Bodies that set guidelines include the General Medical Council, the General Dental Council, the Council for Professions Supplementary to Medicine and the UK Central Council. Klein (1998) observed that in the policy documents, there is a flavour that these guidelines are out of date and no longer reassuring to the public following the high profile media coverage of adverse professional practice. The (1998b) document made it clear that NICE would be working closely with these organisations in the future, along with the Audit Commission, the Health Service Commissioner, the Professional Royal Colleges, the Health and Safety Executive and Social Service organisations in setting and monitoring standards.

3.2.2 Delivering Quality Standards.

This part of the quality model is about ensuring that practitioners *apply* the national and local standards set, in their daily work. To reinforce the delivery of quality standards, 'A First Class Service' (DoH 1998b:32-49) highlighted clinical supervision, performance appraisal, continuous professional development and life-long learning, evidence-based practice, risk management and workforce planning.

Clinical Supervision and Performance Appraisal.

Van Zwanenberg and Harrison (2000:21) defined clinical supervision as:

> '....A formal process of professional support and learning that enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance consumer protection and safety in complex clinical situations.'

Van Zwanenberg and Harrison (2000) recorded the benefits of supervision as improved service quality for patients and stress relief for practitioners working in tense situations. It is noted however by Whitfield (2000), that implementation of clinical supervision is 'patchy,' particularly, among professionals working in isolation, for example, general practitioners. It is further reported that whilst nurses appeared to accept clinical supervision, medical practitioners were more sceptical, and, at the time, gave the General Medical Council a vote of 'no confidence', partly due to its plans for medical performance appraisal and revalidation.

'A First Class Service' (DoH 1998b: 36-37) indicated that practitioners would be expected to engage in systematic continuous professional development and life-long learning. 'Modernised' self-regulation would involve performance appraisal for medical professionals, including for the first time, general practitioners.

In (2003), Middlemass and Siriwardena reported that all general practitioners would be expected to have an appraisal, and to be professionally 'revalidated' every five years. This process would require general practitioners to provide evidence of their professional performance and continuous professional development. This evidence should reflect the basics of professional practice as set out in the General Medical Council's 'Good Medical Practice' performance standards. In other words, revalidation would be necessary for doctors to remain licensed to practise.

Continuous Professional Development and Life-Long Learning.

'A First Class Service' (1998b:41-45) outlined the main purpose and approach to continuous professional development and life-long learning in the context of clinical governance. It was stated that,

> 'the government would work with the professions to reach a shared understanding of the principles that should underpin effective continuous professional development, and the respective roles of the state, the professions and individual practitioners in supporting this activity' (1998:41).

Continuous professional development programmes should meet both the learning needs of individual professionals and service development needs of the NHS (1998b:42). Lifelong learning would be required to keep up to date with new technologies and new approaches to patient care to meet increasing public expectations of the NHS. The role of professional bodies in supporting continuous professional development was highlighted as influencing the standards of clinical practice, promoting professional self-regulation, supporting audit of practice and relating it to learning needs and promoting the value of lifelong learning to professionals. It was noted (1998b:43) that continuous professional development would be best managed locally in order to meet local service needs and those of individual practitioners. Professional and service needs were to be identified in a personal development plan, developed by individual professionals in discussion with colleagues (1998b:44).

Walshe et al (2000) identified a strong link between continuous professional development, life long learning, clinical governance and quality. The benefits of continuous professional development were found to be a raised awareness of contemporary medical issues, improved standards of care, and the meeting of the learning needs of practitioners. It was concluded that this was a positive contribution to well-developed services and the promotion of self-regulation.

Van Zwanenberg and Grant (2004) recently reported that, although doctors should continue to learn more about clinical medicine, they increasingly need to develop areas that are not clinical in nature. The examples cited are, information technology and management, audit and research skills and educational skills. It is noted that general practitioners increasingly share areas of their continuous professional development with other members of the primary healthcare team. Government guidelines offer a framework of continuous professional development that can be applied to all members of the primary care team and to the practice as a whole (DoH 1998b). It is recommended that each member of the primary care team should prepare a personal

development plan. This should record what the continuous professional development is to be, how it will be reinforced and disseminated locally to show how it is improving effectiveness. Individual performance development plans should then form part of a practice professional development plan ,which should address the learning needs of the whole practice, and which should link to national objectives and the practice strategic plan.

Evidence-Based Practice (EBP).

Implementing the evidence base provided by NICE in everyday practice is considered a key to the delivery of the Government's clinical governance agenda (DoH 1998b: 36).

Fitzgerald et al quoted in Mark and Dopson (1999:189) suggests that evidence-based medicine,

> '....involves the diffusion of evidence, particularly new or updated evidence, into clinical practice.....it includes complex processes of understanding, deciding, evaluating, communicating and agreeing.....it involves change and change processes.'

Wallace and Stoten (1999) reviewed evidence-based practice in a clinical governance context and concluded that it contributes positively to improved patient care, and provides tangible evidence about cost-effective new treatments. The challenges identified by the study were that since no new resources are available 'in the light' of evidence-based practice it increases the competition for existing resources. There was still found to be considerable professional resistance to implementing evidence-based practice, and information management and technology did not always support it.

3.2.3 Monitoring Quality Standards.

The final stages in the Department of Health's (1998b:51-68) quality model are the monitoring of quality standards. The government outlines three ways of addressing this, firstly, by establishing the statutory body, the Commission for Health Improvement (CHI, now CHAI) to provide independent examination of local attempts to improve

quality and to address poor performance. Secondly, by using performance indicators to assess the standards of care delivered by the NHS. Finally, by introducing a 'National Survey of Patient and User Experience', to provide comparable information on patient and user experiences.

CHAI. (previously CHI)

The Commission for Health Improvement (CHI), [now the Commission for Healthcare Audit and Inspection (CHAI)], was first established in September 1999 as a statutory body 'at arms length from the government' (D of H.1998b:51). Its mission is to provide national leadership of clinical governance and to support organisations in its implementation. CHAI makes regular visits to NHS Trusts and Primary Care Trusts (PCTs) every 3 to 4 years to ensure that local clinical governance arrangements are in place and working effectively, and that NICE guidance and NSFs are being implemented. In addition its remit is to identify good practice and to undertake external incident enquiries where necessary. CHAI works closely with statutory bodies in cases of under-performing clinicians, making public its recommendations where appropriate (DoH 1998b:51-62).

The National Performance Assessment Frameworks (NPAF) outline performance indicators against which CHAI, strategic health authorities and local commissioners are able to assess the performance of Trusts and PCTs, to ensure they are delivering effective local health services (DoH 1998:63 and DoH 1999:11). Performance indicators are set in relation to health improvement, fair access to services, effective delivery of appropriate healthcare, efficiency, patient / carer experience and health outcomes. (DoH 1998b:63). These are based on statistics collected from across the UK and league tables are produced on a regular basis, which are available to the public. (Walshe et al 2000:121).

More recently the Department of Health has published performance indicators for primary care organisations, and the first star ratings for PCTs based on these indicators, were produced in 2003. (www.chi.nhs.uk/eng/ratings/index.shtml).

The National Survey of Patient and User Experience and Complaints Procedure.

In addition to external accreditation, monitoring of quality of services takes place through the National Survey of Patient and User Experiences. This is designed to collect information about demography, illness and social issues, experiences of primary care and transition where necessary to secondary care (DoH 1999:12).

Bullough and Etchells (2004), report that good complaints procedures provide free information about PCTs and individual practices. These often forestall more serious disputes. These cost time and money and are very stressful for everyone involved. Every PCT and individual practices must now have a complaints manager and a complaints code of practice. It is noted that even non-clinical complaints can reveal serious difficulties within a practice which may then be addressed before there are more serious consequences.

Poor Performance.

Irvine (1999: 1174-7) the (then) president of the General Medical Council, outlined the duties of a doctor, which are in effect 'values' that doctors should demonstrate in their daily work. These include concern, courtesy, and respect for patients, providing understandable information, keeping professional knowledge and skills up to date, recognising the limits of professional competence, being honest and trustworthy, acting quickly to protect patients if it is believed that an individual (self or others) is unfit to practise and avoiding abusing the position of doctor.

Bullough and Etchells (2004) identify the main causes of poor performance. These are mostly in relation to doctors failing to keep up to date. It is noted that often doctors themselves are unaware of this problem. If others do not notice, or feel unable to comment, this often results in no remedial action being taken. Single-handed general practitioners working alone are perceived to be particularly vulnerable. Other factors such as physical and mental health, alcohol and drug abuse, poor working conditions and work overload are also identified. Bullough and Etchells (2004), note that although

Local Medical Councils (LMCs) have set up support mechanisms for general practitioners, traditionally, these have not been much used. However it is reported that newer doctors are more likely to use services such as confidential counselling, and are more aware of a new 'professionalism' that is developing within general practice. Components of this are identified as clear professional values; explicit standards; collective, as well as individual responsibility for standards of practice; local medical regulations based on team-working; systematic evidence of keeping up to date and of adequate performance; and effective systems of dealing with poor performing doctors. It is noted however, that there are a small number of doctors who are simply 'bad', for example, Harold Shipman, who may in clinical governance terms have appeared to be a 'hard working' 'committed' general practitioner!

In 2002 responsibility for poor performance was taken over by PCGs and PCTs. Taylor (2004) identifies the remedial measures that may now be employed in primary care as follows. PCT teams would be required to visit a general practitioner to discuss the perceived problems. Where health is deemed to be an issue, occupational health assessments are undertaken. In making an assessment teams may use methods to 'measure' performance and may possibly observe a GPs practice performance. The Royal College of Practitioners have developed a 'toolkit' for dealing with poor practitioner performance (www.rcgp.org.uk) to assist primary care teams in this process. Problems considered to be less serious are dealt with at local (PCT) level, with educational solutions. More complex situations may require an independent local educational assessment in more depth. This service is provided by postgraduate deaneries.

Taylor (2004) reports that the National Clinical Assessment Authority (NCAA) should become involved when more serious performance issues are identified, or where a doctor refuses an assessment. NCAA advisers are experienced clinicians or health service managers who support the PCT by providing advice and ensuring that local assessments take place. The PCT remains responsible however, for implementing the recommendations of an assessment. The Health and Social Care Act 2001 introduced the power for PCTs to suspend general practitioners pending investigation. This was previously not possible because of the independent contactor status of GPs. For the first

time this Act also requires PCTs to develop a list of locums and non-principal GPs in their geographic area, to assist with investigations.

Taylor (2004) reports that in the case of 'acute' problems of poor medical performance, where patients are considered to be potentially at risk, these are to be immediately referred to the General Medical Council (GMC). After initial screening by the GMC, if the problem is indeed defined as one of poor performance, the doctor will be offered an assessment. If the doctor refuses assessment, he/she will be required to attend a hearing. If an assessment it accepted, following this, remedial action may be recommended. Typically this will be some form of training or occasionally complete re-training (www.gmc-uk.org). If the initial GMC screening identifies serious problems which are not based purely on poor performance, a formal hearing will be required.

The Council for Health Care Regulatory Excellence (previously Council for the Regulation of Healthcare Professionals), was set up in April 2003 by the NHS Reform and Health Care Professions Act 2002, with a mission to protect the public interest, promote best practice and achieve excellence in relation to regulating healthcare professionals. The Council is funded through the department of Health and is responsible to Parliament. The work of the Council covers nine regulatory bodies currently responsible for healthcare professionals throughout the UK including the General Medical Council. The Council monitors how regulators carry out their functions, compare the performance of different regulators and recommend changes in the way regulators carry out their work. This is achieved through regular performance reviews. (www.chre.org.uk)

3.2.4 Culture, Leadership and Teams.

'A First Class Service' (1998b:71) stated that to achieve sustainable quality improvement in the NHS, 'a fundamental shift in culture' would be required. Health organisations would have to be 'engaged from top to bottom in developing and delivering the quality agenda.'

Scally and Donaldson (1998) suggested that the reforms in the 1980s including the introduction of medical audit, general management, clinical guidelines, performance indicators, the Patient's Charter and evidence-based medicine were fragmented attempts to improve the consistency and quality of healthcare services. On the other hand, the post 1997 reforms, including the implementation of PCG/Ts and clinical governance are a more coherent approach, involving the whole workforce. Clinical governance has become a statutory duty on Chief Executive Officers of Trusts to assure quality and continuous improvement. Donaldson (2000) observes that this is the most ambitious quality improvement agenda ever to have been implemented in the NHS and will require the transformation of the NHS organisation culture.

Scally and Donaldson (1998), report that effective clinical governance requires multi-professional team working, strong leadership and an open and participative ('no blame') organisation culture, where ideas and good practice are shared. Roland et al (2001) described the required culture as more open, with accurate reporting and sharing of data, less emphasis on provider confidentiality, and an end to the protection of professional prerogatives. It is argued that a key requirement is for doctors to change their attitudes and behaviour, accepting change which involves better quality team working and leadership, the practice of evidence-based medicine, and the introduction of revalidation of doctors with associated appraisal and continuous professional development.

3.3 Attitudes to Clinical Governance.

There have been a number of studies tracking progress in the implementation of clinical governance, and identifying the positive benefits gained and the barriers encountered in this process. (McColl and Roland 2000; Baker and Roland 2002;
Campbell and Sweeney 2002; Marshall et al 2002; Sweeney et al 2002; Onion 2000; Roland 2003)

A national survey of the opinions of over 23,000 GPs in England was conducted in 2001 by the British Medical Association (BMA). It found that only 18.5% of GPs disagreed with the concept of clinical governance, and only 29.2% disagreed with

professional revalidation (Baker and Roland 2002). Further studies indicate the positive benefits gained from clinical governance. Sweeney et al (2002) report perceptions of improved patient and staff safety and improved working conditions including more interesting and challenging work. There is reduced isolation of practitioners and 'tribalism', and better team working. This was found to be particularly significant for single-handed GPs. Finally, stronger and wider links with other public services were perceived to be beneficial.

Middlemass and Siriwardena (2003) investigated the knowledge, attitudes and beliefs of GPs in Lincolnshire towards appraisal and revalidation. It was concluded that GPs were positive about appraisal, provided that it was done by professional peers, that there was local ownership of the process, and that the purpose was 'educational' leading to agreed development plans. Concerns related to the time and resources necessary to make appraisal worthwhile and the lack of clarity between appraisal and revalidation.

There were also barriers to effective clinical governance in general practice identified by these studies. These barriers include concerns about the pace of change and the large volume of work associated with this; perceptions of a 'blame culture' existing in many primary care organisations, undermining the openness required for shared learning to take place; too few staff and other dedicated resources for clinical governance and a continued 'disengagement' of some practices with the concept of clinical governance. A wide diversity in the levels of care and in the available resources and information technology skills in general practice were also identified as hindering a corporate approach to the implementation of clinical governance (Campbell and Sweeney 2002; Marshall et al 2002).

McColl and Roland (2000) identified the challenges presented by poor standardisation of data recording and retrieval, and the need to develop systems for the comparison of data. The variability in information technology skills of managers and clinicians in general practice was also identified as a challenge. These barriers were re-affirmed by Sweeney et al (2002), who in addition reported the difficulties experienced by GP representatives on PCTs committees, taking the lead in the implementation of clinical governance in general practice (GP leads). These individuals expressed concern about

the ambiguity and uncertainty of their role, and the adverse emotional impact of this. There were difficulties experienced in undertaking a leadership role in a structure without formal line management authority. GP leads reported feelings of powerlessness and lack of control over their workloads, given the shortage of resources dedicated to the implementation of clinical governance. Clinical Governance Leads reported that they had adopted 'softer' facilitative approaches to the general practices in their geographic areas, wanting to be viewed as a resource and advocate for practices rather than an enemy and desiring to represent the views of the practices at the PCTs.

There were criticisms of the central organisations associated with clinical governance. Onion (2000) recognised that NICE would accurately assess evidence and publish clear summaries for clinicians and commissioners of services. Onion (2000) suggests however, that NICE guidance is not 'absolute' and cannot therefore identify bad practice with 'certainty'! Onion (2000) asks, will NICE in effect be a national rationing council? Will NICE mean the end to clinical freedom?

Rowland (2003) questioned CHAI's 'conflicting' roles of support of healthcare organisations on the one hand, and reviewer and investigator of poor performance on the other. The 'real' independence of CHAI was questioned. On the one hand it operates 'at arm's length from the government,' (DoH 1998:51) on the other hand, CHAI is directed by the Secretary of State for Health to undertake specific investigations of alleged poor performance. Roland (2003) concludes that the main purpose of CHAI was always inspection, not the softer more supportive developmental role.

3.4 The New GP Contract and Clinical Governance.

In April 2004 a new contract of service was implemented for general practitioners in England.The clear aim of the contract is to encourage and directly reward the delivery of high quality care. (Buckman and Snell 2002; Gulland 2003; Stokes et al 2005).

The contract provides the option for GPs to opt out of the provision of certain services for patients, including out-of-hours care. Patients will now be registered with the practice rather than with specific GPs. GPs salaries have the potential to be increased

through the delivery of a 'Quality Outcomes Framework', and by the provision of new specialist 'enhanced services'. Participation in the quality outcomes framework is voluntary and the pace of progress towards implementation is to be defined by the practice itself. The costs of delivering the improved standards of quality are to be met by government funding.

There are three elements to the QOF clinical, organisational and the patient experience. Clinical quality is largely about chronic disease management, and is measured in two ways. Larger fields of work, for example, ischaemic heart and other vascular diseases and diabetes, are scored along a sliding scale with practices moving up a range of criteria with rising standards. Simpler areas of work, for example hypothyroidism, epilepsy, chronic obstructive airways disease, severe and enduring mental illness and asthma, are scored by a simpler tiered method. Organisational quality is also tiered so that the practices can work to improve services at their own pace. The patient experience is to be monitored via questionnaires enabling GPs to respond progressively to the patient's needs. The implementation of the new contract is to be monitored using a 'high trust' model with a minimum of bureaucracy. (Buckman and Snell 2002)

Essential elements for practices to make the new contract work are identified by Buckman and Snell (2002) as having auditable records and registers, accurate call and recall systems, and responsive primary care teams willing to co-operate together. Practices will in effect move up a continuum from having accurate disease registers, developing internal audit systems, agreeing and confirming acceptance of the criteria and standards in each of the disease areas to be managed, and systematic implementation of process measures to achieve the change. There will have to be frequent disease reviews accepted by both GPs and patients. This should lead to the achievement of the outcome-based targets. Buckman and Snell (2002) go on to highlight that to make the process work it will be necessary to delegate tasks to the most appropriate member of the primary care team to achieve maximum efficiency and cost effectiveness. This may require GPs to be willing to accept a different skill mix in the primary care team to make the best use of available resources. Multi-disciplinary teams and new work patterns will need to be accepted by all practice staff. It will also be necessary to ensure practice managers are competent and well trained to lead the

change. Accredited information systems will need to be used, and there should be agreed codes allocated to specific medical conditions and associated treatment (read codes) within practices and the PCT. Clinical audit and risk management will be prerequisites to underpin the whole process. PCTs will need to provide appropriate support and training for practices in implementing the new contract.

The main challenges associated with implementing the new contract that have so far identified are firstly, obtaining the support of GPs, particularly in relation to the delegation of tasks that they may still wish to maintain responsibility for; taking on a public health role alongside individual patient management; accepting that patients as consumers are at the centre of the new contract; and finally, persuading practice staff to accept the new culture and patterns of working, and ensuring that routine workloads are managed appropriately. (Buckman and Snell 2002).

It is too soon to conclude as to the full impact of the new GP contract and there is little critical analysis in healthcare management literature yet. Comparing the details of the new GMS contract with the clinical governance framework however, it seems fair to say that it has been designed to positively reinforce the implementation of clinical governance in general practice where the independent contractor status of GPs may have been a significant barrier.

3.5 Clinical Governance, Professional Autonomy and Self-Regulation

'The new NHS Modern Dependable' (1997:Para 7.15) indicated that the government would continue to look to individual health professionals to be responsible for the quality of their own clinical practice,

> 'Professional self-regulation must remain an essential element in the delivery of quality patient services.'

Professional bodies were encouraged to continue to develop national standards in line with changing service needs and increased public expectations,

> '.....The Government will continue to work with the professions, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation by ensuring they are open, responsive and publicly accountable.'

Friedson (1970b) in his study of the medical profession, asserted that professions could be differentiated from other occupational groups by their autonomy and ability to exercise legitimate control over their work. In the case of medical practitioners this was justified in relation to their specialist knowledge and skills, which were perceived to be impossible for outsiders to understand or evaluate. Their adherence to strong value systems enabled them to be trusted to act responsibly without supervision. Professional ethics would, in effect, control their performance. Where individuals under-performed or behaved unethically, professional bodies would be expected to recognise, report and regulate this. Sutherland and Dawson (1998) noted that the General Medical Council (GMC), Royal Colleges, postgraduate deans, teachers and colleagues comprise the framework regulating the medical profession. They further reported that historically there has been a general acceptance of the legitimacy of clinical autonomy. As outlined in the previous chapter, part of the agreement with the medical profession at the inception of the NHS was as much clinical freedom as resources would allow, in exchange for their acceptance that they would deliver a service that covered the whole nation. Quality in healthcare has therefore been dependent on professional autonomy as a control mechanism for doctors. These points were introduced in chapter two of my thesis and are developed more fully in chapter four.

Alaszewski (2002) however, emphasised examples of poor medical performance and mal-practice, where professional self-regulation has failed to prevent injury or death to patients. The Bristol Inquiry is identified as a 'watershed' case because it signifies that the government is no longer willing to 'unconditionally' trust the medical profession to regulate itself and to provide consistent standards of care. The result of this being the introduction of clinical governance, a system designed to both regulate performance and to improve quality.

In 'Clinical Governance and Self-Regulation' (Royal College of Physicians 1999:15), the Royal College of Physicians outlines its position in relation to clinical governance.

> 'The long established mechanisms for regulating the medical profession are no longer enough. The public, the profession and the government all expect a much greater degree of accountability, with less variation in standards of practice and behaviour. It is up to us to demonstrate as clearly as possible, through clinical governance and self-regulation, good and effective practice.'

The document then goes on to indicate how quality of practice should be improved and how this might be demonstrated to the public. Clinical governance, including performance appraisals and continuous professional development for medical professionals, clinical audit, personal development plans and peer led service reviews are thus clearly endorsed by the Royal College of Physicians.

In summary, quality and clinical effectiveness are now to be, in effect, *enforced,* through the tools of evidence-based practice via the implementation of NICE guidance and National Service Frameworks. Clinical performance is then to be *monitored* through performance indicators, bench marking and league tables, and periodically *inspected* by CHAI. Alongside this, practitioners are *subjected to* performance appraisal and required to undertake continuous professional development in order to continue to be licensed to practice. Harrison (1999) argues this is a form of 'neo-bureaucracy.'

Exploring the politics of medicine, Salter (2002) suggests that the control of knowledge (the essence of professional autonomy), is exercised through the three regulation functions of standards setting, monitoring and evaluation and intervention. If this is the case, then what is clear is that clinical governance will increasingly have far reaching implications for the professional autonomy of the medical profession. Sutherland and Dawson (1998) in their study of the roles of doctors and managers in the new NHS, conclude that clinical governance gives managers legitimacy as 'monitors' of the quality of clinical services. It is suggested that this is a direct challenge to traditional medical professional autonomy.

3.6 Conclusion.

This chapter has defined and explored the concept of clinical governance. Clinical governance is defined as the latest phase of managerialism in the NHS (Flynn 2002),

representing a form of 'neo-bureaucracy' (Harrison 1999) and exercising 'soft governance' (Courpasson 2000; Dent 2005) over the medical profession.

Clinical governance represents a shift in the relationship between the state and the medical profession (Flynn 2002). Clinical governance seeks to replace 'professional autonomy' with 'responsible autonomy' (Dent 2005), and to incorporate professional self-regulatory mechanisms within centrally directed managerial organisation structures (Sheaff et al 2003). There is evidence to support Flynn's (2002) suggestion, that clinical governance is a recent manifestation of New Public Management in the NHS.

The literature review supporting my study is presented in the next chapter. The aim of my study is to examine the impact of clinical governance on the professional autonomy and self-regulation of GPs in a PCT in the Northwest of England from the perspectives of PCT directors and managers and medical healthcare professionals working in general practice. Chapters two and three of this thesis have provided a detailed account of clinical governance as an element of the 'New Public Management' of the NHS. The following chapter reviews the literature on the professions as a distinct occupational group and examines the existing literature base seeking to explain the impact of recent healthcare policy on the autonomy and self-regulation of the medical profession. The literature review highlights the key debate concerning whether the medical profession is experiencing deprofessionalisation (Haug 1973; 1975; 1977; 1988) and proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997) or alternatively, an internal restratification (Friedson 1975; 1983; 1984; 1985; 1986). It is to this debate that my study makes a contribution. This is presented in the discussion and conclusion of my thesis in chapters seven and eight.

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2006

Chapter Four

The Professions, Professional Autonomy and Clinical Governance.

'At the heart of a profession is a justifiable autonomy expressed in self-regulation.....this is the compliment that society pays to the professions it trusts and values. It is this that is under threat.....if this goes, much else will go with it and the world for sick people will be a much colder and less safe place' (Tallis 1988:241)

4.1 Introduction.

This chapter presents the literature review underpinning my study. It explores functionalist and processual approaches to the sociology of the professions and focuses on the development of the professions as a distinct occupational group. The chapter demonstrates that the key defining characteristics of a profession are its professional autonomy and self-regulation.

The chapter continues with a review of the Neo-Marxist theories of 'deprofessionalisation' (Haug 1973; 1975; 1977; 1988) 'and 'proletarianisation' (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997) as explanations of the impact of recent healthcare policy on the medical profession. The Neo-Weberian concept of 'restratification' (Friedson 1975; 1983; 1984; 1985; 1986) is also outlined as an alternative way of understanding recent events in the management of healthcare.

The final section of the literature review presents an account of the relatively few existing studies forming the ongoing debate about the impact of clinical governance on the professional autonomy and self-regulation of GPs. The debate centres around

whether clinical governance is contributing to a decline in the professional autonomy of GPs leading to their deprofessionalisation (Haug 1973; 1975; 1977; 1988) and proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; McKinlay and Stoeckle 2002; Coburn 1992; Coburn et al 1997), or whether it is instead leading to a redistribution of power *within* the profession (Friedson 1975; 1983; 1984; 1985; 1986). The conclusion of the chapter identifies how my study aims to contribute to this body of knowledge. The detailed account of the contribution of my study is presented in the conclusion of my thesis in chapter eight.

4.2 The Professions and Professional Dominance.

4.2.1 Functionalist and Processual Perspectives – An Overview.

The literature on the professions is vast and varied and spans more than a century. In 1983, Hall wrote of the near disappearance of sociological interest in the professions in American literature. At the same time however, Halliday (1983), in Europe, was writing that the sociology of the professions was 'alive and well' though undergoing significant change, with the emergence of the power paradigm. Macdonald and Ritzer (1988) suggested that studies of the professions in both USA and UK have not been isolated from each other and that there had been considerable cross fertilisation between the two countries. American studies have tended to be descriptive, focusing on specific occupations, often in isolation from relationships to other social structures and institutions. On the other hand British studies have been concerned with the relationships between the professions and other occupations, government and the class system. British studies have also tended to be more theoretically based on the sociology of Durkheim, Weber and Marx.

In a later attempt to review the literature on the professions, Ritzer, this time writing with Walczak (2001), reported that sociologists have conceptualised professions and the process of professionalisation in various ways including functionalist and trait models, with their roots in Durkheim's sociology of consensus and order, and processual

models, including power and action approaches, taking their theoretical lead from the work of Marx and Weber.

The early functionalist models, attempted to identify the key traits and characteristics of the professions, differentiating them from other occupations, and focusing on their perceived 'function' of maintaining social order (Durkheim1964).

The processual approach may be divided between the power approach and action approaches. The power approach considers how professions acquire the power base which differentiates them from other occupations, and having acquired it, how the situation may be exploited to further enhance that power base. This influential body of literature deals with inter- and intraprofessional conflicts, professions and their relationship with government, and professions and social stratification. More recently, it has also been concerned with loss or potential loss of professional power via 'deprofessionalisation' and 'proletarianisation' resulting from bureaucratisation and corporatisation. (Johnson 1972; 1995; Haug 1973 and 1975; Boreham 1983; McKinlay and Arches 1985; Coburn 1992).

Action approaches emphasise the ability of professionals to influence and shape the organisations and environments in which they operate. Rather than viewing changing patterns of professional control as outcomes of organisational and structural changes, they are seen as outcomes of continuing struggles by occupational groups for legitimacy and institutional recognition. (Friedson 1970a; 1970b; 1984; Larson 1977; Starr 1982; Harrison 1994).

A profession was defined by Ritzer and Walczak as,

> 'An occupation that has had the power to have undergone a development process enabling it to acquire or convince significant others.... that it has acquired a constellation of characteristics we have come to accept as denoting a profession.' (1986:6)

Friedson (1983) suggested that any definition of profession should reflect that it is a changing concept with roots in industrial nations strongly influenced by Anglo-

American institutions. In his own analysis of the medical profession, Friedson (1970b:xvii) defines a profession as,

> '... An occupation which has assumed a dominant position in a division of labour, so that it gains control over the determination of the substance of its own work. Unlike most occupations it is autonomous and self-directing' (1983:22)

Friedson (1983:23-26) presents a useful summary of the history of the professions. He observes that the medieval universities of Europe produced three 'learned professions', medicine, law and the clergy. Johnson (1972) referred to these as the 'true' professions, against which other occupations seeking professional status compared themselves in terms of defining characteristics or traits. These characteristics were defined by functionalist theorists as altruism, autonomy and self-regulation, authority over clients, general systematic knowledge, distinctive occupational culture and community and legal recognition (Parsons 1954; Goode 1957 and Greenwood 1957). Friedson, (1970a; 1970b) stresses the autonomy of the professions and the resulting necessity for self-regulation as the key characteristics of 'true' professions.

Friedson (1983) observes that as the occupational structure of capitalism developed during the nineteenth century in UK and USA, newly formed middle class occupations seeking a secure and privileged place in these economies sought professional status, competing with each other in the process. To achieve this status they had to organise their own training and 'credentialing' institutions. Gaining recognition as a profession was important because its traditionally defined characteristics of lack of self-interest, dedication and learning, legitimated efforts to gain protection from competition in the labour market.

The process of gaining professional status is referred to as 'professionalisation.' Wilensky (1964) suggested that indicators of professionalisation portray a historical sequence of events through which all professionalising occupations must pass in a series of stages to an end state of 'professionalism.' In the USA these were defined as the emergence of a full time occupation, the establishment of a training school, the

establishment of a professional association, political agitation to protect the profession by law and the adoption of a formal code of ethics and conduct.

Rueschemeyer (1983) observed that, particularly since the 1960s more critical attitudes towards the professions and their position in society have developed. The emerging 'power' and 'action' paradigms emphasised professional self-interest rather than selfless altruism. In particular the professions are perceived to achieve high status in society, privileged terms and conditions of work, guarantees of high material rewards and the highly valued professional autonomy and self-regulation. The power approach focuses on the political and social processes by which the professions secure and reproduce their privileged position in society. The action approach suggests that professional status is actively pursued, and is the result of individual and collective action, rather than the result of macro-structural influences. (Larson1977).

The medical profession has achieved,

> 'unparalleled professional power, prestige and income' (Ritzer and Walczak (1986:5).

It has gained a monopoly of esoteric knowledge and has as a result considerable autonomy to define the content of its own work and the right to control its own work. (Friedson 1970a). At the same time there has been considerable debate over the position of doctors within changing healthcare systems, particularly in Britain, Australia, Canada, Scandanavia and America (McKinlay and Stoeckle 1988).

4.2.2 Functionalist and Trait Approaches.

The functionalist and trait approaches to the sociology of the professions are concerned with defining the characteristics of a profession and identifying the role they fulfil in society.

Marshall (1963), stressed the 'altruism' of the professions, and Parsons (1954), defined their collective orientation. Etzioni (1969), classified occupations into 'professions' and

'semi-professions'. Millerson (1964), listed twenty-three elements of the 'true' professions, based on twenty-one definitions from earlier works. Goode (1957) defined the characteristics of 'ideal-type' professions against which occupational groups could assess themselves in their claims for professional status. Two of these characteristics were viewed as essential, these were, prolonged specialist training in a body of abstract knowledge, and a service orientation. From these, ten other characteristics were derived, five of which underpin the concept of professional autonomy. Professional autonomy is here defined as a profession's right to determine its own standards of education and training, legal recognition by licence, licensing and admission boards controlled by members of the profession, and legislation concerning the profession shaped by the profession itself. Practitioners are free of 'lay' regulation and control (Friedson 1975). This results in an ability to determine the nature and content of work and peer evaluation without reference to others outside the profession. (Friedson 1970a; 1970b)

Hickson and Thomas (1969) extended trait theory by going beyond lists of elements of professions and attempting to establish a hierarchy of professions in Britain by putting measurable indicators of 'professionalism' into a Guttman cumulative scale. They suggested that the scale produced a close relationship between the professionalisation score and the age of the various associations included in their study. They concluded that the process of professionalisation is a very long one.

Barber (1963) stressed the unique behaviour of the professions in relation to other occupations. He argued that professional behaviour may be defined in terms of four essential attributes. Theses are a high degree of generalised and systematic knowledge; orientation to community interest, rather than self-interest; a high degree of self-control through codes of ethics, internalised via work socialisation; and finally, a system of rewards, monetary and honorary that symbolise work achievement.

Hall (1968), attempted to define 'the professional model.' He saw this as comprising structural and attitudinal characteristics. Professional autonomy is isolated as an attribute that is both structural and attitudinal.

Structural characteristics are for example, efforts of professional associations to exclude the unqualified and to facilitate the legal right to practice. Attitudinal characteristics are reflected in the manner in which professionals view work, for example, use of professional organisation as a major reference point for ideas and judgement; a belief in service to the public and dedication to work; a belief in the indispensability of the profession; belief in professional autonomy, that the practitioner should be able to make decisions without pressure from outside the profession; and finally, belief that only fellow professionals are able to judge work.

Professional autonomy is structural because it is part of the work context. If the structural pre-requisites for professionalism are met, then the attitude to practice becomes the important consideration in measuring professionalisation. The combination of the structural and attitudinal aspects are seen to be the basics of the professional model and according to Hall (1968) are present to a large degree in highly professional organisations such as medicine and law. These are present to a lesser degree in less professional organisations.

The trait and functionalist approaches to professionalism and professionalisation have been criticised extensively. As early as 1957, Greenwood was critical of the procedure of listing 'attributes' or the relationship between these, without any explicit theoretical framework. In the 1960s and1970s, critics were pointing out that trait theorists could not agree on a definitive list of traits representative of professionalism (Wilensky 1964; Johnson 1972; Roth 1974; Elliott 1972; Dingwall and Lewis1983).

Becker (1962) suggested that professionalism as a symbol differed markedly from professionalism in reality. The ideals of professionalism might become a useful public relations mechanism which few would take seriously.

Wilensky (1964), and Roth (1974), suggested that functionalist and trait approaches were largely descriptive ignoring history and process.

Johnson (1972) pointed out that trait approaches merely accept a profession's own definition of itself. Johnson also stressed that the approach fails to take into account the social conditions under which professionalisation takes place, and that it ignored the impact of government and academia on the organisation of the occupation and the content of its practices.

Rueschemeyer (1964; 1983) is critical of the functionalist approach to specialist knowledge. He argued that this knowledge is assumed to be of equal value to all groups in society, which is not necessarily the case. Rueschemeyer (1964) also questioned the 'bargain' that professionals allegedly strike with society. What happens if they do not fulfil that bargain? The functionalist approach implies that there are effective mechanisms of self-regulation. Rueschemeyer argued that the power of the professions would protect their privilege and autonomy in the event of poor practice. He concluded that the privileges of the professions are similar to those held by any group high up in the social stratification system, and are rooted in the power resources derived from positions in the division of labour.

Torres (1991) argued that the functionalist approach fails to examine power, conflict and other social interactions in the process of professionalisation. Torres (1991) suggested that processual literature on the other hand, concerns itself with intraoccupational conflict between sections of an occupation competing for control of professional functions; intraoccupational interaction between sections supporting or opposing professionalising occupations; and interaction between sections of an occupation and the state and occupational policy makers.

4.2.3 Processual Approaches - Power and Action

The Processual approach may be divided between the power and action perspectives. The Power approach is concerned with explaining how professions acquire and then maintain and enhance their power base. Action approaches explore a profession's ability to influence and shape the organisations and environments in which it operates. Power approaches stress the impact of macro structural and organisational change, whilst

Action approaches are concerned with the impact of human agency in shaping and influencing outcomes.

Power Approaches.

Esland (1980) suggested that the power and influence of the professions lie in their professional autonomy, the degree of control over the management and exercise of specialist knowledge, and the skills which are based on it. In addition, the level of public acceptance and support they can obtain. These are necessary acquisitions for professionalising occupations and gaining these are political activities involving an ongoing task of public persuasion and competitive relationships with other occupations.

James and Peloille (1970) argued that when there is a high degree of 'indeterminacy' in the work of a profession, when tasks are variable and non-rationalised the group is likely to achieve professional autonomy and high status and rewards. On the other hand, if work has been systemised and subject to laid down rules and procedures, it is possible for external forces to control the work process. Social and political factors also create or prevent conditions where elite groups can capitalise on the work situation. At crucial points in a profession's development, pursuit of best practice might cause a group to codify and mechanise their own work, enabling control to be shifted to outside managerial elements.

In attempts to become recognised as a profession, Parry and Perry (1976), emphasised the problem of 'exclusiveness' and 'market control'. To exercise control over the market anyone with expertise must be included, but this results in lowering the standard of higher status members. Parry and Perry (1976) argue that the claim to unique competence, legally supported is the key to professionalisation.

Larkin (1983) and Macdonald (1985) demonstrated that occupations need to continually work to identify the territory they wish to monopolise and also to attempt to control the work of surrounding groups without diminishing their own power and prestige. Secondly, they need to regulate the relations between these groups and the distribution of power between specialities. This obviously generates conflict within and

between occupations. In his study of four paramedical groups, Larkin (1983) noted that the division of labour assures lower status groups of a market, and association with a higher status group provides prestige. He defined an 'arena of tension' between groups, the outcome of which is determined by the degree of access of each group to exterior power sources.

Abbott (1988) argued that the key factor of professional life is interprofessional rivalry. He argued that it is important to have a 'systemic' rather than an 'individualistic' view of professions. It is necessary to look at interdependencies and the overall 'system' of groups engaging in the fight for professional status. It is not the work that the profession performs but the competition over work that is the basis of the dynamic relationship between professions. Abbott (1988) suggested this is explained by the concept of 'jurisdiction.' This is the control a profession exercises over a specific area of work, the right to perform the work, at the same time excluding others, and to define best practice. Jurisdictional claims are made to for example, the law, public opinion, and the state. Abbott (1988) argued that jurisdiction could be created, willingly vacated, and also lost to a more competent group. Fighting for jurisdiction is the means by which the development of professions occurs. Abbott (1988) also argued that knowledge is important, it must have high status in society. Work related knowledge is formalised into an intellectual system, with its own methodology, philosophy, ethics and theory. This knowledge enables a profession to defend its position and claim further jurisdiction. It attempts to re-define human problems into professional problems that it alone is able to solve using its expertise. The system of professions posed by Abbott (1988) provides a framework to explain the range of professional development. Professions may attack each other, external forces may open up or close jurisdictions, jurisdictions may be willingly vacated or shared. In the latter case, junior members of a profession may be supervised by more experienced members of a profession. In this way, inter-professional relations can be co-operative as well as competitive. MacDonald and Ritzer (1988) identify other studies of inter and intraprofessional conflict taking place within the context of ongoing power struggles. (Holloway et al 1986; Podmore 1980).

Other significant contributions within the power approach concern the relationship between the professions and the state. Johnson (1972) in his book 'Professional Power' considers types of professional control. He identifies collegiate control in which the producer defines the needs of the consumer and the way in which these are provided. Secondly, patronage, where the consumer defines his /her needs and how they are to be met. Within this type, 'oligarchic', and 'corporate' patronage are distinguished. Oligarchic patronage arises in traditional societies where an aristocratic patron is the major consumer of various goods and services. Corporate patronage refers to professions in industrial societies, where the demand for services comes from large corporate organisations. The final type of control is 'meditative', in which a third party mediates the relationship between producer and consumer, defining both the needs and the manner in which they will be met. Again this may be sub-divided into capitalism, where the capitalist intervenes between the producer and consumer in order to rationalise production and to regulate markets; and state mediation, where a powerful centralised state intervenes in the relationship between producer and consumer to define what the needs are.

Johnson (1972) highlighted the medical profession in Britain, suggesting that the state defined who would receive medical services whilst medical practitioners determined the manner in which these needs would be met. Johnson (1972) argued that the impact of control on individual occupations would vary according to the historical origins of that occupation. An occupation may bring with it many of the characteristics of professionalism, even though this may be in decline and new institutional forms of control emerging. Where social conditions are influential in affecting the development of an occupation, forms of institutional control will emerge which will vary also depending on the potentiality for autonomy displayed by the occupation.

In 1982, Johnson developed this last point further arguing that the development of the professions could be understood in terms of the opposition between professional autonomy and state intervention. The development of capitalism in Britain involved an interrelated process of state formation and professionalisation. The conclusion drawn was that,

> 'the relationship of state to profession presents itself as one of constant struggle and seeming hostility, while at the same time constituting an interdependent structure. The view that professionalisation is not a single process with a given end-state also suggests that the relationship with changing state forms is in flux.....To claim that the modern professions are a product of state formation does not entail a view of profession as universally the servants of power.' (1982:207-208)

Fielding and Portwood (1980) also considered the relationship of the professions with the state. They present a typology of bureaucratic professions. The dimensions are public / private (workplace and practice) and dependence / autonomy in relation to the state. They concluded that in most cases a formal working relationship has been established between professions and the state and that in the relationship with the state, few professions have lost status and autonomy and that the interdependent processes of bureaucratisation and professionalisation have benefited both parties.

Halliday (1985) argued that the degree of influence a profession has on the state depends on their standing in four areas, the foundations of their knowledge, the forms of authority they can exercise, the institutional centrality of their work, and the organisational characteristics of their professional associations, these impact on their ability to act collectively in relation to the state.

A further interest of processual theorists is the relationship between the professions and the stratification system. Macdonald and Ritzer (1988). Johnson (1980) based his analysis on the work of Marx and analysed the place of the professions in relation to production and therefore the class structure. Johnson (1980) considers the ways in which various professions relate to the dual structures resulting from the antagonistic relations of capital and labour, in relation to the appropriation of surplus value, the realisation of capital and the reproduction of the relations of production. These were seen to generate parallel systems of social control in the maintenance and expansion of capital.

Boreham (1983) analysed knowledge and power in relation to the professions. He argued that professionals achieve and sustain their position by identification with recognised norms and values of capitalist organisation of the labour process. He also

argued that professions align themselves with the values of capitalism and are rewarded by incorporation into the 'upper echelons' of society, where their ideology of a 'calling', masks the contradictions that develop at the level of production and in the organisation of the labour process.

Action Approaches.

Everett Hughes (1963) is often referred to retrospectively, as the main point of reference for the shift in focus in the late 1960s to an 'Action' perspective, which is concerned with the ways in which individuals and groups influence the contexts in which they operate. Hughes (1963) reported that he had,

> '...passed from the false question, 'Is this occupation a profession?' to, 'What are the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people?' (quoted in Macdonald 1995:6)

Becker (1962) highlighted the 'symbols' of professionalism, stating that these represented the ideal base for the control of the work of members, and for defining relationships with clients. He suggested that 'profession' is a label which secures political advantage.

> '.....because the symbol legitimates the autonomy of the worker, occupations that are trying to rise in the world very much want to possess it.....so we find many occupations trying hard to become professions and using the symbol of the profession in an attempt to increase their autonomy and raise their prestige' (1962:139).

Hughes (1971:288) argued that professions claim a legal, moral and intellectual mandate. Individually they gain a licence to practice, at the same time, as a group, they 'presume to tell society what is good and right.' Hughes (1971) suggested that this licence and mandate are the key sources of professional authority. The strength of the mandate varies from one profession to another. In the case of medicine, it is supported by state legislation, which prevents unqualified individuals from practising.

Occupations need to persuade the public and the government that the specialist nature of their work means it can only be undertaken by 'qualified' individuals. Once achieved, this provides considerable internal control over the organisation of a profession. It enables professions through their professional associations, to define the necessary qualifications and criteria for entrance to the profession, and codes of practice. 'Ideologies' are also created emphasising the importance of its specialist knowledge and skills along with warnings of likely dangers if practised by unqualified individuals.

Hughes (1971) also highlighted ideologies of trust as central to the professional mandate. Clients are expected to trust the knowledge and skills of the medical profession, disclosing all 'necessary' personal information to them. At the same time, the profession requires protection from any adverse consequences of their practice. The profession protects its members by making it difficult for outsiders to pass judgement on individual members. Only fellow professionals are 'qualified' to assess the performance of professional work and to establish if a mistake has been made.

The professional mandate is dependent on a negative view of the 'lay' public for its justification. Hughes, (1963 in Esland et al 1975) suggested that this legitimates the existence of the profession. The medical profession can prescribe treatment for 'conditions' defined by itself. Also, the professions 'speak' for society in matters in which they claim to be expert.

> '.... Physicians consider it their prerogative to define the nature of disease and health and to determine how medical services ought to be distributed and paid for.....every profession considers itself to be the proper body to set the terms in which some aspect of society... is to be thought of, and to define the general lines or even the detail of public policy concerning it.'(Hughes 1963 in Esland et al 1975:245)

Illich (1975) also argued that the medical profession created needs leading the public to seek their services. Individuals are persuaded to believe their problems are medical in nature and therefore require the services of doctors.

Building on the work of Hughes (1971) and Friedson (1970a; 1970b), Larson (1977) posed the concept of the 'professional project', also referred to as the 'collective

mobility project'. This uses Weberian concepts of 'exclusion' and 'social closure' to explain how the professions build up a monopoly of knowledge and on this basis also build up a monopoly of service deriving from it. In this way, the resulting claims on professional status which are pursued, are 'projects' which may succeed or fail. There is also an element of Marxian approaches in Larson's work in her analysis of the complexities of hierarchy within professions. An occupation succeeding in achieving professional status may not provide a career path for all members. The rise of one group within a profession may not be to the advantage of another. Also, employing organisations may impose a 'trusted' managerial group on a profession rather than drawing senior managers from the profession itself. It is also recognised that division may emerge within a profession and there may be deskilling at lower levels.

Friedson (1970a; 1970b), argued that medical knowledge was separate from its application. Medical knowledge might be neutral, but in its application, the organised medical profession had interests that might not reflect the needs of patients. Medicine had become a profession which 'dominated' health care in its own interests. Medicine had also produced its own ideology,

> ' a self deceiving view of the objectivity and reliability of its knowledge and the reliability of its members.' (Friedson 1970b:370).

Friedson (1970b) noted that professional control has four dimensions to it. Control over the content of work, control over other health related professions, control over clients and control over terms and conditions of work. Professional autonomy (control over the content of work) however, is perceived to be the defining characteristic of a profession. Friedson (1970b) argued that professional dominance is achieved by persuading the public of its validity. Gaining acceptance brings monopoly powers. This is also achieved by the sponsorship of a social elite, the state, protecting it from encroachment. Dominance is maintained through medical professional associations, and the control of new knowledge through medical schools. The medical profession also controls healthcare through its ability to define and legitimate 'illness.'

Coburn (1992), reported that in 1986, Friedson redefined professions as agents of formal knowledge, credentialed on the basis of higher education. Professions created

exclusive shelters in the labour market for members through the monopolisation of education, training and entry requirements. The important characteristics of a profession had become the links between professional work, for which there must be a market demand, the training provided by the education system, and privileged access to the market for members of the profession. All other powers of professions are viewed as merely supportive of these links between task, training and market. It is this tight control over labour markets that sustain the power and privileges of professionals..

In 1986, in his book 'Professional Powers', Friedson demonstrated how professional powers grew out of their 'market shelters'. Knowledge monopolies are identified as a major source of power because this facilitates control over how work is conducted, which is labelled, 'technical autonomy.' This in turn leads to situationally specific knowledge monopolies. For example, because of their specialist knowledge, professionals normally control case records of clients, this organisationally significant information enhances the power of professionals in work situations. Other special privileges flowing from the specialist knowledge of professionals are more favourable employment rights and terms and conditions of work than enjoyed by other occupations. It is technical autonomy which also creates the alleged necessity for self-direction (self-regulation) of the professions.

A further source of professional power is identified as 'gatekeeping' activity. This is referred to as 'institutional control' over desired resources and involves interpretation and judgement of the benefits required by a client. For example, in England, general medical practitioners are gatekeepers to secondary care. Professional power is defined as greatest where situations combine a monopoly of situational knowledge and gatekeeping in interaction with clients.

Friedson (1994) argued that professionalism has always been a dynamic concept. Chapters two and three of this thesis highlighted the progressive implementation of New Public Management techniques in the English NHS. What has been the impact on the autonomy and self-regulation of the medical profession? Exworthy and Halford (2002) observed that there are three lines of argument in relation to this. Firstly, that 'deprofessionalisation' is taking place (Haug 1973; 1975); secondly, the

'proletarianisation' thesis (Mackinlay and Arches 1985; Mackinlay and Stoeckle 1988); and thirdly, that a restratification within the medical profession is occurring (Friedson 1986; 1994).

Sections 4.3 and 4.4 of this chapter explore the concepts of deprofessionalisation, proletarianisation and restratification as explanations of professional decline.

4.3 Professional Decline. (Are professions losing their privileged position?)

As early as the 1950s, Mills warned of a loss of professional prerogatives and particularly professional autonomy. According to Mills (1956) modern society was becoming progressively bureaucratised, the professions were perceived to be increasingly absorbed into administrative systems where knowledge is standardised and professionals become managers.

> ' Most professionals are now salaried employees; much professional work has become divided and standardised and fitted into the new hierarchical organisations of educated skill and service; intensive and narrow specialisation has replaced self cultivation and wide knowledge; assistants and subprofessionals perform routine, although often intricate, tasks, while successful professional men become more and more the managerial type. So decisive have such shifts been, in some areas, that it is as if rationality itself had been expropriated from the individual and been located as a new form of brain power in the ingenuous bureaucracy itself.' (Mills 1956:112 quoted in Macdonald 1995)

More recently in the 1970s, against the backdrop of social and structural changes impacting on the status and prerogatives of the professions the overlapping theories of deprofessionalisation and proletarianisation, rooted in Marxist analysis have been published.

4.3.1 Deprofessionalisation.

Describing the changing role of doctors, Haug (1973; 1975) first posed 'deprofessionalisation' as an alternative scenario to existing predictions of a generally professionalised society (Friedson 1970a 1970b; Bell 1968; Halmos 1970). Deprofessionalisation was rooted in perceptions of changing relations between professionals and consumers, and was defined as a loss of unique professional qualities, particularly monopoly over knowledge, public belief in the service ethic, professional autonomy and authority over clients. Other proponents of the deprofessionalisation thesis have been Oppenheimer (1973); Betz and O'Connell (1983) and Rothman (1984).

Haug (1973) argued that technological and ideological trends would render professions obsolete. Professions would lose control over knowledge as a result of computerisation, the emergence of new occupations in the division of labour and increasing public sophistication. The result would be challenges to traditional professional autonomy and demands for increased accountability. Such deprofessionalisation would strip away traditional claims of professional authority and deference.

To the extent that scientific professional knowledge can be codified, it can be broken down and stored in a computer memory and recalled as required. Haug (1973) noted that the academic knowledge underpinning professional expertise is largely codifiable and amenable to computer input. This may then be extracted by anyone who knows how to get it, medically qualified or not. It was further observed that this makes peer review of professional performance possible. Increased general educational levels would serve to demystify professional expertise. The availability of training in the field of computing would facilitate information retrieval. The part of professional knowledge gained by experience and therefore not codifiable, could also be gained by lesser academically qualified but well trained, (and therefore cheaper to employ) para-professionals.

Haug (1973) noted that the public service ethic of professionals would also be increasingly challenged. Their emotional detachment from clients deemed necessary not to compromise professional judgement may be viewed as lack of concern for the client.

The public would also become increasingly confident about their rights and would wish to take an active part in professional decision-making. Pressure groups and self-help groups would encourage assertive behaviour on the part of clients.

Fifteen years later, in 1988, Haug re-visited the concept of deprofessionalisation to assess its accuracy in relation to the medical profession. She noted that at that time, the medical profession had been only partially successful in preventing the spread of medical knowledge to lesser qualified para-professionals. New occupations had emerged. The media had popularised much of the increasing bank of medical knowledge making it accessible to a more educated public. Computerised diagnosis and evaluations of decision trees indicating the relative success of various treatments were already available. Haug (1988) observed the increasing unwillingness of patients (in the western world) to unquestioningly accept medical authority, and the tendency to require medics to talk in plain understandable language and not use terminology to obscure and mystify. Changes to organisation structures and governance have also served to erode medical professional autonomy. Haug (1988) argues that the implications of this are that medical autonomy may be dangerous to patients and must therefore be subjected to public scrutiny. Haug (1988) concluded there was insufficient evidence to either prove or reject her original hypothesis, but invited a further look at the turn of the century.

4.3.2 Proletarianisation.

Similarly, based on Marxist analysis, the theory of proletarianisation overlaps to some extent with the deprofessionalisation thesis. McKinlay and Arches (1985:161) define proletarianisation as,

> '.....the process by which an occupation is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities and is thereby subordinated to the broader requirements of advanced capitalism.'

McKinlay and Arches (1985) suggested that control is lost over the criteria for entrance to an occupation, the content of training, autonomy in relation to the terms and content of work, the objects and tools of labour, the means of labour and the amount and rate of reward for labour. McKinlay and Arches (1985) argued that whilst most occupations

have been easily subjected to proletarianisation, the medical profession has been able to delay or minimise this process. However due to the bureaucratic consequences of capitalist expansion this is no longer the case.

Rationality is presented as the underpinning requirement for bureaucracy, translated in terms of the need for centralisation, economies of scale, medical technological advancements and the requirements of efficiency and improved quality of care. Bureaucracy is also suggested to be the only way to deliver medical care to large numbers of people. McKinlay and Arches (1985) perceived however that the 'real' reason for bureaucracy is capitalist accumulation, as a means of controlling educated workers to that end. Bureaucracy maintains loyalty and allegiance by rewarding rules orientation, predictable and dependable behaviour and the internalisation of an organisation's goals and values. Bureaucratic organisation results directly from the need to protect and advance the prerogatives of capitalism by exercising widespread forms of social control on three different levels.

Firstly, social control is exercised by setting organisational goals and the context within which tasks must be undertaken. Secondly, the behaviour of individuals is controlled by hierarchical structures and regulatory norms. Thirdly, the activities of clients are constrained by the first two of these forms of control, of which they may be unaware. The organisation, in effect, controls the pace and direction of work and engenders loyalty and discipline. Standardised evaluation of worker performance promotes conformity and control based on individualistic orientation.

McKinlay and Arches (1985) considered these processes of control in their analysis of the position of the medical profession in America. Doctors were observed to be working less in independent fee-for-service practice and more in large bureaucratic organisations as salaried workers. A further factor encouraging the medical profession out of private practice was the need to avoid malpractice costs imposed on them by a profit orientated health insurance industry.

Growth in specialisation, practiced in large bureaucratic settings instead of smaller general practice was also observed as a contributory factor. In line with Haug's findings (1973; 1975), this was believed to be because of the continual increase in medical knowledge making it impossible for a single individual to have sufficient expertise in all areas, along with the rising levels of expectations and knowledge of the general public. Whilst doctors had until this time been able to maintain their privileged position, avoiding proletarianisation, increased bureaucratisation of medical practice due to subordination to advanced capitalism was reported to now be eroding the privileges of the medical profession.

McKinlay and Arches (1985) make further related observations. When professionals enter a bureaucratic setting they devote themselves to climbing the managerial hierarchy and advancing their relative status and control of the organisation in its operational field. Thus a select group of professional executives (managers), direct operational activities, motivated by organisational priorities (as opposed to professional priorities), shaped by the interests of corporate capitalism. Secondly, specialisation means that doctors are increasingly involved in a highly segmented 'medical care production line'. In effect this breaks down medical care into discrete manageable components. The doctor becomes an expert in a limited area, which is more generally understandable and therefore more vulnerable to codification into bureaucratic rules and procedures capable of being computerised and easily grasped by individuals without a formal medical training.

McKinlay and Arches (1985) argued along similar lines to Haug (1973; 1975) that the use of technology, and organisation structure, initially erode professional autonomy and status, but eventually may go so far as to enable medical professionals to be replaced by less qualified, and therefore cheaper personnel. Professionals are thus losing their monopoly control over strategic knowledge and are becoming de-skilled, cheapening their labour power and diminishing their privileged terms of employment.

McKinlay and Arches (1985) concluded that the proletarianisation of the medical profession may be a slow process and be largely undetected by members due to their 'false consciousness' of the significance of their daily activities, and their elitist concept

of their role. Doctors may not realise that what they are involved in is advancing the interests of capitalism. Doctors, just like any other workers become 'dupes' of a system which is dominated by a process of capital accumulation and expansion.

4.4 Restratification Within Professions.

Based on Weberian analysis, Friedson (1984; 1985; 1986; 1994) poses the theory of restratification as an alternative explanation of the impact of recent health care policy on the autonomy of the medical profession. In 'The Changing Nature of Professional Control' (1984), Friedson takes issue with the theories of deprofessionalisation and proletarianisation. Friedson (1984) suggests that Haug's arguments (1973; 1975), that the professions are losing their prestige and trust is unpersuasive. Friedson (1984) argues that in spite of the narrowing knowledge gap between the medical profession and the general public, and higher standards of education generally, the medical profession continues to possess a monopoly over important segments of formal knowledge, which have not diminished. Friedson (1984) further suggests that whilst the power of computer technology in storing codified knowledge cannot be overlooked, it is members of the professions (not outsiders) who determine what is to be stored and who are able to interpret and employ effectively what is retrieved.

With respect to the proletarianisation thesis, Friedson (1986) argues that employment status is not a good direct measure of control or lack of control over work. Apart from lawyers and doctors, where an increase in salaried employment could be observed, professions had always tended to be in salaried employment anyway. With respect to increased bureaucaracy, it is recognised that there have been studies suggesting conflict between increased bureaucratic administration and professionalism because professionals highly value their autonomy and seek to control their own work and to set their own standards rather than accepting direction from bureaucrats. (Hall 1968;Scott 1966). It is noted however, that organisations employing professionals are more likely to deviate from the bureaucratic type where employees are tightly controlled by rules and procedures. Alternative hybrid structures have emerged, defined by Goss (1961) as 'advisory bureaucracies' by Smigel (1964) as 'professional bureaucracy' and by Scott

(1965) as 'professional organisations'. The term 'organised anarchy' was coined by Cohen and Marsh (1972); and Weick (1976), argued that organisations employing professionals should be viewed as loosely coupled systems rather than tightly managed bureaucratic units. Similar labels have been assigned to professional structures since then, for example Mintzberg's (1983)'professional bureaucracy' and Courpasson's (2000) concept of 'soft governance.'

Friedson (1986) also observed that without careful case-by-case analysis it would be wrong to believe that even in bureaucratic organisations, professionals are placed in a situation directly analogous to industrial workers, lacking discretion in the performance of their work, being closely supervised and having their skills expropriated. Professionals are expected to exercise judgement and discretion in their every day tasks, and have different supervisory arrangements to other types of workers. It could be expected that first line managers would also be qualified professional colleagues. The managerial level immediately above the line manager would also be a fellow professional, usually for accreditation purposes. In this way, unlike blue collar or administrative workers, professionals take orders from superordinate colleagues rather than trained managers who may not share the same professional background. Friedson (1986) recognised that this does reduce the autonomy of individual 'rank and file' professionals, but argues that it does not represent a reduction in the control of professional work for the profession as a whole. Other professional workers create work, and 'lead' rank and file professional workers. Friedson (1986) argues therefore that it is inaccurate to state that professions as corporate bodies have lost control over their member's work, even though to some extent individual members may have done. Deprofessionalisation and proletarianisation are perceived by Friedson (1986) to be inaccurate descriptions of the changing context of professional work.

Friedson (1986) suggests that whilst there has always been competition within professions and stratification of both intellectual power and economic power, the degree of formalisation of these relationships is new. One elite group formulates standards, another directs and controls, and still others perform the work. Something significant has happened to the organisation of the medical profession as a body and to the relationships between its members which has serious consequences for the future of

the profession. Taking his example of the medical profession, Friedson (1986) suggests that despite its internal division by stratification and specialisation, historically it has maintained a degree of solidarity (community), enabling it to be accurately described as a single profession. This community however, is likely to be threatened by the formalisation of professional controls. The profession could be split into distinct groups, the practitioners, the researchers and the administrators, each having its own professional association representing its own separate interests.

Friedson (1986) concluded that although the privileged status of rank and file professional workers will deteriorate, this will not be so much that they will be indistinguishable from other workers. Even though facing more formalised control rank and file professionals will continue to have more discretion in their work than other types of workers. Individual medical professionals will continue to have a distinct occupational identity.

McKinlay and Stoeckle (1988) and Coburn (1992) criticise Friedson's (1986) theory of restratification, and reiterate the validity of the theory of proletarianisation. They argue that Friedson's (1986) explanation is unable to adequately accommodate macrostructural changes. They suggest that professional dominance is a description of the situation in the medical profession in the 1960s and not a theory that explains more recent events. On the other hand the theory of proletarianisation looks to the future, arguing on the basis of what is occurring in the present and what is likely to happen in the future. Finally, McKinlay and Stoeckle (1988) indicate that whilst Friedson (1986) highlights a lack of evidence to support the decline theories, there was very little underpinning empirical data to support his own contributions. Finally, whilst Friedson (1986) had argued that decline theories were no more than slogans with little more than rhetorical value, McKinlay and Stoeckle (1988) present the reminder that proletarianisation is an explanation of a process under development and still continuing rather than an end state to be achieved.

Coburn (1992), compared Friedson's earlier work on professional dominance (1970a; 1970b), with his later work (1986) and highlighted conceptual confusion between 'dominance' and 'autonomy.' Coburn (1992) argued that it is more appropriate to view

dominance, autonomy and subordination as a continuum of control. Coburn (1992) argued that internal differentiation (restratification) does not maintain 'dominance' because medical elites are 'co-opted', working for and developing the goals of the state. Whilst they are leaders of the profession, the profession itself becomes 'corporatised' through them. The profession's knowledge base, nature of work and organisation are compromised.

Since 1997 the New Labour Government's implementation of Primary Care Groups (PCGs) then Primary Care trusts (PCTs), and clinical governance framework have provided the main focus for studies of challenges to the professional autonomy of GPs in the English NHS. These reforms were discussed in chapters two and three of this thesis and have been identified as the most recent attempts to extend managerial control over the work of the medical profession (Flynn 2002), and therefore to present a significant challenge to the professional autonomy and self-regulation of general practitioners (GPs).

The key question addressed by these studies is whether the post 1997 reforms result in a professional decline, deprofessionalisation and/or proletarianisation of general practice; or a restratification within the profession. The conclusions of these studies vary, but there is limited evidence presented of deprofessionalisation, and stronger evidence of both proletarianisation and restratification within general practice.

4.5 Professional Autonomy, Primary Care Groups/Trusts and Clinical Governance – The Case of General Practice.

4.5.1 Salter (2000) identified the underlying political tensions in the relationship between medicine, society and the state, and the implications for the future of the professional autonomy and self-regulation of the medical profession. Salter (2000) argued that until recently the relationship between medicine, society and the state formed a stable set of forces based on the mutual exchange of benefits. Society received healthcare benefits from the state, the state gained legitimacy from society, and relied

on the medical profession to ration healthcare resources. By fulfilling its obligation to society and the state, medicine received the trust of society and the privilege of self-regulation within the NHS, from the state. The right to self-regulation is built on trust. Recent studies demonstrate that increasingly government healthcare policies have challenged this. (Harrison and Dowswell 2002; Harrison and McDonald 2003; Harrison Smith 2003; Sheaff et al 2003; 2004; Dent 2005).

Salter (2000) observed that clinical governance implies that self-regulation is no longer a sufficient guarantee of quality. It represents instead, a systematic management-led quality assurance framework. Self-regulation remains in name but is in effect rooted within a state administration which requires the modernisation of self-regulation, which is open and transparent and responsive to changes in clinical practice and service needs, and accountable for implementing nationally set standards.

Salter (2000) examined the opposing underpinning philosophies of clinical governance and self-regulation. Clinical governance is a rational bureaucratic regulation through rules, procedures, measurement against objective standards, and belief in the effectiveness of surveillance by a directive body. (Harrison and Dowswell 2002; Harrison and MacDonald 2003 and Harrison and Smith 2003).
Self-regulation however, is based on trust of independent, self-sustaining professionals, motivated by the ownership of professional standards and codes. Salter (2000) concluded that if there is to be any way forward, it will be necessary for these separate lines of accountability to be integrated in some way. He observed however, that this will inevitably offend the basic principles of self-regulation which only accepts accountability to ones peers. There would have to be a mutual acceptance of shared ownership and responsibility for the quality of the services with greater collaboration between medicine and the state. The medical profession would in effect have to accept that,

> 'medicine's sovereignty is no longer absolute but contingent upon its delivery of the state's clinical governance agenda. This would involve the re-working of clinical autonomy and peer review to render them contingent upon their contribution to the needs of public accountability.' (Salter 2000:880).

4.5.2 Harrison and Ahmed (2000) and Harrison and Smith (2003) examined the alleged decline in the professional autonomy and dominance of the British medical profession over recent decades. Similar to Salter's (2000) work, these accounts also focus on medicine's relationship with the state and NHS management. They ask, how autonomous is medicine from management and how far does medicine dominate management?

In 2000, this was examined at micro, meso and macro levels of analysis. Professional autonomy at micro level includes control over diagnosis and treatment. Restrictions to this are through the use of pre-set budgets, the identification of individual GPs with untypical treatment patterns, and the implementation of clinical guidelines. Meso level analysis is concerned with institutional relationships between the medical profession and the state, examples of this include the legal basis of state licensure and self-regulation, and the arrangements through which medical interests are mediated, including joint government / professional committees and official recognition of the British Medical Association as the lead professional association. This impacts on the local level through the constitution of governing bodies. The macro-level is depicted by the biomedical model, the underpinning belief of which is that ill health equals individual pathology, and requires medical intervention.

Harrison and Ahmed (2000) concluded that these have resulted in a new 'scientific bureaucratic' medical labour process which runs counter to post-Fordist principles in other industries. This model is 'scientific' because prescriptions for treatment are increasingly drawn from an externally generated body of research (evidence-based medicine), and 'bureaucratic' because it is implemented through bureaucratic rules and clinical guidelines. This implies the Fordist principle of 'one best way' which significantly challenges the professional autonomy of doctors. In most other industries however, there has been a move away from standardised mass production with highly routinised work, to flexible production, where workers are closer to the customer and are empowered to meet their needs. In healthcare services this would be achieved via the professional autonomy of doctors, which has been curtailed by recent policy developments. In predicting the outcome of healthcare policy over the following twenty-five years to 2025, control of the medical profession is seen to be a significant

test of state power. It is suggested that this may be achieved by a new organisation structure, labelled 'neo-bureaucracy', where rules will be enforced through regulatory agencies rather than formal hierarchies. Harrison and Smith (2003) however, question the technical, political and behavioural adequacy of neo-bureaucracies. Rules cannot deal with every situation facing rank and file general practitioners on a day-to-day basis.

Harrison and Ahmed (2000) also questioned the legitimacy of state rationing of healthcare through clinical governance as an alternative to the professional autonomy of doctors. Clinical governance, including clinical guidelines and national service frameworks (NSF) are,

> 'a form of 'blackboxing' ... the condensation of a set of political criteria into a set of ostensibly technical and scientific rules, whose perceived legitimacy suppresses contestation.' (Harrison and Ahmed 2000:142).

Harrison and Smith (2003) suggested the development of such rules for determining clinical decisions, may be perceived by the public as illegitimate denials of need. Previously, professional autonomy would have been the main means of depoliticising and legitimising managerial decisions in a demand-led healthcare service. Harrison and Smith (2003) observed that professional discretion may still be required to get work done without exposing resource inadequacies. They concluded that the existence of performance measures based on rules, results in mistrust between the medical profession and management, inflexibility and as a consequence, reduced ability to respond to crisis. This often results in increased costs as additional layers of bureaucracy are added to deal with the problems.

Harrison and Ahmed (2000) and Harrison and Smith (2003) concluded that recent healthcare policies have resulted in a decline in the autonomy and dominance of the medical profession. This is clearest at the micro and meso levels of professional autonomy. Harrison et al (2000) recognised however, Friedson's (1986) alternative theory of restratification, but suggested that whichever perspective is adopted, doctors must increasingly adopt a managerialist approach in order to progress within their profession, and that clinical decisions must now be externally referenced.

4.5.3 North and Peckham (2001) similarly argued that the implementation of clinical governance and PCG/Ts represents an attempt to extend control over the work of the medical profession, significantly challenging its professional autonomy and self-regulation. Alford's (1975) theory of structural interests in healthcare was used to expose underpinning political pressures in primary care. 'Professional monopolisers' are exemplified by the medical profession, whose power is reflected in and secured by the law and both private and public institutions. The interests of 'professional monopolisers' were seen by Alford (1975) to be challenged by 'corporate rationalisers', administrators and government healthcare planners whose objective was to extend control over the work of 'professional monopolisers'. In 1975 Alford did not believe that healthcare reforms of that day would significantly affect the interests of the 'professional monopolisers'. North and Peckham (2001) argued that since the mid 1990s however the situation has changed. Fundholding meant that GPs could be made accountable for their performance by peers within a managerial rather than a professional context. Fundholders were expected to contain their purchasing of hospital services, prescribing and practice costs within a fixed fund. In effect this incorporated them as 'corporate rationalisers' encouraged by the incentive of being able to reinvest underspends in their practices.

Whereas fundholding was optional, membership of PCG/Ts is mandatory. Budgetary arrangements and the PCG/Ts other roles in implementing policies means that GP's clinical as well as managerial practice will come under the increasing pressure of corporate rationalisation. The limiting of professional autonomy is not perceived to be a specific goal of PCG/Ts but is likely to occur via attempts to manage resources with greater efficiency, and to regulate standards of professional performance. PCGs are seen to be the mechanism by which these strategies are implemented. North and Peckham (2001) argued that,

> 'PCG/Ts are an important locus of struggles between local professional monopolisers and corporate rationalisers.' (2001:431)

PCG/Ts organise the work of GPs through the agency of others who become 'corporate rationalisers' from within. These are general practitioner Board members who in effect 'spearhead' the changes. GP Board members seek to represent the interests of the

profession, but at the same time are accountable for executing state policy. In the case of PCTs the political balance is seen to change within the role of the general practitioner PCT Board member, so that governance, as opposed to representation becomes the main function. North and Peckham (2001) suggested that only committed 'corporate rationalisers' are likely to be appointed to these roles in the future. North and Peckham (2001) further suggested that PCT status is likely to speed up alternative forms of GP employment presenting further challenges to GP autonomy. It was concluded that,

> 'PCG/Ts are organisational forms that become vehicles for change they are the creation of 'corporate rationalisers' at the centre, designed to incorporate 'professional monopolisers' at local level who will be steered by health improvement and clinical governance programmes, constrained by budgets and nudged in the direction of greater plurality in decision-making. However....professional monopolisers may concede only what is necessary to corporate rationalisers, and neither interest group may relinquish anything of substance .....'. (North and Peckham 2001:437).

4.5.4 Mahmood (2001) also observed that NHS managers have gradually achieved a degree of control over doctors and that the creation of PCTs is a recent example of this. In line with the findings of North and Peckham (2001), Mahmood (2001) observed that the status of GPs on PCT Boards is different to what it was on PCG Boards. They are no longer in the majority and are therefore less able to influence PCT policy as a result. On the one hand it could be argued that GP membership on PCG/T Boards represents a restratification within the profession of general practice (Friedman 1986). They retain medical power, avoid lay administration and are able to defend the profession's interests. Mahmood (2001) recognised that critics have challenged this (Coburn et al 1997), maintaining that such restratification provides greater advantage to the state, which controls the profession through these individuals. The individual autonomy of rank and file GPs is lost not to managers directly but to these elites. Mahmood (20001) also observes that GP Board members are not representative of all GP practices. They are more likely to be ex-fundholders from affluent areas. Many of these GPs seek to become allied with NHS managers to establish a dominant coalition within the PCT and to provide a medical viewpoint informing managerial decision-making.

4.5.5 Harrison and Dowswell (2002) conducted a study with forty-nine GPs in Northern England, exploring their perceptions of new governance arrangements, including GP representatives on PCG/T Boards had impacted on their professional autonomy and self-regulation. Harrison and Dowswell (2002) concluded that this does represent a form of restratification, and whilst there was no direct evidence of the deprofessionalisation of general practice, the shift in trust from professional judgement to systems of auditable rules, and the increased routinisation of medical work was interpreted as a feature of proletarianisation.

The increased opportunity for the surveillance of medical work was believed to be impacting on the behaviour of GPs, causing them to work as if they were constantly being scrutinised (Foucault 1977). GPs reported that they felt it necessary to maintain careful records of their clinical decisions, providing the possibility for the external surveillance of their work and that this implied a reduction in their autonomy. The pressure was perceived to come largely from doctors acting in a managerial capacity on the PCG Boards. The agenda of PCGs was believed to be driven by central government. This was interpreted by Harrison and Dowswell (2002) as evidence of restratification.

4.5.6 Sheaff et al (2002) explored the strategies that GPs pursue in response to the implementation of PCG/Ts in England. Three patterns of GP behaviour emerged. Some GPs tried to maintain an 'enclave' of general practice organised much as before the1997 'third way' strategies. They informally discouraged GP participation in PCG/Ts. The impact of new practices like clinical governance was minimised. Some GPs reduced their managerial roles and started to concentrate solely on clinical interests. Salaried GPs transferred practice management work to professional managers or fellow GPs who were interested. A minority of GPs responded by trying to take the initiative in managing the new PCG/T networks.

Sheaff et al (2002) concluded that compared to clinical work, management and professional politics were believed to be of minor interest to GPs. In changing circumstances, it was not surprising that individuals revised their views about how to defend their professional and occupational interests at different speeds. The divergent

responses were also taken to imply that restratification of general practice may be starting to occur in England.

4.5.7 Flynn (2002) uses the Faucauldian concept of 'governmentality', Corpasson's (2000) model of 'soft bureaucracy' and Lam's (2000) 'machine bureaucracy' to analyse clinical governance. The assumptions underlying clinical governance are explored to expose their implications for the regulation of the medical profession. This is then set in a broader context of changes in state intervention in society.

Flynn (2002) describes Foucault's conceptualisation of 'governmentality' as regulation without direct or constricting intervention. Individuals and groups are encouraged to define problems in similar ways and to accept responsibility for changing things for themselves. Flynn (2002) next draws on Johnson's (1995) analysis which argues that professionals are important to the state in its exercise of power and its ability to create, implement and monitor systems to achieve 'governmentality'.

> 'Surveillance becomes institutionalised and routinised in every aspect of economic and social life'. Flynn (2002:163).

Flynn (2002) refers to Osborne's (1993) observations of new methods for governing the medical profession, which rather than reducing the power of doctors, attempts to align managerial and professional perspectives, so that doctors in effect take part in governance. Flynn (2002) concurs with Osborne (1993), that coercive, hierarchical, bureaucratic methods of control are meaningless once managers and professionals engage in self-assessment and performance management. Clinical governance is an example of the medical profession participating in self-surveillance and distancing the process from bureaucratic managerial control.

Flynn (2002) goes on to discuss Courpassan's (2000) concept of 'soft bureaucracy' as an organisation with the rigid exterior of a traditional bureaucracy with a 'loosely-coupled' set of interior practices. Courpassan (2000) argues that organisations employing professionals develop systems of self-governance. Standardised performance criteria may be adopted but it is the profession itself who initiate these. This is different to the management practices applied to non-professionals who may be controlled

through hierarchical supervision, standardisation of work procedures and incentives and sanctions applied through contracts of employment. Courpassan (2000) argues that to gain recognition of their expert effectiveness, professionals are willing to give up some of their autonomy. Simultaneously, managers develop strategies to control professionals by 'instrumentalising' success and failure, for example by performance appraisal; and by 'objectifying' personal responsibility, for example, by linking objectives and tasks with specific individuals, so that decisions and potentially errors can be attributed. (Courpassan 2000:153).

Flynn (2002) observes that this system is 'soft' because performance standardisation achieves 'legitimacy' among professionals in decentralised organisations without external coercion, and this is highly relevant to analysis of clinical governance, because it is a form of governance that brings together internal and external legitimacy. Flynn (2002) argues it is also similar to 'governmentality' because it achieves 'action at a distance.' (Foucauld 1977)

Flynn (2002) next introduces Lam's (2000) ideal-type model of different forms of knowledge linked to organisational forms. 'Embrained knowledge' is individual and explicit and dependent on conceptual or cognitive skills. This knowledge is linked by Lam (2000) to 'professional bureaucracy', where experts acquire skills and knowledge through formal education and training and have a high degree of autonomy. 'Encoded knowledge' is collective, explicit, codified enabling organisational control, but this does not capture tacit knowledge, skills and judgement. This knowledge is related to 'machine bureaucracies' where there is a clear division of labour and specialisation, close supervision, and continual attempts to codify knowledge to reduce uncertainty. There is also a focus on managerially produced rules, monitoring mechanisms and performance standards. The use of tacit knowledge is minimised in a machine bureaucracy, and errors are eliminated through performance monitoring. The third kind of knowledge referred to by Lam (2000) is ''embodied knowledge' which is individual, tacit, practical and context specific. This is linked to 'operating adhocracy' where there is little standardisation of knowledge and work. The emphasis is on problem solving and individuals have a lot of discretion in their work. The final kind of knowledge defined by Lam (2000) is ' embedded knowledge' which is collective, based on shared

'norms', routines, and understandings. This is aligned with a 'Japanese-form of organisation' which relies heavily on team work, flexibility, strong corporate culture, innovation, diffused knowledge through routines and relationships. Lam (2000) highlights that this is an ideal-type model and in reality organisations display characteristics of several or all of these forms.

Flynn (2002) argues that Lam's (2000) model is useful for locating clinical governance. Medicine combines aspects of 'embrained' and 'embodied' knowledge, whilst clinical governance represents an attempt to transform medicine into 'encoded knowledge.' With the full implementation of clinical governance the control of the medical profession is moving away from 'professional bureaucracy' towards 'machine bureaucracy.' Flynn (2002) argues that clinical governance also has many of the features of Foucauldian 'governmentality', in addition, the concept of 'soft bureaucracy' and 'encoded knowledge' are helpful in understanding the changes in organisational control taking place in the English NHS.

Flynn (2002) concluded that in the English NHS the central state is the dominant actor, 'clinical governance is a means of strengthening state control over quasi-autonomous professionals in a decentralised system.' (Flynn 2002:169). In line with Harrison and Ahmed (2000), Flynn (2002) suggests that clinical governance is different from hierarchical (Fordist) bureaucracy. At the same time it is not a post-Fordist, post-bureaucratic organisational model of management with high levels of trust in 'devolved collaborative networks' (Flynn 2000:169). Instead, it is,

> '...a peculiar hybrid', combining different organisational forms, a mixture of rationalities and strategies designed to establish and codify explicit clinical standards, and to achieve a rigorous methods of performance evaluation through the co-option of medical professionals in ways which give some semblance of delegated autonomy.'(Flynn 2002:169)

Flynn (2002) suggests that both Courpasson's (2000) 'soft bureaucracy' and Lam's (2000) 'machine bureaucracy' are evident in clinical governance. Clinical governanace is an example of 'governmentality', where medical professional expertise is essential for the management of health risks, and the profession is regulated through its own self-surveillance and self-management. The profession is

required to accept responsibility for improving quality and accountability for performance through clinical governance, which is informed by managerial concepts like 'total quality management' and 'excellence'; but it differs because it requires discretion, entrepreneurship, flexibility, and self-discipline rather than obedience to rules and management directives. This is in line with professional autonomy, but control of professional performance is measured by managerially generated performance indicators. This is a result of the state's need to control expenditure, health risks and to ensure consistent continuous improvements in healthcare. Clinical governance therefore adopts a bureaucratic form of control, whilst appearing to involve professionals in the design and implementation of the system. Flynn (2002) suggests that clinical governance is to some degree a process to establish 'encoded knowledge' through the use of 'soft bureaucracy'. The question of the 'degree' Flynn (2002) suggests, should be the subject of future research.

4.5.8 Sheaff et al (2003) also use Courpasson's (1997) theory of 'soft bureaucracy' to explore clinical governance and its impact on the relationship between professionals and managers within PCG/Ts. The question is asked, to what extent do general managers and professional leaders in English NHS primary care exercise governance in the way 'soft bureaucracy' describes?

Sheaff et al (2003) observed that 'soft bureaucracy'has two aspects to it. Firstly, 'flexible corporatism', where key professionals are given management positions with relatively weak managerial power over their colleagues. Secondly, to reduce professional resistance to managerial decisions, three legitimations of managerial leadership are employed. 'Instrumental legitimation,' stresses that managerial decisions promote the organisation's aims, defined in terms of performance indicators accepted by all members of the organisation. 'Political legitimation', is where organisational members voluntarily hand over power to managers. Finally, 'liberal legitimation' which is the basis of 'soft coercion' where external organisational threats, are posed as threats to the organisation's survival.

Sheaff et al (2003) observe that whilst Courpasson's (2000) description derives from research in building, energy, finance firms and a police force, recent public policy in Europe and North USA has been to similarly construct networks of providers as a governance structure for managing services. PCTs are examples of such networks. They are small independent medical businesses, lacking the hierarchical governance structures found in traditional bureaucracies. The concept of 'soft governance' is used to explore clinical governance and its impact on the relationship between professionals and managers within these governance structures. It is asked, to what extent do general managers and professional leaders in English NHS primary care exercise governance in the way 'soft bureaucracy' describes.

Leadership in the PCG/Ts was found to emerge largely from GPs who had been active in fundholding or medical audit, informally endorsed as leaders by other GPs. Around this 'core' of leaders were found to be two 'periphery groups'. The 'inner core' comprised solely GPs, locality groups and former fundholding networks. These were now being used for clinical governance purposes. The 'outer periphery' comprised other healthcare professionals according to task. Sheaff et al (2003) suggest that PCG/Ts had few means of exercising power and exacting obedience through hierarchical supervision, coercion, or punishing of uncooperative GPs, because most were self-employed.

Elements of 'flexible corporatism' were found in the PCG/Ts although this was usually 'watered down.' Evidence-based medicine itself was seen to be an impersonal definition of acceptable clinical practice. It is observed that, considering GPs usual sensitivity to threats to their clinical freedom they preferred the more prescriptive coronary heart disease NSF than the less prescriptive mental health one, and had done more to implement it. GPs were unreceptive to anything they perceived as 'managerial norms' for managerial control. The same applied to 'managerial tools.' Various existing audits and educational activities had been re-labelled clinical governance, or included as part of practice or individual development plans. All of these activities were led by GPs. Managers were in a weak position to apply any management norms or tools. PCG/Ts at the time of this research had not developed local indicators of individual clinician performance, but were starting to. GPs reported documenting their clinical decisions

more thoroughly. GP clinical governance leads were visiting the practices to discuss progress towards implementing clinical governance and using these opportunities to 'utter quiet words of warning' where necessary. Competition between GPs was not evident, although some seemed wary of others. The only rewards and sanctions mentioned were peer pressure and comparison with colleagues.

Sheaff et al (2003) suggested that all three forms of legitimation described by Courpassan were evident. Clinical governance activities were legitimated in instrumental ways. Clinical governance leads represented necessary tasks in technical, problem-solving terms, encouraging GPs to adopt self-imposed targets or to volunteer for special projects. Clinical governance leads represented consistent deviance from evidence-based guidelines as clinically and scientifically unacceptable. Local clinical governance policies reflected national policy initiatives, but this was explained as national priorities coinciding with local needs. Sheaff et al (2003) observed, that although clinical governance activity was legitimated in these instrumental terms, instrumental justification referred to the technical health effects of good clinical practice, not its contribution to NHS management objectives.

Sheaff et al (2003) also reported that respondents accepted a variant of Courpassan's 'political legitimation' of clinical governance activity because they feared the threat of NHS management policing their work, introducing a form of scepticism and passivity. Sheaff et al (2003) concluded that a form of 'soft coercion' was occurring. GP clinical governance leads represented national policy as something that could be imposed if it was not adopted voluntarily, even though in reality clinical governance policies merely represent guidance, the regulatory status of this being unclear. The 'tacit' threat was of managerial inteference in medical decision-making, reduced professional discretion, more paperwork and tighter financial controls. To support this, GP clinical governance leads reported referring to national policies relating to quality, in particular the formation of NICE and CHI (now CHAI), and the media and other reports of failures of medical self-regulation. Local clinical governance policies

were also represented by clinical governance leads as a protection from the external threat of 'heavy-handed' government and NHS management initiatives. Sheaff et al (2003) suggest that this legitimated one GP intervening in the practice of another, at both the clinical level and at practice level, in terms of how it was organised, even though GP practices are small independent businesses. Under this 'soft coercion' many (but not all) GPs were willing to share some of their decision making with GPs in other practices and the PCG/T leads. This 'politiacl legitimation' of professional colleagues as leaders was reported to be still weak.

Sheaff et al (2003) noted, that both medical and managerial informants represented clinical governance activities and networks as self-managed by GPs and not therefore an exercise of managerial control. It was also emphasised that clinical governance was not to be imposed on GPs. Clinical governance leads reported that they had found it necessary to make performance comparisons none threatening, that self-criticism was encouraged rather than external criticism, success stories were well publicised whilst problem areas remained highly confidential. Education and training was the means used to influence clinical practice because this was perceived by GPs to be non-threatening. GPs had been willing to legitimate leadership and give up some power to medics, but not to NHS managers. It is reported that GP clinical governance leads believed their task was to construct the 'trust' of other GPs. This is understood by Sheaff et al (2003) as an example of legitimating clinical governance activities in 'political' terms.

Sheaff et al (2003) concluded that whilst centralised policy making leadership does exist in PCG/Ts, there are few other features constituting them as bureaucracies. GP Board members had little hierarchical authority or other means of coercion of rank-and-file GPs. Individual GPs were unwilling to transfer decision-making authority to NHS managers. However, by exposing individual GP practice to the 'gaze' of collective professional leaders, this helped to establish technically legitimated rules of professional practice which regulate the work of rank-and-file GPs. Thus the focus of self-regulation has moved away from individual GPs to GP leaders on PCG/T Boards. There is therefore evidence of restratification in general practice, but this is complex and multi faceted. Sheaff et al (2003) found no evidence of deprofessionalisation of GPs. PCG/Ts were found to a degree to substitute for a traditional bureaucracy as a governance

structure through which managers and professional leaders can exercise soft leadership over professional general practitioners.

With respect to the value of the concept of soft bureaucracy as an analytical tool, Sheaff et al (2003:421) argued that it identifies that managers do not influence doctors directly, but through local professional leaders who have a 'boundary role' of communicating managerial priorities and conserving a degree of autonomy for the profession. The influence of these leaders is exercised through a,

> 'combination of knowledge management, collective self-organisation and the innuendo of political threats rather than overt financial, administrative or regulatory controls.' (2003:421)

The focus of self-regulation has shifted away from the individual doctor to medical leadership. Sheaff et al (2003) suggested that such restratification should be understood as a differentiation of roles between intermediaries and fellow professionals rather than difference of occupational group or employment status, as if doctor and manager were mutually exclusive categories. Sheaff et al went on to point out the similarities and differences between Friedson's (1986) and Courpassan's (2000) ideas. Both describe bureaucracies structured in a hybrid way to take account of a professional workforce, and both perceive a move away from informal methods of control within professions to more formal controls. Both understand control to be exercised by a supervisory group from within the profession itself and a consequence of intensified market competition. Both agree that one consequence is the reduction of individual power and autonomy. Friedson however, maintains that these changes do not necessarily reduce the power of the profession as a whole, whilst Courpassan sees the construction of new (although still limited) forms of managerial domination. Whilst Friedson (1986) divides professional elites into a knowledge elite, and a supervisory elite, Courpassan views knowledge mangement and supervision as two aspects of the professional leaders role, rather than a difference in status.

4.5.9 Sheaff et al (2004), drawing on Foucauldian theory, examined the effect clinical governance policies have on self-regulation, in particular the 'governmentality' and discipline of English general practice. The question is asked, what forms of professional

discipline are emerging as PCG/Ts start to implement clinical governance policies? It was concluded that medical networks still influence GPs more than NHS managers do. The profession still exercises self-regulation to avoid managerial control. Professional leaders still mediate between fellow GPs demands and those of health care policy. GPs maintain decision-making power in relation to clinical governance, local healthcare needs and strategies to deliver these. The technical quality of GPs work is still determined by GPs reviewing fellow professionals work via some form of peer review or evidence-based medicine. At the local level, a new form of GP self-regulation is evolving which is different from earlier forms. Constant surveillance of GPs clinical practice is replacing the 'occasional glance' of the local Medical Audit Advisory Groups, Local Medical Councils, and the Royal College of General Practitioners,

> 'Permissive exception management is gradually yielding to routinised, more comprehensive and directive technologies of power focused on mainstream clinical practices and the largest care groups' (Sheaff et al 2004:100).

Professional discipline is more collective with professional autonomy and self-regulation redefined in more collegial terms.

> 'A medical discourse is shifting the emphasis from individual autonomy to corporacy.' (Sheaff et al 2004:100).

This is leading to greater transparency in GPs clinical practice to local medical leaders 'gaze' and to that of NHS managers. It is gradually becoming more difficult for rank-and-file GPs to block changes in clinical practice. This collective control is being exercised through semi-formal local networks. There is an emerging group of professional leaders who mediate between professionals and managers as in the case of hospitals. It is noted that whilst GPs remain influential they are no longer able, in isolation, to determine what questions may be asked about their work. PCG/Ts are increasingly monitoring the work of GPs and the criteria used increasingly originating from national bodies subject to the influence of government policy. It is finally concluded that as in the case of hospitals, where medical leaders have for some time been strengthening professional discipline in order to avoid further managerial trespassing upon medical self-regulation, and where some doctors as a result lost power,

but the profession as a whole became stronger, a similar process appears to be occurring in general practice. A form of professional restratification is occurring.

4.5.10 Armstrong (2002) explored the way in which GPs make prescribing decisions in the context of evidence-based medicine. Evidence-based medicine is used to exemplify stratification theory, with rank and file GPs implementing the results of clinical research conducted by medical elites. Armstrong (2002) found that evidence-based medicine enabled general practitioners to resist some of the challenges to professional autonomy, since applying scientifically proven treatments provides less justification of external constraints. Armstrong (2002) reported that the prescribing practice of GPs maintains an individualistic approach to the varying needs of patients and to the idiosyncratic prescribing experiences of GPs. Armstrong (2002) concluded there was tension between the concepts of professional autonomy of individuals and the concept of restratification, but there was no conclusive evidence of restratification occurring in general practice.

4.5.11 Dopson et al (2003) examined the origins and impact of evidence-based medicine and the mixed reactions of clinicians to its implementation. Dopson et al (2003) suggest that the interest of policy makers in evidence-based medicine and the resulting clinical guidelines are interpreted by some clinicians as a cost cutting mechanism whilst at the same time maintaining standards of care, and as a potential vehicle for the rationing of health care. Dopson et al (2003) further suggest that NHS managers may perceive evidence-based medicine as a means of increasing control of the doctor's work. Evidence-based medicine seeks to create a culture in which practitioners automatically think in an 'evidence-based' way and this shapes their behaviour and clinical decision making. The medical profession has both accepted evidence-based medicine and has also resisted it.

Dopson et al (2003) highlight the significant influence of the medical profession on evidence-based medicine in its early stages, but recognise that support for this did not mean it was being applied in every day practice. This is referred to as the 'implementation gap'. The 'implementation gap' is explained partly in terms of the power of the medical profession, although the professional leadership of the

implementation of evidence-based medicine is perceived to have helped to limit medical resistance. Doctors have been able to undermine evidence-based medicine either to bring about change perceived to improve the patient experience when the evidence for this is not strong, or to reject unwanted change on the basis of evidence being still under trial or weak.

The 'implementation gap' is explained in terms of the perceived threat to medical professional autonomy posed by evidence-based medicine, which may be viewed as reducing or eliminating a clinicians right to make medical decisions without challenge. Acceptance or other wise of evidence-based medicine and the resulting clinical guidelines depends to some extent on whether a doctor sees these as an authoritative and credible assistance to improve his/her practice, or as a form of imposed managerial control.

Dopson et al (2003) conclude that healthcare continues to be complex requiring medical expertise in both the construction and application of clinical guidelines. Haug's (1973; 1975) theory of deprofessionalisation is not therefore an adequate explanation of the impact of evidence-based medicine on the autonomy of the medical profession. Friedson 's (1986; 1989) restratification theory is accepted as a more plausible alternative. Overall, the medical profession retains the power to determine its own practice and to avoid managerial control, achieved by the emergence of a supervisory hierarchy within the profession. Evidence-based medicine and the resulting clinical guidelines are viewed as,

> '....a classic example of stratification, in which some doctors with expert status, sift the evidence and provide guidance for other doctors to put into practice.' (Dopson et al 2003:323)

4.5.12 A study conducted by **Locock et al (2004),** was part of a Department of Health funded evaluation of the implementation and impact of PCG/Ts in England. The aim of the study was to determine the experiences of GPs in PCG/Ts and to explore the extent to which GPs manage or are managed by these structures. Stratification theory (Friedson 1986; 1989) was used to examine whether PCTs will strengthen medical

control over resource allocation, whilst avoiding management control of clinical decision making. The study also explored whether GPs not involved in decision-making at PCG/T level feel a loss of control over decisions and their own clinical practice.

The conclusions drawn were that at that time there was inconclusive evidence of PCG/Ts strengthening collective medical control over resource allocation and the ability to fend off managerial control over decision making. There was however, clear evidence that there had been no significant impact from PCG/Ts or other government policies on individual professional autonomy of general practitioners.

The results of the study suggested that some GPs were optimistic about PCTs, others were less positive describing strategies for resisting unacceptable interference. Key concerns were the level of paperwork, meetings and the generally increased workload. With respect to clinical guidelines and protocols, some felt these were beneficial others disliked the prescriptive nature of these. Some felt clinical freedom was at risk, but this was more an anticipated concern for the future. With respect to the impact of PCTs on the quality of care locally less than half of the participants felt there was potential or actual improvement in quality. With respect to the impact of the PCG/T policies on their own individual clinical decisions, responses ranged from rejection of any constraint imposed to the welcoming of greater standardisation. Many GPs said that they felt constrained but would do whatever was in the best interest of patients regardless of guidelines. Some GPs had no problem with the principle of guidelines but wanted to reserve the right to make decisions that differed from the guidelines in individual cases where necessary.

Many GPs reported strategies being used to persuade them to abide by PCG/T policies, including the use of financial incentives, which were believed to be an effective mechanism given the independent contractor status of GPs. There were no examples of financial penalties for non-compliance although there were fears of this reported for the future. Some GPs mentioned peer pressure and local audit. GPs who were not PCG Board representatives reported minimal involvement in decision-making structures. Many believed good clinical decisions were being over-ridden because of financial considerations. Many GPs saw primary care as relatively powerless even though the

Boards were trying to ensure policies and decisions were supportive of clinical practice. Confidence of rank and file GPs in the GPs who represented them on the Boards was high. There was a lack of understanding of what motivated these individuals however. The reasons suggested were political ambition, the desire to exercise power and make themselves a name, visionaries with a will to be innovative to improve patient care, those bored with or not good at direct patient contact, alternative sources of job satisfaction, workaholics, those feeling that somebody has to do the job so it might as well be them. Many GPs felt there was no tension between GPs involved at Board level and rank and file colleagues. Where tensions were reported these tended to be because policy decisions were felt to threaten professional autonomy or the quality of care, or because, colleagues were believed to be 'selling out' to corporate managerial interests.

4.5.12 Dent (2005) considers the introduction in 2001 of an overarching Council for the Regulation of Health Care professionals and other post 1997 reforms on the professional autonomy and self-regulation of the medical profession and on the nursing profession. Dent (2005) suggests these have resulted in a shift from 'tolerant professional autonomy' to a 'responsible professional autonomy'. This has resulted in a de-emphasis of individual clinical experience and professional judgement, in favour of evidence-based medicine and 'Prescribed Pathways of Care'. Dent (2005), similar to other authors also comments on the attempts of the government to integrate medicine into management. Dent (2005) argues that these reforms represent a shift from previous models of making autonomous professionals accountable, to one of subordinating the medical profession to state management systems of surveillance. Concurring with Harrison and Macdonald (2003), Dent argues that this has resulted in 'scientific bureaucratic' medicine which has diminished the tacit element of medical practice.

> 'Integrated Care Pathways, clinical guidelines and protocols are introduced to be obeyed rather than as navigational aids, informing rather than directing clinical practice' (Dent 2005:6)

Similar to Sheaff et al (2003; 2004), Dent (2005) regards these as examples of 'soft bureaucracy' ensuring that central governmentally defined targets are achieved.

Dent (2005) observes a potentially expanded role for the nursing profession resulting from the post 1997 reforms. The medical profession is still however perceived to retain its dominant influence within the healthcare professions. It is observed however, that both the medical profession and nursing (and other health care professionals) have been placed under the control of the Commission for the regulation of Health Care Professionals. Whilst nurses and some other health care professionals perceive this to provide them with grater professional status and recognition, doctors interpret this as the means by which their professional self-regulation is subordinated to the Privy Council and/or Parliament. For the medical profession this represents,

'..a shift away from professional self-regulation to a more tightly defined suzerainty vis-à-vis government.' (Dent 2005:9).

Dent (2005) concludes that the medical profession will be unlikely to accept its own undermining by government regulation and nurses encroachment on their traditional areas of work. Elite elements within the medical profession will however, accept and champion the reforms representing a restratification within the medical profession. (Friedson 1886; 1989)

4.6 Conclusion.

This chapter has reviewed the nature and development of the professions as a distinct occupational group from functional and processual perspectives. It has argued that the key defining characteristics of a profession are its professional autonomy and self-regulation. This has many dimensions to it, but in essence, it is the ability to determine the nature and content of work and the right to self-regulation without reference to others. The dominance of the professions is based on its unique access to and regulation of a body of knowledge valued by the state and society. Professional autonomy empowers the negotiation of other privileges including institutional influence, the ability to achieve premium financial rewards and entry to exclusive markets, and the opportunity to influence policy and its implementation.

This chapter has explored challenges to professional autonomy. Neo-Marxist analysts interpret reductions in professional autonomy in terms of two overlapping concepts of deprofessionalisation (Haug 1973; 1975) and proletarianisation (McKinlay and Arches 1985; McKinlay and Stoeckle 1988). Deprofessionalisation explains the erosion of professional legitimacy and knowledge monopolies resulting from the improved levels of general education and a less deferential society. Medical mistakes are open to greater scrutiny. Doctors are in effect, technicians producing medicine for the consumer according to standard protocols. This implies that non-medical professionals could do the job, the doctor's monopoly of knowledge may be easily eroded and managers can monitor professional performance. Proletarianisation suggests that in advanced capitalist societies professional work is 'bureaucratised' and 'corporatised', reducing its status to that of any other type of worker in a capitalist system. Professionals work to achieve organisation goals rather than to serve clients.
Regulation and inspection reduce their freedom to practice. Whilst they continue to receive high rewards, surplus value is still extracted from their labour.

Neo-Weberian analysts prefer explanations which focus on changes within the profession. Restratification implies a decline in collegiality, with elite groups emerging within a profession and limiting the autonomy of 'rank-and-file' practitioners. The power and dominance of the profession as a whole is maintained. Medicine has become more hierarchical. It has simultaneously responded to and shielded itself from managerial control by ensuring that professionals themselves take on significant managerial positions. Professions acquire power which was previously the sole domain of managers, but the distribution of this varies within the profession. A previously homogenous group is divided into those with and those without a wider organisational stake. (Friedson 1984; 1986).

Chapters two and three of this thesis examined New Public Management techniques applied in the English NHS. Since 1997 the New Labour Government has implemented Primary Care Groups, which have since evolved into Primary Care Trusts, and a framework of clinical governance. These have been described as the latest phase of managerialism in the English NHS (Flynn 2002). Recent studies in the primary care sector have focused on the impact of these reforms on the relationship between the

medical profession and the state, and on the professional autonomy and self regulation of general practitioners (Salter 2000; Harrison et al 2000; Harrison and Dowswell 2002; Harrison and Smith 2003; North and Peckham 2001; Sheaff et al 2002; 2003; 2004; Flynn 2002). The key question addressed in these studies is whether restratification is occurring in general practice, as it is already believed to have occurred in the case of hospital consultants (Hackett 1999; Sheaff et al 2004). These studies present limited evidence of deprofessionalisation, and more significant evidence of both proletarianisation and restratification (Salter 2000; Harrison et al 2000; Harrison and Dowswell 2002; Harrison and Smith 2003; North and Peckham 2001; Mahmood 2001; Flynn 2002; Sheaff et al 2002; 2003; 2004). Other studies indicate that the evidence is inconclusive (Armstrong 2002; and Laycock et al 2004).

The debate about whether restratification is occurring in general practice in the English NHS as a result of post 1997 reforms is ongoing. The purpose of this study is to contribute to this debate. The aim of the study is to compare managerial and professional perspectives of the impact of clinical governance on the professional autonomy and self-regulation of general practitioners in a primary care trust in the Northwest of England. The study is differentiated from existing studies reviewed in this chapter in that its main focus is clinical governance rather than PCG/Ts as new organisational forms. The definition of clinical governance in my study is broader than in existing studies which have largely focused on the implementation of National Service Frameworks (Sheaff et al 2000; 2003; 2004) and evidence-based medicine (Dopson et al 2003; Armstrong 2002). At the time of collecting data for my study the new General Medical services contract was being negotiated and most of the participants referred to this in their responses, providing additional insight into managerial and professional perceptions of the impact of the new contract on the implementation of clinical governance in general practice. Whilst most of the existing studies use qualitative research methods, there are no in-depth single site case studies of this nature, comparing managerial and professional perspectives. The aim of my study is to add to the existing body of knowledge by focusing on the impact of the *whole* process of clinical governance on the professional autonomy and self-regulation of GPs and to employ a single site exploratory case study methodology to paint a rich and detailed picture of the 'human-side' of the Utopian PCT and the associated general

practices. The next chapter presents the research methodology, research design and data collection methods employed in my study.

Chapter Five

Methodology.

'We can, and I think must, look upon human life as chiefly a vast interpretative process in which people, singly and collectively, guide themselves by defining the objects, events, and situations which they encounter.....Any scheme designed to analyse human group life in its general character has to fit this process of interpretation' (Blumer 1956:686).

5.1 Introduction.

The aim of this study is to examine the impact of clinical governance on the professional autonomy and self-regulation of general practitioners (GPs) in a Primary Care Trust (PCT) in the Northwest of England from the perspectives of Primary Care Trust directors and managers, and medical healthcare professionals working in general practice.

The objectives of this research are:

- To explore clinical governance in the context of general practice and to identify the requirements for and the barriers to its implementation.
- To examine the role of GP Medical Representatives on the Primary Care Trust (PCT) Board and Professional Executive Committee (PEC) in the implementation of clinical governance in general practice.

- To analyse the impact of clinical governance on the professional autonomy and self-regulation of GPs to determine whether this is contributing to the deprofessionalisation, proletarianisation or restratification of general practice.

This chapter outlines and justifies the research methodology and data collection methods employed in my study in the context of the research questions, aim and objectives. The chapter is presented in five sections. The first section is the introduction. The second section locates the research in the 'qualitative research paradigm' and justifies this choice in the context of the research aim and objectives. The third section provides details of the research design, which is a single-site exploratory case study employing semi-structured interviews, focus groups, non-participant observation and documentary analysis. The fourth section considers the trustworthiness of the data. The final section discusses issues relating to organisational access and research ethics.

5.2 Justification for the Paradigm and Methodology.

A significant contribution to the understanding of epistemological and ontological issues in social and organisational research was made by Burrell and Morgan (1985) who produced a matrix of four paradigms representing mutually exclusive approaches to the research process (Bryman and Bell 2003). The matrix is displayed at Figure 1 overleaf.

THE SOCIOLOGY OF RADICAL CHANGE

	'Radical humanist'	'Radical structuralist'	
SUBJECTIVE	'Interpretive'	'Functionalist'	OBJECTIVE

THE SOCIOLOGY OF REGULATION

Figure 1: Source:-Burrell G. and Morgan G. (1985:22) Sociological Paradigms and Organisational Analysis

Johnson and Duberley (2000) observe that the two axes of the matrix are based on different assumptions about the nature of social science and the nature of society. All social science theory makes assumptions along these dimensions and is located somewhere in the matrix according to those assumptions. The horizontal axis makes assumptions about the nature of the social world and the methods used to research it. Choices are made about ontology, epistemology, human nature and methodology. By accepting one set of alternatives the opposite ones are excluded. The vertical axis of the framework represents assumptions about the nature of society and at one extreme represents 'the sociology of regulation' and at the other, 'the sociology of radical change.' The two dimensions produce four paradigms which are labelled 'radical humanism', 'radical structuralism', 'the interpretive paradigm' and 'the functionalist paradigm.' Burrell and Morgan (1985) argue that whilst the paradigms share some characteristics they are sufficiently differentiated to be treated as four distinct and separate approaches. This produces paradigm incommensurability, because the paradigms represent commitment to opposing beliefs about the world and how to research it. Jackson and Carter (1991) argued that this incommensurability is important because it protects the diversity of scientific thought.

Reed (1985:205) suggests however that the boundaries between the paradigms are not so distinct and 'clear cut.' Isolating research into incommensurable paradigms of this nature reduces the

> 'potential for creative theoretical development.'

Willmott (1993:23) argues that the subjective/objective dualism leads to a polarisation of methodological approaches. Paradigms should rather,

> 'arise through critical reflection on the limitations of competing approaches'.

The approach to research methodology (the philosophical underpinning of research techniques) has implications for the research methods (the investigative techniques) employed. Bryman and Bell (2003) suggest that there are two different approaches. The 'epistemological version' which, like the Burrell and Morgan (1985) model outlined above, views research methods as embedded in the research paradigm. Quantitative and qualitative research from this perspective would be based on incompatible epistemological and ontological principles. The 'technical version' on the other hand, focuses on the strengths of data collection and data analysis techniques associated with quantitative and qualitative research, and acknowledges therefore the possibility of mixing these methods whilst at the same time recognising that these are associated with different epistemological and ontological assumptions. This opens up the possibility of combining qualitative and quantitative research methods.

Symon and Cassell (1998) observe that for some researchers the most important factor is selecting the most appropriate technique for the research questions to be addressed. This perspective allows for research techniques to be used within a number of different paradigms. Researchers provide their own interpretations of research methods influenced by their own ontology and epistemology.

In line with the observations of Bryman and Bell (2003), Creswell (2002) observes that two paradigms are widely discussed in the research methods literature, the qualitative and the quantitative paradigms. Qualitative research is defined as,

> ' an inquiry process of understanding a social or human problem based on building a complex, holistic picture, formed with words, reporting detailed views of informants and conducted in a natural setting.' (Creswell 2002:1 & 2)

Quantitative research is defined as,

> 'an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether predictive generalisations of a theory hold true.' (Creswell 2002:2)

Denzin and Lincoln (1994:4) compare these approaches, stating,

> 'Qualitative researchers stress the socially constructed nature of reality.....They seek answers to questions that stress how social experience is created and given meaning. In contrast quantitative studies emphasise the measurement and analysis of causal relationships between variables, not processes.'

Writers such as Firestone (1987); and Guba and Lincoln (1988) contrast the assumptions of theses paradigms. Firestone (1987) reports that there are five sets of assumptions underpinning both paradigms which at the extreme positions may be viewed as diametrically opposed. These assumptions are ontological, epistemological, axiological, rhetorical and methodological.

Ontological assumptions relate to the nature of reality. Is the 'reality' to be investigated external to the individual, or the outcome of individual consciousness?
In qualitative studies 'reality' is subjective as seen by the participants in a study. In quantitative research 'reality' is objective and viewed as separate from the researcher.

Epistemological assumptions relate to the nature of knowledge and therefore the relationship of the researcher to the subject of the research. Can knowledge be acquired, or is it something that has to be personally experienced? The researcher interacts with the researched in the case of the qualitative paradigm, and is independent from it in the case of the quantitative approach.

Axiological assumptions relate to the role of values in a study. The qualitative researcher recognises that the study is 'value-laden', and identifies and reports his/her values and biases along with the value nature of information gathered. On the other hand, the quantitative researcher believes his /her values are isolated from the study.

Firestone (1987) refers to rhetorical assumptions or the language of research and suggests that qualitative language is more informal, whilst quantitative language is impersonal and formal.

Firestone (1987) argues that from these four sets of assumptions the fifth has emerged, the research methodology. This embraces the other four and refers to the entire process of the research. Quantitative methodologies include for example, experiments and surveys including cross-sectional and longitudinal studies using questionnaires or structured interviews for data collection. The intent is to generalise from a sample to a population (Babbie 1990). Qualitative methods and traditions are many and varied and include for example, interviewing, participant observation and the diary method (Easterby-Smith et al 2002; non-participant observation, text analysis and discourse analysis (Silverman 2001); and conversation analysis (Have 1999). Ethnography, phenomenology, grounded theory and case study methodology are also traditions associated with the qualitative paradigm (Creswell 1998).

Qualitative methodology uses 'inductive' logic where issues emerge from the informants in a study rather than being identified in advance by the researcher. Creswell (2002) argues that this provides,

> 'rich, context-bound' information which leads to 'patterns or theories' helping to explain a situation or phenomenon' (2002:7).

Quantitative research on the other hand uses 'deductive' logic, where theories and hypotheses are tested for cause and effect. Creswell (2002) observes that concepts, variables and hypotheses are chosen before the study begins and remain fixed throughout.

Quantitative research has a long history flowing from the natural sciences and is varyingly referred to as traditional, positivist, experimental or empiricist research established by writers such as Compte, Durkheim, Newton and Locke (Smith 1983). The qualitative paradigm is termed the constructivist, naturalistic or interpretive approach. (Lincoln and Guba 1985; Smith 1983). Smith (1983) argues that the qualitative paradigm began as a countermovement to the positivistic paradigm in the late nineteenth century through writers such as Weber and Kant.

Brewerton and Millward (2001) similarly observe that within the social sciences some have challenged the positivist paradigm as inappropriate for the investigation of social phenomenon on the basis that in this context reality is constructed and cannot be explained in terms of universal laws; rather it is relevant to search for meanings and interpretations. In the case of research into the professions for example, Everett Hughes (1963), quoted in Macdonald (1995:6) reported that he had,

> '....passed from the false question, is this occupation a profession? to, what are the circumstances in which people in an occupation attempt to turn it into a profession and themselves into professional people?'

This spawned research which as outlined in chapter four of my thesis continues to this day, which emphasises the ability of professionals to influence and shape the organisations and environments in which they operate, and seeks to identify how individuals perceive their social and organisational worlds. (Friedson 1970a; 1970b; 1984; 1986; Larson 1977).

Collis and Hussey (2003) highlight the key criticisms of the positivist paradigm, firstly, that it is impossible to treat people as being separate from their social contexts, they cannot be understood without examining the perceptions they have of their own activities. Secondly, the highly structured research designs of the positivist approach are perceived to impose constraints on research results and may ignore more relevant and interesting findings. Thirdly, it is not realistic to believe that researchers can be objective and independent. They are a part of what they observe, and they cannot do anything other than bring their own interests and values to the research. Finally, it is argued that to try to capture complex phenomena in a single measure is misleading.

Saunders et al (2003) highlight that researchers selecting the qualitative paradigm, perceive the social world to be complex and unique, a function of a particular set of circumstances and individuals. It is observed however that this may raise the question of the 'generalisability' of the results of such research. This is a complex issue, but Saunders et al (2003) argue that in qualitative research generalisability is not perceived to be important. The social world is changing all the time, and every set of circumstances is unique. If this is accepted then there is no need for research results to be generalisable. On the other hand, it is necessary to explore subjective meanings motivating individual action. People interact with their environments and make sense of this through their interpretation of events and the meaning that they extract from these. It is the role of the researcher therefore to try to understand the subjective reality of participants in a study to make sense of motives actions and intentions.

Collis and Hussey (2003) observe that the positivist paradigm requires research findings to be credible. To be credible findings must be 'reliable' and 'valid'. For positivists, research findings if they are to be reliable, must obtain the same results should the research be repeated. However under the qualitative paradigm, the criterion of reliability is not given so much status, and is differently interpreted. The question becomes, would similar observations and interpretations be made on different occasions or by different researchers?

Validity is the extent to which the research findings accurately represent what is really happening in a situation. Collis and Hussey (2003) point out that because the positivist paradigm focuses on the precision of measurement and the ability to repeat an experiment reliably, there is a danger that validity will be low. The measures used may not reflect the phenomena the researcher claims to be researching. On the other hand, the very aim of the qualitative paradigm is to identify the essence of the phenomena under investigation, and to extract data which is rich in meaning and explanation, as a result, validity tends to be higher.

Creswell (2002) suggests that the purpose of the research and the nature of its central inquiry, along with the researchers 'worldview', education, experience and psychological attributes will influence the researcher's research philosophy and design. I believe 'reality' to be largely socially constructed, and subjective. For this reason I am

interested in discovering manager's and GP's individual perceptions of clinical governance and the requirements for and barriers to its effective implementation in general practice. I also want to explore manager's and GP's perceptions of the role of GP medical advisers in the implementation of clinical governance and its impact on the professional autonomy of GPs. Do managers, GPs and other healthcare professionals in general practice perceive clinical governance to reduce the professional autonomy of GPs or is it merely 'changing hands' *within* the profession?

5.3 The Research Design.

I have chosen to use a case study methodology for my research. The unit of analysis is a Primary Care Trust (PCT). The data collection methods used are in-depth, semi-structured interviews, focus groups, non-participant observation at the Clinical Governance and Risk Management Committee and the General Practice Sub-group at the PCT, and the analysis of PCT documentation relating to the implementation of clinical governance.

5.3.1 *An Exploratory Study.*

This research takes the form of a single site exploratory case study. Exploratory studies are, according to Robson (2002:59)

> 'a valuable means of finding out, what is happening; to seek new insights; to ask questions and to assess phenomena in a new light.'

The aim of my research is to explore the concept of clinical governance in the context of general practice, and to discover manager's, GP's and other healthcare professional's (working in general practice) perceptions of clinical governance on the professional autonomy and self-regulation of GPs. I did not set out to specifically test existing theories, but I was guided by a set of propositions which stemmed from reading the literature on the professions. Could it be that the professional autonomy of GPs in the Utopian area is declining as a result of the implementation of clinical governance in

general practice? (Mckinlay and Arches 1985; Mckinlay and Stoeckle 1988) Has the professional autonomy traditionally experienced by all GPs in Utopia been redistributed to elite groups emerging within the profession? (Friedson 1984; 1986)

5.3.2 *A Case Study.*

Robson (2002:178) defines a case study as,

> 'a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence.'

Yin (2002) identifies the characteristics of case study research. The researcher seeks to understand phenomena within a particular context and uses multiple methods for collecting data which may be both quantitative and qualitative. Yin (2002) also highlights that it is valid to use case study methodology working within either the quantitative or qualitative paradigms.

Yin (1991a and 1991b) identifies three different kinds of case studies exploratory, descriptive and explanatory. Scapens (1990) adds two other types, illustrative and experimental. Exploratory case studies seek to assess phenomena in a new context. Descriptive case studies attempt to describe current practice. Explanatory case studies use existing theory to understand and explain phenomena or events. Illustrative case studies attempt to illustrate new and innovative practices, and experimental case studies examine the difficulties in implementing new procedures or techniques and seek to evaluate the benefits obtained.

I have chosen to use an exploratory case study approach for my research study. Yin (2002) suggests that case studies are appropriate research strategies when research questions ask 'how' and 'why' as well as 'what' questions in relation to a contemporary set of events, over which the researcher has little or no control. My research focuses on the perceptions of managers and GPs of the 'nature' of clinical governance in the 'context' of general practice and 'how' this impacts on the professional autonomy of

GPs. I am seeking to work within the qualitative paradigm. According to Robson's (2002) definition of a case study, and Yin's (1991a; 1991b; 2002) explanations of when it is appropriate to use case study methodology, this is a suitable research strategy to achieve the aim and objectives of my research study.

I recognise however, that in focusing on individual meaning other qualitative research strategies could have been adopted. In particular an ethnographic approach would have been a valid approach to adopt. Saunders et al (2003) observe that ethnography seeks to interpret the social world the research participants inhabit and the way in which they interpret it. The research method that dominates ethnography is identified by Gill and Johnson (2002:113) as participant observation, where the researcher,

> 'attempts to participate fully in the lives and activities of subjects, and thus becomes a member of their group, organisation and community'.

To use this approach would require me to work with all three groups of participants in their organisational settings, firstly at the PCT and then in individual practices. This would have been too time-consuming a process and impossible to achieve along side a full time teaching job and within the parameters of a part time PhD. Also, the very nature of general practice which respects the confidentiality of patients would have been prohibitive. I would not have been allowed to observe GPs during consultations to fully understand how GPs perceive clinical governance to impact on their work.

5.3.3 The Parameters of the study – The' unit of analysis'

The unit of analysis in my study is Utopian Primary Care Trust (PCT). The number of participants in the study is fifty. This includes thirteen PCT directors/managers, nine professional representatives at the PCT, twelve 'rank and file' GPs (Thirty four participants). In addition eight practice managers participated in two focus groups, and eight practice nurses participated in two further focus groups. The field work took place in three phases. The managerial participants and the professional representatives at the

PCT were interviewed first over a 12 month period, February 2003 to February 2004. The GPs in the field were interviewed next. During this phase it became apparent that practice managers and practice nurses could add interesting insights to the study. At the same time, I was conscious of time moving on and was anxious not to get 'side tracked' into related issues of interest to practice managers and nurses, but not of direct relevance to the study. I decided therefore that the final phase of the fieldwork would be to hold focus groups for these participants. The interviews with GPs and the focus groups took place over an eight month period, from March 2004 to November 2004.

Bryman (1989) observes that some of the classic studies in organisational research have derived from the detailed investigation of one or two organisations. (Blau 1955; Gouldner 1954; Roy 1954; 1960 and Selznick 1949). These studies all took 'an organisation' or 'a department' as constituting 'the case'. Bryman (1989) states however, that people, events and activities can also be viewed as the 'unit of analysis' in case studies. Bryman observes that case studies can involve more than one 'site' usually to try to improve the generalisability of research results, the absence of which is a well documented criticism of single-site case studies. Bryman (1989) argues that when large numbers of 'sites' are involved in a study, the distinctiveness of the case study approach is questionable. In my study the aim is not to generalise from the case study to the wider population, but to take a 'snapshot' at a particular time of the situation in a particular location (Saunders et al 2003). This enables me to complete the research process within the financial and time constraints of my part time PhD. The outcome of this exploratory case study however, does provide the basis for the study to be repeated in further sites in the future if a researcher perceives the new situation to be sufficiently similar to the circumstances of this case to make the parameters of the study transferable (Lincoln and Guba 1985). It is pertinent at this point however, to reiterate a point made earlier in this chapter, that the social world is changing all of the time and every set of circumstances is unique. There is no need therefore for results of a study to be generalisable. Instead, what is important is to try to understand the subjective reality of the participants in a study in whatever circumstances are present at the time (Saunders et al 2003).

Bryman (2004) observes that often in qualitative research the numbers of participants and how they are selected is not transparent. Saunders et al (2003) suggest that the sampling methods most often associated with qualitative research are classified as non-probability sampling. Participants tend not to be chosen at random but deliberately because of the contributions they make to achieving research objectives. The sampling methods most often used are defined as quota sampling (although this is also used for surveys in the quantitative paradigm), purposive sampling, snowball sampling, self-selection sampling and convenience sampling.

Purposive sampling is most often associated with case studies, and enables the researcher to use judgement, selecting a sample that is perceived to best meet the research objectives. Snowball sampling enables the researcher to identify other suitable or significant participants through other participants during the process of the study. Self-selection sampling occurs when individuals are invited to participate and choose to accept or decline the invitation. Convenience sampling is used when participants are selected because they are easy to obtain, for example, stopping people in the street and asking for their participation.

In my study the PCT managerial participants were selected using the purposive sampling method including every PCT director and manager involved with clinical governance in the context of general practice. These individuals were key informants and are identified by job title in the study. They include, the PCT Chief Executive Officer who is statutorily accountable for clinical governance at the PCT as well as in associated independent contractor organisations. The Director of Clinical Services who is the clinical governance 'lead co-ordinator' at director level and her Deputy Director of Clinical Governance and Professional Development. The Director of Primary Care who is responsible for the implementation of clinical governance in general practice and other independent contractor organisations. Other directors with functional responsibilities for clinical governance included in the study are the Director of Modernisation, the Director of Human Resources, and the Directors of Finance (Acting). The lay Chair of the PCT Board and a Non-executive Directors were included not only because of their roles but also because of their previous extensive experience of working with general practitioners.

Other managers with responsibilities for clinical governance included in the study are the Clinical Governance Facilitation Manager who leads a team responsible for supporting independent contractors in the implementation of clinical governance; the Risk Manager; the Corporate Affairs Manager responsible for the employment of GPs who have opted for direct employment with the PCT (two only at the time of data collection), and the Head of Health Improvement responsible for the development and implementation of key performance indicators at the PCT. There are a total of thirteen director and manager participants in all.

The professional representative participants were selected using a mix of purposive sampling and snowball sampling techniques. The professional participants included the GP Chair of the Professional Executive Committee, and three GP representatives two of whom are also clinical governance 'leads' at the PCT. In the course of these interviews I was informed that the two practice nurse representatives, the two pharmaceutical advisers and one of the allied health professional representatives also had extensive knowledge of working in or with general practice. I decided to interview these individuals also. There are a total of nine PCT professional representative participants in all.

The second phase of my fieldwork involved interviewing a sample of twelve 'rank-and-file' GPs working in the Utopian area and associated with the Utopian PCT. There are 70 GPs in the Utopian area, two are directly employed by the PCT and the remainder work in 30 independent practices, thirteen of which are 'single handed' practices.

I had been 'warned' by the managers participating in the first phase of my study at the PCT, that the GPs in the field are very busy individuals and might be unwilling to participate in my study. This naturally alarmed me, so I decided to write to all of the practice managers explaining my study and initially inviting all GPs to participate. One of the GPs employed by the PCT agreed to participate. I heard nothing from the practice managers! I started to make follow-up telephone calls to the practice managers and eventually made appointments with seven GPs at different practices. Several of these were subsequently cancelled and then re-arranged.

The Clinical Governance Facilitation Manager, whom I had befriended at an early stage in my study, contacted me and invited me to a Protected Education Time (PETS) event, where GPs were going to meet to discuss the financial implications of the new GMS contract. This was a great opportunity to make personal contact with GPs who had already agreed to meet me, but also many who had not. By the end of the session another four GPs had agreed to allow me to interview them. This made up my non-probability sample of 12 GPs. Two of these were 'single handed' practitioners.

In an ideal world I would have liked to have used purposive sampling so that I could have selected GPs who would have added interesting insights because of their varying experiences, perhaps because of being 'single-handed' GPs, or because of the size of their partnership, or perhaps because of previous fundholding experience. The reality is however, that given the circumstances described above I used a mixture of self-selection sampling and snowball sampling. The same methods were also used to identify practice nurse and practice manager participants for the focus groups.

Creswell (2002) observes that qualitative research is an emergent process using inductive logic. Issues emerge from the informants in a study rather than being identified in advance by the researcher. In my study, this proved to be the case, participants identified further individuals whose expertise was significant to the study. For example, the GP professional representatives highlighted the significance of the insights that could be added by the practice nurse, pharmaceutical and allied health professional representatives, leading me to invite these individuals to participate in the study. Similarly GPs in the field, identified the significance of the potential input from practice nurses and practice managers in the field, hence the focus groups were arranged. There is a danger however, that the study is never ending. I found this aspect of the process challenging, where to 'draw the line' under the fieldwork.

5.3.4 Data Collection Methods.

Yin (2002) observes that researchers using case study methodology employ a range of data collection methods. In this study I used semi-structured interviews, focus groups, non-participant observation at the PCT Clinical Governance and Risk Management Committee and the sub group of that committee for general practice, and documentary analysis of PCT documentation relating to the implementation of clinical governance.

Semi-structured Interviews.

Bryman (2004) suggests that interviewing is widely used in qualitative research and often takes the form of unstructured or semi-structured interviews. In unstructured interviews the interviewer may ask only one question, or possibly use a set of prompts as a memory aid. The participants respond freely with the interviewer following up key points. In the case of semi-structured interviews the researcher has a list of topics or questions to be followed. At the same time the interviewee has a lot of opportunity to reply freely, introducing other related issues. Questions may not follow on exactly as indicated in the interview schedule, and the interviewer may ask supplementary questions or omit questions from the schedule as deemed appropriate during the interview.

I used semi-structured interviews in this research study. After biographical details had been obtained, the interview schedules for all participants, both managerial and professional followed the same three themes which were derived from my research objectives and were influenced by my earlier literature review. These were, 'the nature of clinical governance in general practice', 'implementing clinical governance in general practice', and 'the impact of clinical governance on the work and role of GPs in practice, and the role of GP medical advisers in the implementation of clinical governance.' I identified a set of generic questions to use as prompts within these themes, but these were varied and focused according to the role of the participants. In the case of the professional representatives and GPs in the field, these individuals were

asked the same questions, but when other related issues were identified by the participants, I probed further, encouraging the participants to express themselves freely in relation to these areas. Examples of the interview schedules used are at a Appendix 1. Each interview lasted approximately sixty to ninety minutes.

The recording or otherwise of interviews is debated in research methods literature. Patton (1990) strongly recommends this, whilst, for example, Lincoln and Guba (1985) suggest that recording interviews is intrusive and prone to technical failure with potentially disastrous consequences for the research study. I did however record the interviews with participants in my study using a Samsung Digital Voice Pen (SVR-S133). I found this unobtrusive recorder to be very effective. I think sometimes individuals forgot they were being recorded because of the absence of microphones and wires. After each interview I 'uploaded' the recording onto audible files on my laptop computer. From here I was able to transcribe the interviews into word documents which I filed on hard disk and floppy disk. I also printed off hard copies and kept these in A4 ring-binder files for later analysis.

Semi-structured interviews are criticised in relation to their 'reliability' and the related issue of bias. Easterby-Smith et al (2002) and Healey and Rawlinson (1994) point to the lack of standardisation in these interviews. Would other researchers identify similar information? These authors also observe that both interviewers and interviewees can introduce bias into the interview process. It is also possible for an interviewer to introduce bias in the way the responses are interpreted. I do not believe it is possible for a researcher to be entirely objective and independent from the participants in a study. I accept that during the interviews I conducted I may have impacted in some way on the interviewees. Throughout the research process however, I attempted to genuinely and honestly interpret and represent the views of my participants as carefully as possible. I tried not to ask leading questions or to express a personal viewpoint during the interviews, whilst at the same time demonstrating a keen interest in what the participants had to say, and keeping as natural an atmosphere as possible. Where I was unclear as to meaning, I asked the participants for further clarification. At the end of each theme within the interviews I summarised the key points that I believed had been

expressed to enable the participant to correct any misunderstanding that may have occurred during the interview. After each interview was transcribed, the participant was provided with a copy of the transcript of the interview to check for accuracy.

Marshall and Rossman (1999) and Saunders et al (2003) note that within the qualitative paradigm the view is that it is not necessary to replicate the findings from semi-structured interviews, since they reflect the situation only at the time the data was collected, in a situation which is subject to perpetual change. I would present this argument in the case of my study where the circumstances explored are complex and dynamic. The advantage of using semi-structured interviews was that the flexibility of these allowed me to explore this complexity and build a detailed 'snapshot' of the case.

Focus Groups.

Bryman and Bell (2003) differentiate focus groups from group interviews. Focus groups explore a specific topic in depth, whereas group interviews span more widely. In focus groups, the researcher is interested in how the participants discuss the issue as a member of a group, rather than simply as individuals.

As outlined above I had not initially planned to include practice nurses and practice managers in my study. During the course of the interviews with the GP professional representatives at the PCT I had been encouraged to interview the practice nurse and allied health professional representatives who had extensive experience of the issues in the study because of their work with general practitioners. These individuals, as well as GPs in the field had also encouraged me to include 'rank and file' practice nurses and practice managers from individual practices in the study.

I was concerned about timescales in relation to my study, and admit that this was partly my reasoning for holding focus groups. I was however also interested in how these individuals would relate to each other in a focus group as they discussed their own involvement in their practices in relation to the implementation of clinical governance, and the impact clinical governance was having on the role and day to day work of GPs.

The very diverse nature of general practice and the way these individuals were given widely varying responsibility for implementing clinical governance in the practices became very clear in the process of all of the focus groups.

There were four focus groups in all, held in an interview room at the PCT. The focus groups comprised two groups of practice nurses each with four members, and two groups of practice managers each with four members. I used the same themes to structure the focus groups as had been used for the semi-structured interviews, but did not identify specific questions. Instead I asked participants to share their experiences relating to the implementation of clinical governance in their individual practices. I found it necessary to provide more structure to the focus groups to prevent the participants from straying from the main point than had been necessary in the individual interviews. The focus groups were recorded and transcribed in the same way as the interviews. They were of course more time consuming and difficult to transcribe. Saunders et al (2003) highlight the problem of inhibiting contributions and issues of trust and image management that may arise from gathering people together in groups. As noted above, these individuals did self-select as participants, but I was careful not to include individuals from practices that were in close proximity to each other in the same group. Although the participants did know each other from PCT meetings and in some cases had attended common Protected Education Time (PETS) sessions, they were not close associates.

Observation at PCT Committees.

Patton (1990) suggests that observation provides knowledge of the context in which events occur and can enable the researcher to identify things which the participants themselves are unaware of. Bryman and Bell (2003:178) define non-participant observation as,

> 'a situation in which the researcher observes but does not participate in what is going on in the social setting in which he or she seeks to observe the behaviour of members of the group, organisation, community.'

Non-participant observation is further divided between structured observation and unstructured observation. Structured observation is where the researcher formulates and applies rules for the observation and recording of the behaviour of participants. Unstructured observation does not require the use of formal rules and observation schedules for recording behaviour. The aim is to develop a narrative account of participant's behaviour in as much detail as possible.

Over the same twenty months during which the interviews and focus groups took place, I also attended as a non-participant observer, the quarterly Clinical Governance and Risk Management Committee at the PCT and the follow up sub group meeting for general practice. I was not however allowed to record these meetings or to take notes, but I was provided with the agenda and minutes of the meetings. I kept notes of my observations which I tried to write immediately after each of the meetings recording my perceptions of the issues and interactions between the committee members. I was particularly interested in the interactions between the GP medical advisers and PCT managers in relation to the implementation of clinical governance in general practice.

Brewerton and Millward (2001) discuss problems and issues associated with participant and non-participant observation. They suggest that this process requires high levels of skill, time and experience. In the case of unstructured non-participant observation, it is concluded that there are concerns of validity and reliability because there is scope for many alternative interpretations. There is no way of determining that my interpretations of the events in the Clinical Governance and Risk Management Committee (CGRMC) and its general practice subgroup are accurate. The Assistant Director of Clinical Governance and Professional Development and the Risk Manager are key members of the CGRMC. After every meeting I attended I met with these individuals to discuss, and I suppose I could say, 'confirm' my thoughts about what had occurred in relation to the roles the GP Medical Advisers had played in the meetings. I went through the same process after the general practice sub group, with the Clinical Governance Facilitation Manager who is Chair of this group. I tried to record my observations immediately after these meetings whilst they were still clear in my mind.

Bryman and Bell (2003) also observe the problem of participants changing their behaviour due to being observed. I was introduced to the members of the CGRMC on the first occasion I attended, as a lecturer from the local University undertaking a research project about clinical governance. After several attendances and as I started to get to know members of the committee through their participation as interviewees in my study my presence seemed to be accepted. I do not believe that my presence changed the behaviour of the members of the CGRMC, in the heat of the debates in those meetings my presence was almost entirely overlooked!

Documentary Analysis.

Yin (2002:81) states that documentary information is likely to be relevant to every case study topic. Its most important role is to corroborate and supplement evidence gathered from other sources. It is observed that,

> '... if the documentary evidence is contradictory rather than corroboratory, the case study investigator has specific reason to inquire further into the topic.'

It is in the context of confirming the data collected using the methods outlined above that documents pertaining to the implementation of clinical governance in general practice have been used. I never intended to undertake qualitative content analysis, semiotics or hermeneutics as a means of interpreting documentary evidence.

Department of Health documentation and NHS Executive Guidance were referred to in my literature review, and used as a key to understanding the concept of clinical governance and its surrounding issues. Later in the study NHS guidelines relating to the implementation of the new General Medical Services (GMS) contract were also examined. Other PCT documentation referred to include the Local Delivery Plan (LDP); documentation from the Local Implementation Teams (LIT) for the implementation of National Service frameworks (NSFs); the Clinical Governance and Risk Management Development Plan; the PCT Medicines Management Plan; the PCT Communication Strategy; the Agendas and Minutes of the Clinical Governance and Risk Management Committee (CGRMC) meetings and its sub group relating to general practice. In addition, I had sight of some of the summaries of NSFs that were circulated to GPs as

examples of points made by the pharmaceutical advisers to the PCT; and blank outlines of the self-assessment questionnaire and action plans used by the Clinical Governance Facilitation Team with general practices to determine their baseline position for clinical governance.

Yin (2002) observes that the strengths of using documents in a research study are that they can be repeatedly reviewed and they are exact in that they contain details of contact names and events. The weaknesses are identified as difficulty in retrieving documents or accessing them, and that they might reflect the unknown bias of the authors. I found the documents I used a useful source of contact names in the research process; a very useful source of background information about implementing clinical governance in the Utopian area, and as suggested by Yin (2002), a useful way of validating the data collected from other sources. I did not have difficulty accessing the documents that are in the public domain. Over time as the various participants got to know and trust me and to understand more fully the nature of my research, they started to include me on circulation lists and to advise me of documents they thought might be useful. As participants referred to documents in their interviews, I asked for copies which were nearly always provided.

5.3.5 Data Analysis.

Tesch (1990) suggests that working within the qualitative research paradigm there are various styles of data analysis, and no one 'right way' of undertaking the process. Data analysis requires the researcher to be comfortable with developing categories and making comparisons and contrasts. The researcher also needs to be 'open minded' to alternative explanations of their findings. (Creswell 2002).

Tesch (1990) refers to processes of 'de-contextualisation' and 'recontextualisation', where large quantities of information are reduced to 'patterns' and 'themes' and then reinterpreted using some framework and built into a larger consolidated picture.

Creswell (2002:154) observes that,

> ' whilst flexible rules govern how one goes about sorting through interview transcriptions, observational notes, documents and visual materials.....it is clear that one forms categories of information and attaches codes to these categories. These categories and codes form the basis for the emerging story to be told by the qualitative researcher.'

Analysing the interview and focus group transcripts

I began by reading through all of the interview transcripts, and in some cases listening again to the recordings of these to get a sense of the whole picture. I sorted the transcripts into two categories, 'managerial', including PCT directors and managers and the practice managers; and 'professional', including the GP Chair of the PCT Professional Executive Committee, the GP medical advisers to the PCT, other professional advisers to the PCT, GPs in the field and practice nurses in the field. The interview transcripts within these two categories were then numbered. Within each separate transcript every paragraph was assigned a letter of the alphabet, A-Z, then A1-Z1, A2-Z2 and so on. This was to facilitate quoting from the transcripts when reporting the results of the study.

As the literature review had informed the construction of my research questions from which I had derived my research aim and objectives, I similarly used the literature review to construct a framework of key concepts relating to clinical governance, and the theories of deprofessionalisation, proletarianisation and restratification. This framework can be found at Appendix 2. I did not set out to 'test' theory in this study but was guided by a set of propositions stemming from the literature on the professions, the initial framework for analysis of the data allowed for these to be considered.

Starting with the 'managerial' category of transcripts I examined these for the concepts in my framework of analysis and coded the transcripts in relation to these. Sometimes, the participant's comments related to more than one of the concepts these were assigned additional codes. I made notes in the margins of the transcripts as ideas occurred to me. I constructed key points to be made in relation to each of the concepts in the framework

of analysis. These were then organised under headings and sub-headings derived from the three themes and related questions in the original interview schedules. As additional points emerged from the data these were assigned new codes and included under relevant headings. In this way the data analysis began with a framework of key concepts derived from the literature review, but there was sufficient flexibility in the process to enable further related concepts to 'emerge' from the data.

Analysing the observation notes.

The purpose of the observations of the Clinical Governance and Risk Management Committee meetings and the general practice sub-group meetings was to observe the interactions of the GP medical advisers and PCT directors and managers. To what extent did these individuals behave as professional representatives of GPs in the field in the managerial decision making of the committee, and to what extent did they advise the PCT managers about the best way of achieving GP compliance with PCT policies, procedures and initiatives? In analysing the notes from these observations, I identified the issue involved, and categorised the behaviour of GP advisers into 'professional representative' and 'management adviser/change agent'.

Analysing documents.

In line with Yin's (2002) observations, I used NHS and PCT documentation as a source of corroboratory evidence to support the results of the interviews, focus groups and non-participant observations. The documentation was also a useful source of background information because it contained detail of structures, systems and procedures in relation to the implementation of clinical governance. As I accessed each document I read through it, making notes of key points and issues. These were a useful source of additional background information to have during the interviewing process. This information enabled me to more fully understand the comments made by participants and enabled me to probe any contradictions between the documentation and the comments made during the interviews. Of course I did not receive all of the documentation at the start of the study, and so my background knowledge and

understanding increased as the study progressed, and I was increasingly able to benefit from the use of the documentation in this context.

5.3.6 Reporting the results.

After the analysis of the data was completed the results were reported initially in two documents, one presenting the 'managerial' perspective and the other reporting the 'professional' perspective in relation to the aim and objectives of the research study (these documents are available on request). The overall aim of the study however, is to explore the concept of clinical governance in the context of general practice and to examine the impact of clinical governance on the professional autonomy and self-regulation of GPs in the PCT forming 'the case', from the perspectives of both managers and professionals. The initial two documents presenting managerial and professional perspectives were therefore amalgamated into a single comparative report of the results of my study which is presented in chapter six of this thesis. The headings and subheadings developed during the analysis of the data described above form the structure of this chapter. All key points made are evidenced with reference to quotations from the interview transcripts. These are referenced with the key informant's job title, (GP participants in the field are assigned a number), the number of the interview, the page number and paragraph letter from the original interview transcript. This chapter is then used as the basis of my discussion presented in chapter seven, where the findings of my research are located in the context of the existing literature in the field of inquiry previously outlined in my literature review in chapter four. The discussion chapter also draws on the contextual material presented in chapters two and three of my thesis.

5.4 The Trustworthiness of the Data.

Creswell (2002) observe that qualitative researchers have no single position in addressing validity and reliability in qualitative studies. Lincoln and Guba (1985) suggest however that there are four useful criteria to evaluate the results of a qualitative study, 'credibility', 'transferability', 'dependability' and 'confirmability'. The key issue is,

> 'How can an inquirer persuade his/her audience that the findings of an inquiry are worth paying attention to?' (Lincoln and Guba 1985:290)

Credibility demonstrates accurate presentation of the views of the participants. The researcher's interpretations should be supported by the research data. There should be logical 'internal consistency' so that the conclusions of a study correspond with each other. There should also be 'external consistency' so that the research participants can recognise the results presented in a research study. (Gummeson 2000). Lincoln and Guba (1985) suggest that credibility can be achieved by the researcher immersing him/herself in the study over a prolonged period of time to gain depth of understanding. Credibility can also be enhanced by triangulation, using different sources of information, different data collection methods and by gaining participant validation of the research findings.

The parameters of a PhD dictate to some degree the time available for undertaking a research study. I was involved with the participants of my study, collecting data over a twenty month period during which time I believe I became a well known figure at the PCT. This was less the case in the second phase of my data collection when I mostly only visited individual practices once to undertake an interview. Throughout this time period I was building up a detailed picture of the issues relating to the implementation of clinical governance in general practice in the Utopian area, and of the impact on the work and professional autonomy of GPs.

As already outlined, data was collected from different sources and using different data collection methods, and I made every attempt to ensure that the data I collected and the way in which I interpreted it genuinely represents the views of the research participants.

Lincoln and Guba's (1985) 'transferability' refers to whether the research findings can be applied to another situation which is sufficiently similar. I have already declared that my study is not designed to be 'generalisable' to other settings, nor is this necessarily a requirement of qualitative research studies of this nature (Saunders et al 2003). Instead it is an attempt to explore what is occurring at a particular time in a particular situation,

'the case'. As observed by Lincoln and Guba (1985) it is for the reader to decide whether or not the findings of my study are applicable to another situation.

'Dependability' (Lincoln and Guba 1985) is concerned with the research process. Has it been conducted systematically and is it rigorous and well documented? 'Dependability' in qualitative research has some parallels with 'reliability' in a quantitative study. The research design of this thesis as outlined in this chapter adheres to the established procedures for case study research strategy (Yin 2002) and the selected data collection methods, set within the qualitative research paradigm. The results are triangulated by using different sources of data, different data collection methods and by involving to the degree possible the research participants in confirming the results of the study. In addition comparisons are made with other related literature in the field of inquiry in the discussion of the results. Throughout the research I have tried to keep accurate records. I have both electronic and 'hard' files of my research instruments, transcripts, and observation notes. I have all of the PCT documentation used in the study filed, and have audible files of my interviews and focus groups on hard disk and on back up CD.

'Confirmability' (Lincoln and Guba (1985), refers to whether the findings from the research flow from the data collected. It relates also to the way in which the researcher is interpreting the data. As outlined earlier in this chapter, I used a 'hybrid' approach to this process, deriving a framework for analysing the data from the literature review, but also allowing new themes to emerge from the data itself. The results flowing from my analysis are broadly in line with other similar studies as outlined in the discussion in chapter seven of the thesis and add further insights into the area of the inquiry as explained in the conclusion to my study presented in chapter eight.

4.5 Access and Ethical Considerations.

Bryman and Bell (2003) observe that ethical issues are directly related to the integrity of a piece of work, and are concerned with the treatment of research participants. Diener and Crandall (1978) suggest that there are four overlapping areas to be considered by

researchers, potential harm to participants, whether there is 'informed consent', invasion of privacy and possible deception.

Harm to participants relates to potential physical harm, harm to development or self-esteem, harm to career prospects or future employment, and 'inducing subjects to perform reprehensible acts' (Diener and Crandwell (1978:19). Bryman and Bell (2003) suggest that lack of informed consent relates mostly to situations where the true identity of the researcher is unknown to the participants, so that they are not given the opportunity to refuse to participate in the study. This is related also to invasion of privacy. Bryman and Bell (2003:544) observe that,

> 'to the degree that informed consent is given on the basis of detailed understanding of what the research participants involvement is likely to entail, he or she, in a sense, acknowledges that the right to privacy has been surrendered for that limited domain'.

Finally, 'deception' (Lincoln and Guba 1985) is deemed to have occurred when researchers represent their research as something different to what it is.

In my study the process of gaining access to the PCT is closely related to ethical issues. I made the initial contact with my research site through an MBA student whose dissertation I had supervised. I was introduced to two directors in order to explain the purpose of my proposed research and to outline the access requirements of the study. Access was granted 'in principle' by these individuals, but I had to make a formal submission of a research proposal to the PCT Research Ethics Committee and gain its consent before access could be finally granted. The paperwork for this process was very complicated although the timescales involved were quite short because the committee was due to meet within a few weeks of my initial interview with the PCT directors. I was required to complete a lengthy form with many personal details requested to judge my suitability and qualifications to undertake the research proposed. I also had to submit the aim, objectives and research questions for the study along with a summary of the research design. The complication was that I had to gain the consent of all proposed

participants before the committee would grant access. This posed few problems in relation to the directors and managers of the PCT, but presented a difficulty in the case of the independent contractor participants, the GPs. I knew that it would be time consuming and difficult to negotiate with GPs for their participation so far in advance of the time I wanted to interview them. After much discussion with members of the Research Ethics Committee it was agreed that the PCT would simply give me a letter of introduction, confirming my identity and stating that I had been granted access by the PCT Research Ethics Committee. I could then produce this when I was ready to involve the independent contractors. They would then have to make their own decisions about whether or not to participate in the study.

I was granted access initially for one year; this was eventually extended by a further year. I was asked to produce a management report communicating my key findings in relation to the research objectives at the end of the study.

In relation to potential 'harm to participants' there is one area of concern with my study. This relates to the anonymity of some of the participants. In the case of the GPs, practice managers and practice nurses there are no issues because these individuals are not identifiable in my study. In the case of the PCT Chief Executive Officer, directors and managers and to a lesser extent the professional advisers these are not identified as individuals, but they are identified by job title. It has been necessary to do this to present a sufficiently detailed authoritative account of the subject of the research from the managerial perspective. In the context of their specific roles these individuals have been key informants in the study. The identity of the PCT is disguised which goes some way to ease the problem of anonymity for these individuals. To minimise any potential harm to managerial participants in this study there will be limited access to this study for a period of time following completion of the project.

In the context of 'informed consent and issues of privacy' (Lincoln and Guba 1985), as previously identified, I had to gain the consent of the managerial participants in advance of access being granted by the PCT Research Ethics Committee. In the case of the independent contractor participants and members of their practice staff, I had to present

a letter of introduction from the Research Ethics Committee, identifying me and explaining the purpose of my research when making contact to negotiate access to their organisations.

5.6 Conclusion.

In this chapter I have differentiated between the quantitative and qualitative paradigms whilst recognising an ongoing debate about the validity of this distinction. I have located my research in the qualitative paradigm justifying this choice in the context of the aim and objectives of the research and my own personal ontological and epistemological preferences. I have identified the research design which is a single-site exploratory case study. I have outlined the data collection methods which are semi-structured interviews, focus groups, non-participant observation and documentary analysis. I have discussed the trustworthiness of the data and explained how I have analysed and reported the results of my study. Finally, I have outlined the procedures I followed to gain access to Utopia PCT and issues relating to research ethics. The next chapter presents the results of my study. Chapters six to eight are presented in Volume 2 of this thesis.

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