

# **Working the production line: Productivity and professional identity in the Emergency Department**

**Fiona Moffatt**  
**B.Sc. (Hons), M.Sc., MCSP**

School of Health Sciences  
University of Nottingham

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## **Abstract**

In the UK the National Health Service (NHS) faces the challenge of securing £20 billion in savings by 2014. Improving healthcare productivity is identified by the state as essential to this endeavour, and critical to the long-term future of the NHS. However, healthcare productivity remains a contentious issue, with some criticizing the level of professional engagement. This thesis explores how contemporary UK policy discourse constructs rights and responsibilities of healthcare professionals (HCPs) in terms of productive healthcare, how this is made manifest in practice, and the implications for professional autonomy/identity. Using analytical lenses from the sociology of professions, identity formation and the Foucauldian concept of governmentality, it is proposed that policy discourse calls for a new flavour of professionalism, one that recognises improving healthcare productivity as an individualised professional duty, not just for an elite cadre but for all healthcare professionals. Adopting an ethnographic approach (participant observation, semi-structured interviews, focus group and document analysis), data is presented from a large UK Emergency Department (ED), exploring the extent to which this notion of self-governance is evident. The study elucidates the ways in which: professional notions of productivity are constructed; productive work is enacted within the confines of the organisational setting; and tensions between modes of governance are negotiated.

The findings of this study suggest that HCPs perform identity work via their construction of a multidimensional notion of healthcare productivity that incorporates both occupational and organisational values. Whilst responsibility for productivity is accepted as a 'new' professional duty, certain ethical tensions are seen to arise once the lived reality of 'productive'

work is explored *within* the organisational field. The complex interplay of identity work and identity regulation, influenced by the co-existence of two differing modes of governance, results in a professional identity which cannot be represented by a static occupational/organisational hybrid, but rather one that is characterised by continual change and reconstitution. Understanding healthcare productivity from this perspective has implications for professional education, patient care, service improvement design and the academic field of the sociology of professions.

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## Published papers and conference presentations

### Papers

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### Conferences

*Working the production line – Reconciling productivity and professionalism in healthcare.* European Sociological Association Conference, Turin, 2013

*How do Healthcare Professionals Understand Emergency Department Productivity?* College of Emergency Medicine Academic Conference, Sheffield, 2012

*The Construction of Productivity in the UK National Health Service – Towards a New Professionalism?*

British Sociological Association (BSA) Medical Sociology Annual Conference, Leicester, 2012

*'I'm afraid there is no money' – UK Healthcare Professionals and Productivity* BSA Annual Conference, Leeds, 2012

*From 4-Hour Target to Lean Thinking: Emergency Department Professionals and Productivity*

International Conference on Emergency Medicine, Dublin, 2012  
(Poster presentation)

*Lean Thinking in the Emergency Department – Business as Normal?*

Health Services Research Network Annual Conference, Manchester, 2012

*Healthcare Professionals and Productivity – A Case of Borrowed Technology*

BSA Medical Sociology Annual Conference, Chester, 2011

## List of abbreviations and acronyms

A&E	Accident and Emergency
ABCDE	Airway, breathing, circulation, disability, exposure
ANP	Advanced Nurse Practitioner
AP	Assistant Practitioner
APLS	Advanced Paediatric Life Support
CEM	College of Emergency Medicine
CN	Charge Nurse
CoW	Computer on wheels
CQUIN	Commissioning for Quality and Innovation
CSW	Clinical Support Worker
CT	Computerised Tomography scan
CT1-3	Core Trainee 1-3
DH	Department of Health
ECG	Electrocardiogram
ED	Emergency Department
EDA	Emergency Department Assistant
EDIS	Emergency Department Information System
ENP	Emergency Nurse Practitioner
EPP	Emergency Physiotherapy Practitioner
GMC	General Medical Council
GP	General Practitioner
HCP	Healthcare Professional
HoCCPA	House of Commons Committee of Public Accounts
HoCHC	House of Commons Health Committee
I/T ratio	Indeterminacy/technicality ratio
IAT	Initial Assessment Tool



IAU	Immediate Assessment Unit
ITU	Intensive Therapy Unit
JDoc	Junior Doctor
LT	Lean Thinking
MAU	Medical Admissions Unit
Max-fax	Maxillo-facial
MIST	Mechanism, injuries, signs, treatment
MRSA	Methicillin-resistant Staphylococcus aureus
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NPM	New Public Management
-obs	data collected via observation
ODP	Operating Department Practitioner
PI	Principal Investigator
PIS	Participant Information Sheet
PV	Per Vaginam
QIPP	Quality, Innovation, Productivity and Prevention
Resus	Resuscitation Area
SDoc	Senior Doctor
SIL	Service Improvement Lead
SN	Staff Nurse
SSN	Senior Staff Nurse
ST4-6	Specialist Registrar
TARN	Trauma Audit and Research Network

## Chapter 1: Introduction

*"[H]ow can we get a lot more bang for our health care buck?"*

*(Kauffman Task Force, 2012)*

The performance of healthcare systems has come under increasing scrutiny as global trends mean that both costs and demand escalate (North and Hughes, 2012). Compounded by austere times, improving healthcare productivity is deemed a universal challenge (Numerato *et al.*, 2012). This thesis examines one such healthcare system, the UK's National Health Service (NHS) where improving productivity is viewed as essential to securing long-term financial security (Jones and Charlesworth, 2013; Wanless *et al.*, 2007), with a number of contemporary reforms and strategies (Department of Health, 2010a, 2009, 2000) advocating improved healthcare productivity as a fundamental objective of policy and professional work. In particular it explores professional identities, examining how austerity (and specifically the call for improved healthcare productivity) influences subjectivities, and how Emergency Department (ED) healthcare professionals (HCPs) mediate their responses to dominant discourses and differing modes of governance.

This introduction constitutes a metaphorical funnel into the thesis. It commences with a reflexive account of my own background and passage into this field. It then seeks to contextualise the study within the wider body of literature, and demonstrate its relevance to sociological scholarship and contemporary healthcare. The chapter closes with an overview of the structure that 'scaffolds' this thesis.

## 1.1 Reflection/Motivations

In conceptualising, designing, moulding, executing, analysing and representing this work, I have become an integral part of the study itself. Without situating myself within this work, the reader would be denied a sense of my influence. A physiotherapist by background, I was working as an extended scope clinician within a Critical Care Outreach Team during 2010. An essential part of my work was to implement change across a large NHS Trust such as introducing new equipment or promoting acceptance of a universal physiological scoring tool. I had become increasingly curious regarding clinician engagement – why did some wards apparently embrace change, whilst others appeared resistant? During this time I noticed an advertisement for a PhD studentship, broadly predicated on engaging HCPs with productivity improvement strategies. This seemed an ideal opportunity to expand my understanding of clinician engagement, and in October 2010 I commenced my doctoral studies. At an early stage, I took opportunity to reflect upon my own ideas regarding productivity. This account (and a subsequent postscript) is reproduced below:

*December, 2010*

*As a clinician, how would I interpret this notion of productivity?*

*Certainly being productive is something I would aspire to and consider an important professional goal, but one that for me would have professional rather than organisational connotations. In part, my conception is heavily influenced by the nature of my work – complex cases, patients invariably in critically ill states, emotionally charged situations, difficult communication challenges. None of this can be*

*rushed. Perhaps this has influenced what criteria define me as 'productive'?*

*For me, being productive would be a function of outcome and not one of time or output. If I had prioritised appropriately and achieved a positive outcome (not always saving a life, but perhaps managing a death in a painless and dignified manner) then I would consider myself to have been productive. In some instances, this may have taken the best part of my working day. One 'case' completely consuming all my working hours. I'm not sure the organisation would deem that productive.*

*Have I always felt this pressure of productivity? I think the answer is probably no. As a newly qualified professional I was so enamoured with day to day life within my chosen vocation that I was almost certainly blind to such issues. It would not have been something that I would have expected to stumble across within my code of professional conduct.*

*However, as I progressed in my career it became something that I was more cognisant of. Perhaps this was because I assumed greater managerial responsibility. Perhaps it was because I became a trade union representative and so gleaned experience of the inner sanctums of the organisational board room at staff side meetings. Perhaps it was a by-product of changes in my personal circumstances – having to run a home and manage a family. Or perhaps it was just the over-bearing influence of the NHS climate. I remember bumping into a colleague in the corridor not long after the Nicholson Challenge<sup>1</sup> had been announced. We discussed the implications for our practice. I remember feeling surprised at the feelings she expressed. I remarked that she seemed to have taken the*

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<sup>1</sup> The 'challenge' established by Sir David Nicholson (NHS Chief Executive 2006-2014), driving NHS efficiency savings of £20billion, to be achieved by 2014/5

*challenge very personally. Her belief was that she, as an individual, would have to make significant changes to her practice. Sometime later I completed my annual performance review. I was asked to bring to the meeting suggestions for revenue generation. This was a novelty (the nature of critical care activity does not particularly lend itself to external income generation), but I duly did as I was instructed. After the meeting I reflected on this, and asked myself, 'When did this become part of my job? How has it insidiously crept in without me noticing?'*

*Postscript July 2013:*

*As I now bring my study to a close, and complete the demanding process of recounting my findings and interpretations, I have been intrigued to stumble across another author who expresses similar thoughts to my own. Trudy Rudge, a professor of nursing at the University of Sydney, in her article 'Desiring productivity: nary a wasted moment, never a missed step' writes about her experiences of student nurses who increasingly ask to talk about organisational issues and the effects of neo-rationalism. Rudge (2013:202) writes:*

*"As I listen, I wonder what is operating that leads them to be concerned about these issues; how have these operations of management and government taken control over nurses' work...?"*

## **1.2 Situating the study**

From my personal account above, it is apparent that my professional notion of healthcare productivity was one that was far from simplistic, nor was it one that I found easy to articulate. The literature regarding healthcare productivity and productivity improvement was rife with controversy

(Berwick, 2005; Black, *et al.*, 2006; Smith, 2010), with some questioning its validity in contemporary healthcare practice (Black, 2012), and others indicating professional resistance to change or reluctant engagement (Young and McClean, 2008). Given the widespread political imperative to improve productivity within the NHS (Appleby *et al.*, 2010; Department of Health, 2009, 2008, 2010b, 2010a; House of Commons Committee of Public Accounts, 2011, 2011; House of Commons Health Committee, 2010; Hurst and Williams, 2012; National Audit Office, 2010; NHS Confederation, 2006; Wanless *et al.*, 2007), this professional recalcitrance was invariably presented as problematic (House of Commons Health Committee, 2010; National Audit Office, 2010; Wilkinson *et al.*, 2011). Many of the papers concerning productivity improvement strategies demonstrated a bias towards publication of positive results, but only a few acknowledged the importance of the wider socio-cultural context (Holden, 2011; Joosten *et al.*, 2009; Waring and Bishop, 2011). Sandberg (2000) suggests that in order to understand workplace performance, interpretative consideration of this socio-cultural perspective is essential, as the way in which HCPs deal with a phenomenon (such as productivity) is related to the way in which they understand and experience it. A discrete body of literature was unveiled that explored HCPs' notions of productivity (Arakelian *et al.*, 2011, 2008; Cattaneo *et al.*, 2012; McNeese-Smith, 2001; Nayeri *et al.*, 2006, 2005). This revealed that productivity was generally perceived to be multifactorial in nature and that; in general, there was some parity between issues of quality and issues of quantity.

There were however, numerous lacunae within this body of literature. Fundamentally, the research studies regarding HCPs' notions of productivity

had all been conducted outside the UK (Iran, USA, Italy and Sweden). Furthermore, the data from all studies was gathered using interview methods alone and generally failed to empirically consider the wider context within which these professionals worked. In particular, these studies ignored the dominant productivity discourses to which professionals were exposed, and therefore gave no critical account of identity regulation. It is suggested here that failure to appreciate this 'bigger picture' produces an incomplete account of professional engagement (or lack of) and the nature of professional work.

This thesis aims to address this gap by exploring the ontological nature of the relationship between contemporary healthcare work and professional identity. It considers the identity regulation conducted at a national and local political level and empirically explores the identity work undertaken by professionals within a specific context, offering a more nuanced account of productive practice within healthcare. Theoretical perspectives from the sociology of the professions, identity formation and the Foucauldian concept of governmentality inform this account. The empirical research was conducted within a large UK Emergency Department, using an interpretive, ethnographic approach. The specific ED selected was considered relevant as it faced a persistent productivity challenge in the form of the four-hour target<sup>2</sup> and had recent experience of a productivity improvement programme predicated on Lean Thinking (LT)<sup>3</sup>.

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<sup>2</sup> A target established by the Department of Health in 2004 mandating that 98% of patients arriving at an Emergency Department should be assessed, offered treatment, admitted or discharged within 4 hours of arrival. The target was reduced to 95% in 2011.

<sup>3</sup> A management philosophy and process improvement technology derived from the manufacturing industry (see appendices)

The theoretical contribution made by this thesis is that political identity regulation concerns the promulgation of a novel flavour of 'new professionalism' whereby *all* HCPs are responsibilised for productive work and productivity improvement as a mode of self-governance. The empirical research within the context of the ED illustrates how (in this specific context) this 'new professionalism' emerges in practice, particularly where there exists an alternative, and potentially conflicting, mode of governance. By exposing how productive professional identities are influenced and developed, it is proposed that a better understanding of professional healthcare work during times of austerity can be attained. These findings contribute to sociological scholarship by developing the understanding of contemporary forms of professionalism. In particular, by moving away from a purely binary managerial hegemony/professional resistance framework, the study has responded to calls for more nuanced views of neo-liberal healthcare reform (Numerato *et al.*, 2012). In this manner, the data has demonstrated how apparently antagonistic modes of governance can co-exist in a negotiated, and sometimes complementary, balance. Implications for healthcare practice and policy include a provisional working model of 'professional productivity' upon which future policy, strategy and governance arrangements could be based.

### **1.3 Structure of the thesis**

#### **Chapter 2 - Literature Review**

This chapter provides the framework to the empirical study. It considers a number of theoretical perspectives regarding professionalism and professional work and highlights a relevant lens for the study based upon the notion of professionalism as a discourse (Evetts, 2012). It also presents a



socio-historical view of healthcare professionalism, debating whether professional autonomy is in decline or, rather instead, whether new models of professionalism are emerging in response to contemporary healthcare reform. In order to contextualise this proposed change to the nature of professional work, a second theoretical lens - professional identity formation – is presented, with particular attention to the interplay between identity regulation, identity work and self-identity (Alvesson and Willmott, 2002). These two lenses are linked conceptually via the work of Michel Foucault. Specifically, the concept of governmentality is adopted to demonstrate how dominant discourses may operate on professional subjectivities, instrumentalising self-regulating tendencies (Skinner, 2012).

The second part of the chapter focuses on the notion of productivity within the UK NHS. It identifies it as a long-standing ‘problem’, but one that has received significant interest given recent austerity measures. Healthcare productivity is demonstrated as a ‘slippery’ concept, rife with contested definitions. Fundamentally, the chapter exposes that whilst there are a small number of studies which qualitatively explore UK HCPs’ notions of efficiency reforms in general, there are none which explore their understandings of healthcare productivity *per se*. This section closes with three research objectives that arise from the gaps identified within the literature.

### **Chapter 3 - Methodology and methods**

The philosophical assumptions that underpin the study, and empirical methods used to collect data are detailed within this chapter. Attention is

paid to the issue of reflexivity (design, data collection and subsequent analysis) as well as ethical considerations.

#### **Chapter 4 - Setting the scene: Professionals, productive work and the ED**

This chapter represents the first of four that reveal and discuss the empirical data. This first chapter is intended to provide a thick description of the study setting, detailing the specific nuances of Emergency Medicine as a medical specialism; the nature of the NHS Trust and ED and the healthcare workers employed therein. Utilising a series of 'ED snapshots' it offers a literary image of the process of care, the organisation of work and the productivity challenges faced. The centrality of 'flow' or forward motion is depicted, and the analogous portrayal of Emergency Medicine as a 'desirable production line' is introduced.

#### **Chapter 5 – Constructing notions of healthcare productivity: The call for a new professionalism?**

As a critical analysis of productivity discourse at national and local political levels, this chapter argues that a novel flavour of 'new professionalism' is visible, whereby all HCPs (rather than a professional/managerial elite) are responsibilised for healthcare productivity. The chapter illustrates how these dominant discourses construct the rights and responsibilities of professionals. Whilst the national discourse conceptualises 'new professionalism', the local discourse endeavours to operationalise it via reconfiguration of the professional self to an ideal-typical, self-governing 'productive individual'.

## **Chapter 6 – What I talk about when I talk about productivity: ED professionals and their notions of productivity**

Chapters six and seven aim to explore to what extent this form of professional government had translated into practice within the study setting. Specifically within Chapter six, the remit was to explore how ED HCPs conceptualised productive professional work. A conceptual model is revealed that is broadly constructed on the tenets of both occupational and organisational professionalism. The multi-dimensional nature of this model supports previous empirical work conducted in non-UK settings but, critically, identifies that the HCPs participating within this study identified productivity as a contemporary professional duty.

## **Chapter 7 – Seeking new professionalism: Political ideal or lived reality?**

Whilst it might be argued from the findings of Chapter six that the pre-conditions for self-governance and ‘new (productive) professionalism’ were evident, Chapter seven focuses on these professional notions of productivity *within* the organisational context. The data reveals a potentially competing mode of organisational governance that gave rise to a number of tensions or problematics for the ideal of new professionalism. At times, these problematics caused HCPs to change their view of the ED production line to one that was maladaptive. Whilst tensions clearly existed between ‘professional’ notions of productivity and the perceived ‘organisational’ version of productivity, the data revealed that professional subjectivities could not solely be represented by a simplistic dualism of professional capitulation or resistance, and a more nuanced explanatory model was required.

## **Chapter 8 - Discussion and conclusion: Working the production line – A tale of time and motion**

Chapter eight summarises the vertical arguments offered within each of the data chapters, and addresses the research objectives formulated within Chapter two. In addition it aims to develop the horizontal themes that permeate the data chapters into a coherent narrative. It considers the redefinition of duty and accountability for productive healthcare as a form of identity regulation, and HCPs' multidimensional construction of productivity as identity work. This identity work not only permitted HCPs to reconcile the culture of caring with that of efficiency, it also offered certain agential opportunities. The final stage of the thesis considers the empirical interplay between the two modes of governance, and suggests how this interaction produces a 'productive' professional identity that is not represented by a static form of hybrid professionalism, but rather one characterised by a state of flux. The chapter closes with consideration of methodological and theoretical limitations, and an account of the potential contributions of this work to research, clinical practice and policy.

## Chapter 2: Literature Review

*"I hold every man a debtor to his profession"*

*(Bacon, 1630: preface)*

### 2.1 Introduction

The broad remit of this thesis is to consider the implications of austerity on professional work, specifically the drive for improved healthcare productivity. Acknowledged as the *"economic engines of post-industrial societies"* (Bourgeault *et al.*, 2009:475), professional workers necessarily constitute the focus of investigation. This chapter will consider the sociological analysis of professional work, exposing how the professions have come to be understood and conceptualised in modern history. More recent considerations of the nature of professionalism will then be considered, in particular the ways in which the discourse of professionalism is used by professional workers, their managers and the state *"as an instrument of occupational change (and resistance to change) and social control"* (Evetts, 2006:141). Attention will be paid to the specific nature of healthcare work, including the ways in which this has been challenged and changed in contemporary society. The chapter will also offer a review of professional identity; in particular, the theoretical foundations utilised by other authors to understand and explain professional self-formation will be presented, with a specific focus on neo-Foucauldian perspectives. A review of the phenomenon of productivity (as applied to healthcare) will be considered, including the associated process/productivity improvement technologies that are increasingly utilised. HCPs will once again be placed centre stage, most notably in terms of their constructions of productive practice. The chapter

will close with a reflection on the identifiable lacunae within the literature and formulation of the study's research objectives and aims.

## **2.2 Professionalism and professional work**

The concept of a 'profession' has been recognised in one form or another since the Guilds of the Middle-Ages (Coburn and Willis, 2003). It has garnered significant public, political, and sociological debate and often polarised opinion (Bourgeault *et al.*, 2009; Carr-Saunders and Wilson, 1933). Nettleton (1995) maintains that in order to appreciate the changing role of health professionals during any period of reform or re-organisation, it is imperative to be cognisant of the socio-historical processes of professionalisation and professionalism, as well as wider societal changes in policy and economy that steer health care reforms. Whilst it is acknowledged that the literature pertaining to professional work is not only vast but also fragmented (Morrell, 2007), an overview of the key theories and theorists that inform this study will be provided here. Specifically, three perspectives will be considered, each based upon a different epistemological assumption:

1. The perspective that considers the characteristics and content of professional work as critical to addressing the key debates within the sociology of the professions (section 2.3)
2. The perspective that considers the process of professionalisation (a construct largely intended to serve professional self-interest) as critical to addressing the key debates within the sociology of the professions (section 2.4)
3. The perspective that considers professionalism as a discourse of control as critical to addressing the key debates within the sociology of the professions (section 2.5)

### 2.3 Trait and functionalist theories

Early sociological scrutiny of the professions focused primarily on lists of traits said to adequately represent the common core characteristics of the ideal-typical profession (Carr-Saunders and Wilson, 1933; Rees-Jones, 2003).

Work by Flexner (1915, cited by Porter, 1998) defined six descriptors of professional activity, and this approach was then extensively adapted and developed. Indeed, Millerson (1964) undertook an extensive review of trait theory literature and elucidated 23 different and much debated criteria.

Nonetheless, a general consensus of constitutional characteristics includes:

- Use of 'public service' skills based upon specialised, theoretical, esoteric knowledge and lengthy vocational training
- Collective organisation and collegial control
- Altruistic ideology and a code of conduct ensuring ethical integrity

(Brint, 1993; Freidson, 1988; Millerson, 1964; Nettleton, 1995).

Others attempted more cogent approaches, but still emphasised socially functional traits (Macdonald, 1995). For example, Parsons (1951) characterised professions according to his pattern variables - dichotomies utilised to analyse individual choice and discriminate between normative patterns within cultural systems (Brante, 1988). The professional was associated with affective neutrality, universalism, achieved competence, role/functional specificity and collective orientation (Porter, 1998). It was postulated by Parsons (1951) and other theorists of the functionalist tradition that occupations possessing such traits and attributes were integral to the functioning of modern and complex societies, a stabilizing force in a

capitalist society and pioneers of the future<sup>4</sup> (Evetts, 1999). As such, they were awarded privileged and validated positions via financial reward, autonomy, legitimated self-regulation and elevated social status (Evetts, 2012; Parsons, 1951). Although Parsons considered the concept of power, it was embedded with trust in the client-professional relationship, rather than as an overtly exclusionary tactic (Abbott, 1988).

During the early 1970s this functional orthodoxy became the recipient of increasing criticism. This traditional approach to the professions was challenged epistemologically as being naive and tautologous; *“the sociological perspective simply reflects the dominant view of the profession itself”* (Turner, 1995:132). Furthermore, empirical work demonstrated that there were anomalies within the previously assumed value systems and enumerative attributes (Rees-Jones, 2003; Brante, 1988). This approach also failed to consider the role of power and monopolistic privilege that professions experienced (Abbott, 1988; Turner, 1995). A concomitant paradigm shift ensued, from structure to action, with a move from what a profession ‘claimed’ to be, to a new focus on how professions negotiated, maintained and extended their privileged position (Larson, 1977).

It should be noted that more recently sociologists have suggested that the criticism of Parsons was over zealous, and predominantly based on his reputation as a functionalist and that a more sympathetic approach should

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<sup>4</sup> To some degree, this premise was developed by Freidson in his later works, where he maintained that the ‘third logic’ - that of professionalism (as distinct from logics of the market and the organisation) - should remain the primary organising principle in knowledge intensive work. In this way he sanctioned monopolistic professional control because it was seen to govern a particular and specialised knowledge that was of benefit to society at large (Larson, 2003).



be fostered (Evetts, 1999). A clear, functional definition of a subject is often a necessary stepping off point for more comprehensive investigation, and therefore some contemporary theorists retain an interest in the legacy of functionalism (Morrell, 2007). However, it remains clear that this functionalist approach, in failing to consider power dynamics between the professions and the state/organisation, is likely to reveal only a limited view of contemporary professional work.

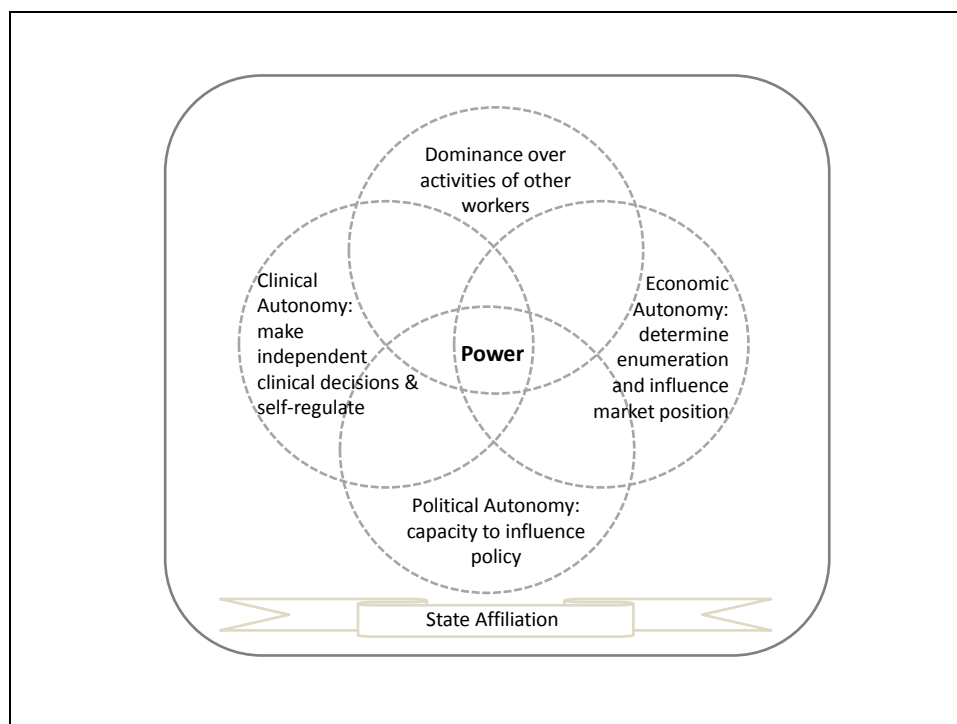
## **2.4 Interactionist theories**

In a direct response to the limitations ascribed to the trait/functionalist theories, alternative approaches have considered the process of professionalisation. Failure to consider the monopolistic nature of the professions was viewed as a critical flaw of the functionalist theories, and consequently gave rise to the power theories. These depicted professions as occupations that used exclusionary or closure strategies to command market control. Monopolism then enabled professions to exert control at many levels (Coburn and Willis, 2003). Professionalisation can be viewed as a dynamic, social and historical development process involving an occupational group, their clientele and the state, achieving a market shelter from where work and workers can be regulated, and competitors deterred (Timmermans, 2008). The main contributors will be considered here.

### **2.4.1 Occupational closure - Freidson**

Hughes (1958) was amongst the first to acknowledge the power associated with a profession's state-granted licence to practice, and mandate to demarcate all aspects of work (particularly supply and demand). Freidson (1988) further developed this neo-Weberian perspective of 'social closure' or

*“monopolization of opportunities”* (Brante, 1988:127), highlighting professional dominance in the division of labour. Basing his work on the principles of market control and social closure, he demonstrated how the medical profession was able to achieve clinical, political and economic autonomy, and concomitant socio-cultural authority (Freidson, 1970; Sandstrom, 2007; Willis, 2006). Dominance, he argued, was achieved via subordination, limitation or exclusion of allied occupations (Turner, 1995). In combination, dominance and autonomy *“are such as to give the professions a splendid isolation, indeed the opportunity to develop a protected insularity without peer among occupations lacking the same privileges”* (Freidson, 1988:369). Figure 1 portrays how this partnership of dominance and clinical/political/economic autonomy produces a synergistic effect resulting in the establishment of a hegemonic power. In Freidson’s account, the state’s intervention (in providing a market shelter) does not undermine the technical (or clinical) autonomy of a profession, but rather, runs in parallel establishing the moral and social foundations of practice (Johnson, 1995).



**Figure 1: Model of Professional Power ~ Autonomy and Dominance<sup>5</sup>, based on Freidson (1988) & Elston (1991)**

Latterly, Freidson acknowledged that his original works were written at what would prove to be the end of the golden era for medical dominance, and critics have argued that this now renders his work less significant (Coburn, 1992). Freidson conceded that socio-historical influences markedly shaped the nature of the professions and consequently continued to develop his work into the 21st century (Freidson, 2001). Dingwall (2008:136-7) describes Freidson's perspective of (medical) professional dominance shifting, *"away from the occupancy of a particular niche at the apex of labour in hospital to a much broader exploration of the status and authority of professions in*

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<sup>5</sup> Dominance, it is suggested, has also been achieved in a more dispersed form by the medicalization of life, whereby the 'normal' life events of the populace (pregnancy, childhood, ageing and dying) have become subject to medical control and scrutiny (Illich, 1976). This thesis is, however, increasingly challenged, with authors suggesting that in the post-modern era, medicalisation is no longer a uni-directional process, but rather one that is evermore influenced by modern day healthcare consumerism (Ballard and Elston, 2005).

*contemporary societies*". Freidson increasingly acknowledged the state as a major independent actor, *"a key force required for the creation, maintenance, and enforcement of the ideal-typical professional. Whether or not it does so depends upon its own organisation and agenda, which varies in time and space."* (Freidson 2001:128-9).

#### **2.4.2 Professions and power - Johnson**

Johnson (1972) also explored the relationship between the professions and state bureaucratic control in his concept of 'Professions and Power', but challenged Freidson's conceptualization of this relationship. He argued that professions were an integral part of the apparatus of the state, and in later works adopted the Foucauldian concept of governmentality (Johnson, 1995; Macdonald, 1995). For Foucault, the notion of governmentality arose from his conceptualization of power as a *"relationship... localised, dispersed, diffused and typically disguised through the social system, operating at a micro, local and covert level through sets of specific [discursive] practices"* (Turner, 1997:xi-xii). Consequently, the notion of governmentality was constituted by the idea that power was an ever present element of society, aimed at surveying and regulating the populace, and dependent upon a system of knowledge and truths. Central to Johnson's argument (1995:5) was that, *"expertise, as it became increasingly institutionalised in its professional form, became part of the process of governing"*. In this way he asserted that professions developed in association with governmentality and *"emerged as part of that apparatus that constitutes the state"* (Johnson, 1995:7). An example of this is developed in Foucault's 'Madness and Civilisation' (Foucault, 1988a) whereby the 'expert' classification of madness in the 17th century is presented as fundamental to governmental control of pauperism, vagrancy, prostitution, orphanage

*etcetera*, and that the specialism of psychiatry emerged as an immanent part of that governmental policy. In this way, the dualism between state and professions is effectively eliminated (Johnson, 1995).

### **2.4.3 System of the professions - Abbott**

Abbott considered power via an alternative lens. By examining the system of the professionals he evaluated inter-professional competition or 'jurisdictional disputes'. He defined jurisdictional boundaries as fluid and impermanent, the professions therefore constituting an interacting system or "*ecology*", with every change having ramifications for others within the system (Abbott, 1988:33). Success for a profession was therefore considered a complex interplay between structure, competition, the profession's own actions, and the effect of external forces (technological, political and social). Abbott (1988) claimed that a profession's ability to preserve its jurisdictional boundaries was related in part to the power and prestige of its academic knowledge system, and in part to the nature of its social organisation. A profession would claim jurisdiction amongst a number of audiences in an effort to attain market control and other privileges. Jurisdictional conflict may be settled in full, by subordination, by division of contested labour or by allowing one party to retain an advisory capacity. Abbott maintained that the optimal way to analyse changes within professions was to consider the forces that affect content and control of work, whilst investigating the corollaries of those forces within the system of professions and jurisdictions (Abbott, 1988:112).

#### 2.4.4 The professional project - Larson

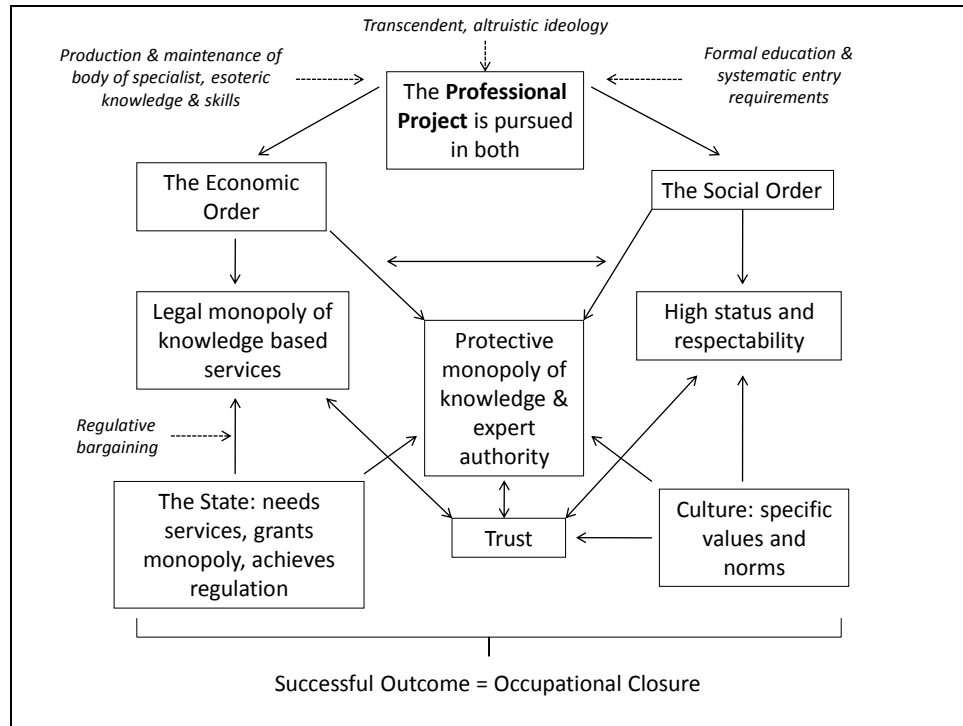
Larson (1977) proposed the concept of the 'professional project' which conceptualised how an occupational group may gain market control ('market project'), develop claims to a privileged social position ('collective mobility project'), and subsequently maintain that status (Coburn & Willis, 2003).

Larson demonstrated both a clear affinity to Weberian action orientation (Macdonald 1995) and recognition of Freidson's earlier work (Freidson 1970).

The 'market project' is represented by Figure 2, and requires a body of relatively esoteric knowledge that has both practical application and market potential. By controlling and mandating this knowledge/skill, the 'power elites' of the profession can then collectively enter a position of regulative bargaining with the state - attaining sponsorship and legitimization of a monopoly on knowledge and skill, education and training (Macdonald 1995; Rees-Jones, 2003). Economic advantage would therefore be achieved by limiting the supply of 'practitioners', whilst simultaneously courting respect from the populace and a revered position of influence (Freidson, 2001). The profession would aim to close the doors to 'non-eligibles' in order to both maintain the monopoly and extend it via usurpation (Rees-Jones, 2003). Through these methods, professions could establish their own distinctive niche in the social stratification system. Rees-Jones (2003) encapsulates this:

*"The ideology of a successful profession supports its dominance by defining social reality. The specialist scientific and technical expertise of a profession acts as a conduit for diffusing its influence. The position and role of the profession is maintained and extended by maintaining standards and influencing the terms of interaction between the profession and the public. The professional project is thus an important contributor to processes of social stratification in that the knowledge and*

*skills-base of the profession are translated into monopolistic practices, restricting of supply and market positioning, which are, in turn, translated into money and power” (Rees-Jones, 2003:238).*



**Figure 2: Diagrammatic representation of Larson (1977) Professional Project (Adapted from Macdonald, 1995:32)**

### 2.4.5 Knowledge as power

Knowledge has been an integral thread throughout many of the theories presented. Indeed, in Foucault's analysis of power, the two dimensions are inextricably linked (Mackey, 2007). Knowledge monopolies are a principle source of professional power, underpinning technical autonomy, and essential for occupational closure and establishing the power relationship between the professional and the client. The manner in which professions construct, develop, credentialise and present their knowledge for socio-cultural evaluation are of particular importance. For Abbott (1988:30),

*"[t]he organisational formalities of professions are meaningless unless we understand their context. This context always relates back to the power of the professions' knowledge systems, their abstracting ability to define old problems in new ways. Abstraction enables survival."*

Jamous and Peloille (1970) defined the indeterminacy/technicality (I/T) ratio where indeterminacy refers to esoteric, tacit knowledge, and technicality refers to more reproducible science. The higher the I/T ratio, the more codified and abstract the knowledge, and the greater the social distance between professional and client (Turner, 1995). It has been suggested that modern clinical guidelines and evidence based practice have succeeded in lowering the I/T ratio in medicine by rationalising and demystifying the technicalities of knowledge (Coburn & Willis, 2003). Specialization can also be viewed as a consequence of a profession's knowledge base:

*"The epistemological character of disciplines bears on the degree of the division of labour in that when they are empirical and technical rather than normative, a complex organisation of many specialities and sub-specialities is likely. Complex divisions of labour can be organised hierarchically around a dominant occupation..." (Freidson, 2001:164).*

Whilst an understanding of professionals' motivations and actions in assuming a position of power is clearly important, these theories can also be critiqued - regarding a profession solely in terms of power may be considered as blinkered and dogmatic as the trait approach (Brante, 1988). Consequently, this interpretation has received diminished sociological attention in recent times, although remains important in the analysis of



emergent occupations (Evetts, 2011). As such, the following section will consider an alternative perspective; professionalism as a discourse.

## **2.5 The appeal of/to professionalism**

Evetts (2003a) casts a different perspective on the professions. She describes a relatively recent shift in focus from the 'optimistic' functionalist, and 'pessimistic' interactionist theories of professionalism previously discussed, and instead points to the increasing use of the discourse of professionalism as a focus for sociological study, because *"[t]he concept of professionalism has an appeal to and for practitioners, employees and managers in the development and maintenance of work identities, career decisions and senses of self"* (Evetts, 2012:4). The reading of Evetts' work suggests that she does not reject or renounce other theories per se, but rather integrates elements into an alternative approach. This approach, she suggests, constitutes a powerful tool to analyse change and social control in diverse contexts (including professional organisations with complex modes of governance). This potentially offers a more balanced re-appraisal acknowledging that public interest and professional self-interest are not necessarily mutually exclusive (Saks, 1995). In creating a market shelter, it is postulated that professionalism can also constitute an integral part of civil society as proposed in the Durkheim model of occupations as moral communities (Evetts, 2003a).

Evetts, (2003b) discusses the increasing use of the discourse of professionalism in occupational and organisational contexts as a way of effecting occupational change, as well as discipline and control. The relative plasticity of the discourse of professionalism relates to its ontology as both a normative value system and an ideology of control (Evetts, 2003a). As such,

the appeal of professionalism to occupational groups is based upon factors such as exclusivity of knowledge, collegiality, autonomy and discretion of judgement in complex matters ('occupational professionalism'). When generated from within the professional group, the benefits can be significant, such as constructing an identity, promoting a desirable image and negotiating regulatory responsibilities with the state (Evetts, 2012, 2003a).

The reality, however, is often very different with professionalism being imposed ideologically from above as a rationale for promoting occupational change, and usually influenced by managerial and organisational logics, accountability and efficiency ('organisational professionalism') rather than occupational control of the work by the workers (Bezes *et al.*, 2012; Evetts, 2012; Evetts, 2006; Fournier, 1999; Pickard, 2009). In this way:

*"organisational objectives regulate and replace occupational control in practitioner/client relations thereby limiting the exercise of discretion and preventing the service ethic that has been so important in professional work" (Evetts, 2012:6).*

Such 'disciplinary logic' inculcates certain professional identities and practices that are considered appropriate by the organisation (Fournier, 1999). The ideal-types of occupational and organisational professionalism infer certain characteristics which are represented in Figure 3.

This review of the sociology of the professions literature demonstrates that there are clearly many ways of understanding the control and organisation of professional work. Some critiques have been presented, but it is the notion of professionalism as a discourse that emerges as a contemporaneous and potentially powerful lens for analysing crises, continuities and change within

professional work. In acknowledging the plasticity of professionalism - its ability to embrace normative values and ideological interpretations (Evetts, 2012) - this approach permits consideration of power dynamics without renouncing notions of professionalism as an ideal-type. In this way, professionalism as a discourse pays attention to issues of both structure and agency. Consequently, it is this perspective that will provide a significant contribution to the theoretical framework of the study.

<b>Organisational professionalism</b>	<b>Occupational professionalism</b>
Discourse of control	Discourse constructed from within profession
Rational-legal forms of authority	Collegial authority
Standardised procedures	Discretion and occupational control of work
Hierarchical structures of authority and decision making	High levels of trust by patient and employer
Managerialism	Controls operationalised by professionals
Accounting procedures, external regulation, targets and performance review	Professional ethics monitored by professional regulatory bodies
Aligned to Weberian models of organisation	Aligned to Durkheim's model of occupational communities

**Figure 3: Ideal types of occupational and organisational professionalism (From Bezes *et al.*, 2012:e38)**

## 2.6 The (changing) nature of professional work in healthcare

The NHS has experienced unprecedented levels of change since its inception in 1948. From managerialisation to marketisation (Gabe and Monaghan, 2013), HCPs have negotiated a mutable landscape in terms of professional governance and division of labour. These changes continue apace, particularly as the ever-tightening financial belt constrains NHS spending. Consequently, this section seeks to explore what influence these and other changes have had for the nature of professional healthcare work. Throughout the Western world, healthcare systems are responding to the significant challenges of diminished resources, rising demands, new modes of citizenship and concerns regarding public safety (Kuhlmann, 2006). The resultant changes in ethos and modes of governance have profound implications upon professional work and professionalism *per se* (Bolton, 2005; Tonkens *et al.*, 2013; Weber *et al.*, 2011).

The traditional mandate and licence for the ‘caring and curing’ professions of healthcare have been described by Light (2003) as:

*“[t]he practicing medical profession, along with nursing and the other clinical professions, exists to treat the ill and more broadly to maximise the well-being and functioning of the population using specialised knowledge and techniques. This definition indicates that the profession exists for society, in partnership with other clinicians, to both treat patients and carry out public health functions”.*

Yet critics have suggested that healthcare licence and mandate have fallen prey to the logics of the market and commodification (Tonkens *et al.*, 2013):

*“Professional work is defined as service products to be marketed and price tagged and individually evaluated and remunerated, and are in that sense commodified” (Svensson, 2003:122)*

Here commodification implies a concept that is invariably invoked in a derogatory manner to condemn the infiltration of market logics into sanctified realms such as healthcare (Timmermans and Almeling, 2009).

Whilst this perspective assumes a binary model that polarises economic and social realms to avoid the degradation of the latter by the former, other views suggest a blurring of boundaries between the two realms with commodification increasingly shaped by social values, and the suggestion that:

*“sociologists cannot assume that there is one paradigmatic version of all medicalised commodification... we should remain analytically open to the possibility of improvements due to the commodification of health care” (Timmermans and Almeling, 2009:24).*

This provokes the authors to promote a new research agenda that does not make *a priori* assumptions about commodification, but rather one that investigates consequences of reforms empirically and contextually (Evetts, 2012). This has resulted in an increasing number of collaborative partnerships between organisational sociology and the sociology of the professions (Muzio and Kirkpatrick, 2011). The following sections will further consider the nature of these changes and the consequences for professionalism. Finally, the changes in governance will be discussed in relation to professional power, questioning whether HCPs are losing their autonomy.

## 2.7 Healthcare professionalism – A changing sociological perspective

As discussed earlier in the chapter, the traditional sociology of the professions literature depicted the professions as self-governing, with social control of the professional achieved via *“the silent pressure of opinion and tradition... which is around him [sic] throughout his professional career”* (Carr-Saunders and Wilson, 1933:403). During the last half century however, this process of social control became increasingly questioned, with professions often depicted as self-serving and poorly controlled (Freidson, 1984). The changing sociological perspectives (Abbott 1988; Larson, 1977; Johnson, 1972) combined with the political and economic transformations during this time were witness to numerous strategies intended to increase state or managerial control over the professions. Hunter (2006:3) states that *“each of the major reorganisations that have convulsed the NHS since 1974 has sought to shift the frontier between medicine and management decisively in the favour of management”*. As such, a new sociological perspective emerged, that a change in social control was responsible for eroding professional autonomy (Elston, 2004; McKinlay and Marceau, 2002; Ritzer and Walczak, 1988).

Within the UK NHS this perceived need to extend control over the professions was invariably predicated on some notion of ‘crisis’: rising costs, increased public expectations/demand, inefficient management and budgetary constraint. Early crises were conducted at a mainly political level, but the ramifications for NHS staff increased over time as more extensive efforts were made to ‘reform’ the supply side of healthcare provision. Given the widely reported and egregious failings of NHS care (Francis, 2013) and the on-going economic constraint, the current ‘crisis’ is one that is also framed by critiques of professional ethics and compassionate care, as well as

inefficient use of resources and failing productivity (Jones and Charlesworth, 2013; Smith, 2002).

Anxieties regarding NHS resource management have existed for many years with concerted government efforts made from the early 1980s to create a less paternalistic, more business-like service via a change in culture and power dynamics secondary to the introduction of private-sector management practices (Doolin, 2002; Kirkpatrick and Lucio, 1995; Lapsley, 1997). These management practices, introduced following the advice of Roy Griffiths, head of a supermarket chain, were founded upon the tenets of what came to be termed new public management (NPM). NPM has been referred to as a “*doctrinal puzzle*”, but one fundamentally aimed at cutting costs (Bezes *et al.*, 2012:e15). The key features of NPM have been detailed as:

- A shift from a mandate model predicated on trust and accountability, to a contract model with explicit standards with multiple accounting measures
- Disaggregation and decentralisation of public services
- Logic of output and performance
- Introduction of competition through quasi markets and contracting
- Management practices translated from the private sector
- Emphasis on resource management and cost improvement
- Public users identified as ‘customers’
- Frequently competing discourses of quality and quantity
- The notion of ‘enterprise’ as a central leitmotif

(Barratt, 2008; Bezes *et al.*, 2012; Gabe and Monaghan, 2013; Hunter, 2006).

The alignment of clinicians with such reform has been significant because of the considerable clinical autonomy that the health professions have traditionally enjoyed (Ham, 2009). For example, in the Normansfield Report (1978) it was stated that at the inception of the NHS, health professions were required to act within 'broad limits' of acceptable medical practice and resource use, but would not be held accountable to NHS authorities for those judgements. Attempts have nonetheless been made by the state to influence professional behaviour in the use of health resources (Department of Health and Social Security, 1976). Resource management and productivity initiatives have generally been circumscribed by managerialism and directed at a cadre of senior clinicians rather than professionals en masse (Pollitt *et al.*, 1988). It is claimed that there has been a strong sense among the professions that doctors' and nurses' professional responsibilities lay with patient care, whilst managers would only be concerned with "*industrial style management with all associated ideas of productivity, efficiency and the consequent financial restraints*" (Salvage, 1985:158). Consequently, professionals have interpreted such managerialism as an intrusion "*into the sacrosanct ethical world of professional and caring values*" (Cox, 1992:32; Harrison and Ahmad, 2000).

The devolution of fiscal responsibility to certain professionals has continued, with both doctors and nurses assuming greater responsibility for the utilisation of NHS resources, resulting in professional restratification (Freidson, 1988) and the development of 'new' professional roles for individuals such as clinical directors and nurse managers, a case of poachers turned gamekeepers (Ham, 2009) or professional mediators (Bolton, 2005; Spyridonidis and Calnan, 2011). This approach is consonant with a contemporary notion of the 'new (medical) professionalism' increasingly



evident within both policy and academic literatures (Christmas and Millward, 2011; Elston, 2009; Kuhlmann, 2006), and related to clinical governance, leadership, regulation, partnership and trust.

## **2.8 The decline of professionalism at the hands of NHS reforms - Are professionals losing their autonomy?**

In any process of healthcare reform, a critical concern is professionals' reluctance to adopt managerial values and priorities. This is often played out via *"tension between professional values encapsulated within the doctrine of clinical autonomy and managerial demands for improved efficiency, cost control and accountability"* (Forbes *et al.*, 2004:168). Consequently neo-liberal reforms (with their concomitant increase in standardisation, audit requirements, organisational control and calls for entrepreneurial behaviour) may be construed by HCPs as an attack on autonomy or an attempt to devalue or commodify their unique contribution by diluting professional values and cultural norms (Bezes *et al.*, 2012; Sox, 2007; Tonkens *et al.*, 2013).

Clearly bureaucratisation, marketisation, standardisation and rationalisation have implications for professional status at macro, meso or micro sociological levels. The incorporation of medicine and healthcare into powerful bureaucracies has arguably reduced the control that professions have over their work by strategies such as sub-contracting specific tasks to non-professionals, and it is also suggested that the rise of scientific bureaucratic medicine has regularised and rationalised medical practice (Harrison and Ahmad, 2000). For some, these reforms have been conceptualised by the thesis of deprofessionalisation/proletarianisation (Demailly and de la Broise,

2009; Elston, 2004; Haug, 1988; McKinlay and Stoeckle, 1988; Annandale, 1998), whereby professions are reconstituted via:

*“a decline in the possession, or perception that the professions possess, altruism, autonomy, authority over clients, general systematic knowledge, distinctive occupational culture, and community and legal recognition.” (Ritzer and Walczak, 1988:6).*

In the UK such theories have received significant interest as health provision has become increasingly dominated by a state managed market which some perceive as subordinating clinical to financial expertise (Dingwall, 2008). A number of studies have indeed demonstrated professional logics and values to be under attack. Harrison and Ahmad (2000) for example, suggest a decline in medical autonomy and dominance, most markedly visible at micro (clinical autonomy) and meso (relations with the state) levels, rather than macro (the biomedical model). In their review of medical autonomy in the UK between 1975 and 2000, they claim that it is increasingly evident that doctors must assume a managerial perspective in order to progress professionally, and that clinical decisions are evermore dictated by evidence bases and clinical guidelines. Furthermore, they conclude that whilst capitalist states tend to exhibit new modes of production represented by a shift from standardised mass production to flexible production, medical work in the UK flouts this trend by moving in the opposite direction.

Despite such empirical data and sociological opinion, the notion of declining professionalism remains open to debate (Evetts, 2012; Hunter, 2006; Tonkens *et al.*, 2013), challenging the thesis of deprofessionalisation/proletarianisation. A particular issue for contention concerns defining an appropriate endpoint

or outcome measure. One could point to the increased bureaucracy within the NHS as an endpoint, but counter this with the appointment of clinical directors who are *“located at the nexus of managerial and professional power... creating new forms of expertise through managerial assimilation, to extend their jurisdiction...”* (Thorne, 2002:14). In this vein, Thorne (2002) considers this attainment of advisory jurisdiction (Abbott, 1988) a process of ‘re-professionalisation’ rather than de-professionalisation.

This fortification of professional roles has been demonstrated empirically in the case of both doctors and nurses who assume managerial responsibilities in addition to their clinical remit (Bolton, 2005; Llewellyn, 2001). It has been proposed that by embracing aspects of NPM doctrines (e.g. quality, productivity and efficiency) semi-professionals, such as nurses or allied health professionals, have been able to compete for new jurisdictions and escape the shackles of medical domination (Acker, 2005; Bezes *et al.*, 2012). Freidson (1988) however offers a word of caution with reference to this reactionary re-stratification whereby the upper echelons of the profession colonise the managerial strata. By establishing an elite triumvirate (disciplinary, educational and administrative), the profession can keep external control at arms-length, but this may be, it is suggested, at the expense of the ‘rank and file’ who are subjected to greater scrutiny and evaluation, and a diminished sense of collegiality (Brint, 1993, Thorne, 2002). Numerato *et al.* (2012) adopt a slightly different view, claiming that whilst there are tendencies towards medical re-stratification and increasing control, there is no overt evidence of marketisation, bureaucratisation and commodification *qua* medical deprofessionalisation. Indeed, these authors point to examples of re-stratification processes whereby new opportunities

were created for the lower echelons of the medical profession, in this case the *“professional emancipation and repositioning”* of general practitioners (Numerato *et al.*, 2012:637).

In addition to progressively more complex associations between central government, bureaucracy and medicine, relationships between medicine and other healthcare professions have also undoubtedly changed. Roles such as advanced nurse practitioners, extended scope practitioners, non-medical prescribers and clinical directors, bisect traditional jurisdictions and challenge allegiance (Annandale, 1998). Nancarrow and Borthwick (2005) describe the transformation of existing healthcare professions as well as the introduction of new (often unskilled) workers. This situation is attributed to developments in technologies, education and research, the rising consumer movement that calls for greater service flexibility and systemic changes in organisation, regulation and purchasing. Inter-professional working and education is becoming increasingly commonplace and HCPs are often delegating specific tasks and roles to other professional or occupational groups (North and Hughes, 2012). An example of this is medicine’s move to relinquish certain historically defined prerogatives (such as drug prescription and minor surgical procedures) to other professions. But does this represent deprofessionalisation? In their analysis of workforce evolution, Nancarrow and Borthwick (2005:912) suggest that whilst *“professional boundary changes are commonly described using the language of combat and protection... the current climate of workforce change... whilst not without difficulties, appears to be more consensual than the battlefield language implies”*. They point out that tasks delegated to other disciplines often constitute the less desirable duties, and rather than eroding autonomy, this process can in fact be viewed as

exploitative, reinforcing the model of dominance, particularly when 'recipients' of the new task remain under the control and jurisdiction of the original profession. Equally, by jettisoning the lower-status work, professionals are able to stake claim to more *"virtuoso roles"* (Hugman, 1991:95). Whilst the new recipients are afforded greater status within their own professional or occupational group, they invariably fail to cultivate the same standing or financial remuneration as the original professional (Mazhindu and Brownsell, 2003). In their conclusion, Nancarrow and Borthwick (2005:913) assert that the vertical and horizontal substitution of tasks within and without professions does not appear to be deprofessionalising the healthcare workforce:

*"Instead, there is a disaggregation of knowledge from more highly specialist groups to generalist, or less specialist groups... The labels applied to particular professions still appear to be associated with the provision of particular services, ownership of a body of knowledge, autonomy and authority".*

Consequently, it could be argued that the sociological focus of deprofessionalisation is unidirectional and deterministic, and may overlook explanations that other conceptual frameworks offer (Bolton, 2005; Chamberlain, 2010; Petrakaki *et al.*, 2012). Light (1995), for example, acknowledges that medicine is under attack from many external forces, elucidating the contingent nature of medical dominance. He endorses the concept of countervailing powers for understanding this position, focussing *"attention on the interactions of powerful actors in a field where they are inherently interdependent and yet distinct. If one party is dominant... its dominance is contextual and eventually elicits counter moves by other powerful actors, not to*

*destroy it but to redress an imbalance of power*" (Light, 1995:26). This theory is perhaps a more coherent and situated method for assessing relative powers of interacting occupations than the concepts of proletarianisation and deprofessionalisation.

In their comprehensive review of managerialism on medical professionalism, Numerato *et al.* (2012:637) also state that the interplay between professionalism and management is more nuanced than overt "*clashes, hegemony and resistance*" and that sociological perspectives should consider a move away from the hegemony/resistance framework in contemporary analyses. These authors suggest that the impact of managerialism and the transformation of medical professionalism within an organisational context can be represented on a continuum framed by two interconnected domains – the socio-cultural and task related aspects of professionalism. This continuum is represented diagrammatically and with relevant descriptors in Figure 4, and would suggest that reform could produce any number of effects on professionalism as represented by the central row.

In this way, the literature has demonstrated the tensions between NPM and HCPs (Bezes *et al.*, 2012) and suggested a theoretical shift away from a notion of declining professionalism to one that instead considers novel ways of enacting professionalism. In this manner it is suggested that rather than being reified and considered as diametrically opposed, the potential for professionalism and managerialism (or occupational and organisational logics) to co-exist can instead be held to be plausible (Bezes *et al.*, 2012; Noordegraaf, 2011). This then raises the questions: how do HCPs mediate

their position along this continuum in response to neoliberal reforms, and what forms of ‘new’ professionalism ensue?

Socio-cultural	Managerial discourse as a governmentality	Impact of management limited to the use of the principles, discourses and logic of management by professionals who maintain jurisdictions and local control	Hybrid identities (interface between cultures)	Reverse managerialism (Professionals retain external facets of managerial ideology /discourse while their perspective, identity and culture remain unaffected)	Retention or re-inforcement of professional norms in response to managerialism
	Managerial hegemony	Co-optation	Negotiation	Strategic adaptation	Professional opposition
Task related	e.g. evaluation, monitoring and evidence based medicine	e.g. guidelines reinforcing clinical autonomy	Blurred boundaries e.g. clinical directors	Professionals intervene in rule or protocol creation, or are involved in implementation	Resisting, ignoring or sabotaging strategies

Figure 4: The interplay between managerialism and medical professionalism (From Numerato *et al.*, 2012)

## 2.9 The rise of a new professionalism?

New professionalism is a term that has been widely deployed in recent sociological and healthcare literature (Christmas and Millward, 2011; Evetts, 2011; Leicht *et al.*, 2009; Spyridonidis and Calnan, 2011). In this thesis, new professionalism refers to the reconceptualisation of the classic model of the profession in an era where professionals are situated as expert knowledge workers but within public organisations influenced by NPM (Bezes *et al.*, 2012). This view of ‘new professionalism’ is particularly topical within healthcare. In their scoping report for The Health Foundation, Christmas and

Millward (2011) suggest that a key focus should be: the nature of professionalism in healthcare organisations, in particular the nature of the compact between the organisation and the professionals; the meaning of autonomy for the modern professional; the skills required to underpin professionalism within healthcare organisations; and the interplay between professional motivations and organisational goals.

Evetts (2011) explores how aspects of professionalism have changed under the purview of NPM. Whilst the effects on professionalism and professional work are accepted as profound, Evetts (2011) argues that there are also elements of continuity (Figure 5). She characterises this changing tide as a drift between the two notional ideal types of organisational and occupational professionalism introduced in section 2.5. The critical factor dictating this 'drift' between the two is the extent to which the discourses of organisational professionalism are perceived as a threat to professionalism as an occupational value (Evetts, 2012). In this way, a 'new' professionalism is constituted that contains elements of both ideal types.



<b>Changes</b>	<b>Continuities</b>
Governance	Authority
Management	Legitimacy
External forms of regulation	Prestige, status, power, dominance
Audit and measurement	Competence, knowledge
Targets and performance indicators	Identity and work culture
Work standardisation and financial control	Discretion to deal with complex cases, respect, trust
Competition, individualism, stratification	Collegial relations and jurisdictional competitions
Organisational control of the work priorities	Gender differences in careers and strategies
Possible range of solutions/procedures defined by the organisation	Procedures and solutions discussed and agreed within specialist teams

**Figure 5: Changes and continuities in professionalism as an occupational value (From Evetts, 2012)**

Hybrid approaches to professionalism may be viewed as mutually beneficial for both the organisation and the HCP. For example, Noordegraaf (2007) suggests that hybridisation offers new opportunities for perpetuating professionalism in times when it finds itself under threat. Evetts, however, suggests that hybridisation may be viewed as a threat to professional autonomy particularly if the impetus for change comes from above rather than from within the profession (Evetts, 2003a, Bezes *et al.*, 2012).

To conclude this section on the changing nature of professional healthcare work, it would appear apposite to follow the lead of authors including Evetts (2012), Tonkens *et al.* (2013) and Noordegraaf (2011) who accept healthcare bureaucratisation and commodification as a process that instigates changes to professional work but warn against portraying HCPs as either docile recipients of, or militant antagonists against, such a process. Instead, it is recommended that researchers explore how new linkages are created between organisations and the professions, and:

*“... examine how [professionals] make use of their discretionary powers... to reposition themselves... not looking for typologies of professionalism as that would produce static images... [but] rather... capture processes and understand how professionals respond to commodification by enacting professionalism in different ways”*  
(Tonkens *et al.*, 2013:3).

Of significant interest is the idea of ‘enacting professionalism in different ways’. This resonates with views expressed by Gleeson and Knights (2006) who acknowledge the agency/structure dualism, but rather than attempting to reconcile it, advocate that researchers illustrate its mediation in the practice of public professional work. They critique research that emphasises deprofessionalisation as a response to ‘structural’ pressures from government or policy makers, suggesting that it ignores the ways in which *“professionalism is constructed through struggle from within the cracks, crevices and contradictions of practice”* (Gleeson and Knights, 2006:289). A paradigm shift is recommended, whereby the focus turns from what they refer to as professionalism (‘structural’ assumptions regarding regulation of work, managerialism and control) to professionalism (an ‘agential’ authority that is

mediated by changes in identity and self-regulation). However, one does not become privileged over another, Gleeson and Knights (2006:283) consider them as “*combined in a co-production of professionalism*”. For these (and other) authors, understanding identity formation as a basis for reconceptualising or ‘re-storying’ professionalism is a key consideration, exploring the lived experiences of professionals facing tensions between policy and practice (Brown, 2001; Gleeson and Knights, 2006; Stronach *et al.*, 2002). In response to these pleas, and in seeking to explore and understand the motivations and behaviours of individual professionals confronted by austerity measures, the following section will consider the concept of professional identity.

## **2.10 Professional identity**

To fully expose the potential emergence of new forms of professionalism and understand the basis of HCPs’ responses to attempts at modifying their practice, it is imperative to consider how individuals come to understand, define and re-define their own professional value systems, beliefs, traits and motivations (Doolin, 2002; Halford and Leonard, 1999; Ibarra, 1999). To overlook this field would be to elide the importance of professional self-formation and provide only a unilateral and superficial perspective of contemporary professionalism and clinicians’ autonomy. Sveningsson and Alvesson (2003) note that this approach has become an increasingly popular focus of professional and organisational studies, particularly as some authors suggest that certain public sector reforms have been primarily concerned with the modulation of professional identity (Du Gay, 1996). The following sections will consider the relevance of identity to professional work in general and this study in particular. Two key areas – identity work and identity regulation – will be explored in detail, as previous authors have

demonstrated their utility in studying the nature of professional work within organisational contexts (Alvesson and Willmott, 2002).

### **2.11 Theorising identity**

Sociological, philosophical, psychological, anthropological and organisational literatures have all made valuable theoretical contributions to the concept of identity and self (Elliott, 2008). It is not, however, within the remit of this thesis to present a comprehensive review of the self/identity theoretical field. To this end, essentialist and functionalist positions that posit identity as fixed and immutable (Jenkins, 2008) are rejected, and instead I assume an epistemological stance that draws heavily from the social constructivist and post-structuralist perspectives, whilst still acknowledging the principle of reflexivity that is central to Meadian theory (Boyns, 2007), and which offers a basis for understanding agency (Callero, 2003; Carroll and Levy, 2008). Such combined perspectives are increasingly central to contemporary considerations of identity within organisational studies (Callero, 2003; Sveningsson and Alvesson, 2003; Watson, 2008). This approach ensures that social actors are not merely viewed as passive pawns (Alvesson and Willmott, 2002), but instead are actively engaged in 'storying' their own lives (Watson, 2008). For example, in Alvesson and Willmott's (2002:628) account of attempted organisational control through managerial discourse, they conclude that such regulation could not be fully realised because of the countervailing effects of *"other elements of life history forged by a capacity to accomplish life projects out of various sources of influence and inspiration"*.

In this fashion, identity is portrayed as something that is unbounded, malleable and dynamic; a multilateral, perpetual and infinite process of 'becoming' relative to social and discursive contexts (Ashforth and Saks, 1995; Gotsi *et al.*, 2010; Jenkins, 2008; Watson, 2008). In keeping with the Meadian dictum (paraphrased by Stryker and Burke, 2000:285) "*society shapes self shapes social behaviour*", identity is considered both a "*social product and a social force*" (Callero, 2003:121). Furthermore, this stance creates an epistemological space for (potentially) a number of identity positions (Watson, 2008) or, as Mead (1934) describes, a "*parliament of selves*" existing within each individual (cited by Pratt and Foreman, 2000:18).

## **2.12 Constructing identities: Identity work in organisational settings**

Research in identity construction has become increasingly predominant, mediated by interest in how individuals deal with complex and often discordant and ambiguous work situations and the acceptance that individuals' orientations and identities in relation to work frequently change over time (Alvesson and Willmott, 2002; Alvesson *et al.*, 2008; Tietze and Musson, 2010; Watson, 2008). Halford and Leonard (1999) assert that there is strong evidence, both theoretical and empirical, to support the claim that public sector changes (through dominant discourses and changing occupational roles) have had significant effects on identity. Carroll and Levy (2008:76) describe this relatively recent emergence of 'identity work', proposing that:

*"...theory and research focusing on the workings of identity construction (as opposed to the outcome of it) reveal the on-going and elusive efforts of organisational actors to understand who they are and aren't, what they do and don't do, and what they should and shouldn't do. In short,*

*identity work is pivotal in understanding how actors insert themselves into organisational life” (emphasis added).*

This construction process, or identity work, refers to the way in which social actors “*strive to shape a relatively coherent and distinctive notion of personal self-identity and struggle to come to terms with and, within limits, influence the various social identities which pertain to them in the various milieux in which they live*” (Watson, 2008:123). This striving is dialogic in nature, and occurs in contexts and within interactions whereby particular subjectivities are impressed upon individuals (Foucault, 1980) such that “*identities exist and are acquired, claimed and allocated within power relations*” (Jenkins, 2008:45).

Identity work is undertaken on both an individual and collective level – who am I, and who are we? – and is essentially a way of dealing with the agential elements of identity formulation against a fluctuating structural discursive background predicated upon socially generated ‘truths’ (Alvesson and Willmott, 2002; Halford and Leonard, 1999). This conceptual lens differs from more static theories of social identity (Ashforth and Mael, 1989; Stryker and Burke, 2000), and is consonant with the epistemological position that accepts identity as an iterative process of becoming rather than being (Beech *et al.*, 2008). Some authors describe identity work as a continuous process of maintaining and reproducing identity (Carroll and Levy, 2008), whereas others conceptualise it as a process that is operationalised during periods of flux, crisis or transformational change, as individuals enact roles and rituals which constitute the production of a relatively ‘permanent’ sense of self (Ibarra, 1999; Tietze and Musson, 2010).

The reflexive construction of self through multiple and, often competing, discourses (Alvesson and Willmott, 2002) results in identities that are often multi-dimensional and possibly incompletely integrated (Gotsi *et al.*, 2010; Halford and Leonard, 1999). Whilst the existence of multiple and shifting identities may be potentially conceived of as a source of tension, in some studies, multiplicity (or creation of an “*integrative meta-identity*”) has proven to be synergistic, mitigating conflicts and defensiveness particularly where neo-liberal strategies have created a business oriented identity that juxtaposes with more traditional identities related to craft, skill or artistry (Gotsi *et al.*, 2010:782). This highlights not only the often ambiguous and paradoxical nature of identity work, but also the importance of selecting an analytical perspective that is not overly deterministic or polarised (Hotho, 2008).

The exact nature of identity work has been described empirically in multifarious ways (Beech *et al.*, 2008; Tietze and Musson, 2010; Watson, 2008). What is consistent across studies is the ways in which social actors attempt to establish the salience or degree of congruence between self-identity and other dominant identities and discourses (Carroll and Levy, 2008). For example, when considering professional role identity, only when a role becomes closely oriented to the individual’s sense of identity does the individual behave in accordance with that role (Jain *et al.*, 2009). In enacting a new role, a professional may perceive aspects to be personally gratifying or ungratifying, and may have aspects validated and reinforced by stakeholders, or overlooked and disciplined. Ashforth and Saks (1995) suggest that these internal and external responses then influence evolution of professional identity. Ibarra (1999) maintains that there is a further

dimension, that of self-conception – what ‘sort’ of professional they are, and the possible identity they would like develop (or avoid) in the future (Beech *et al.*, 2008; Markus and Nurius, 1986; Yost *et al.*, 1992). These self-conceptions are iteratively maintained or remodelled relative to individuals’ own behaviour and the reactions of others, as well as changes within the social environment.

Carroll and Levy (2008), whilst also promulgating the view that formulation of self-identity is as much a function of ‘what we are not’ as ‘what we are’, further extend this notion of possible selves. They suggest that identification or dis-identification with roles or dominant identities/discourses are not necessarily polar opposites. At times, rejection of identification may indeed be characterised by negation, but on other occasions it may represent replacement by an alternative identification. Consequently, rather than pursuing notions of ‘anti-identity’, they suggest a construct based upon ‘default identity’ suggesting that this allows consideration of the interdependence and dynamics between prevailing identities. The premise of a default identity is, they suggest, based upon three pre-requisites:

- The default identity must be previous to an emergent identity
  - The default identity possesses a different emotional valency (positive or negative) from the alternative, emergent identity
  - Default and emergent identities have a complicit relationship whereby the emergent is inextricably interlinked with the default
- (Carroll and Levy, 2008).

Utilising this construct to analyse managerial and leadership identities, they concluded that *“the presence of a default identity alongside an emergent identity... requires that focus and attention must be paid to the relationship and interaction*



*between the two rather than to the exclusive regrouping around one pole or another"* (Carroll and Levy, 2008:83).

In her study of professional adaptation, Ibarra (1999: 765) claims that people undertake identity work by experimenting with temporary resolutions or *"provisional selves"*. These provisional selves constitute notional bridges between professionals' current state and the representations they possess regarding the 'expected' values and behaviours within a new role or future state. In this manner, the adaptation process can be conceptualised as *"creating, testing, and refining provisional identities"* (Ibarra, 1999:767).

In Ibarra's study, the process of identity work was underpinned by three tasks. The first involved identification and observation of role models, whereby professionals learned the implicit rules, behaviours and language for signalling important professional attributes. The second task concerned experimentation with provisional selves. Participants displayed either imitation strategies or true-to-self strategies, where previous role identities were adhered to and the styles, skills and behaviours associated with the earlier role were transferred to the contemporary one. For those participants who adopted the true-to-self route, Ibarra reports that their bias towards traditional routines limited the subsequent development of their repertoire of habits, skills and styles, thereby *"providing a meagre store of material and experience base from which to select and retain possibilities"* (Ibarra, 1999: 778). This task of experimentation permitted participants to test out and rehearse their repertoire of possibilities, allowing them to judge the elements worth keeping, and those to reject or modify. The final task related to an evaluation process, whereby participants conducted internal assessments (the

congruency between their public professional persona and the professional that they aspired to be), and external assessments (where the explicit or implicit feedback of stakeholders within the field illustrated the gap between their current persona and the identity deemed appropriate or desirable for the role). Ibarra notes that the most dominant theme in the self-evaluation was the internal assessment of congruence, and reflects the importance of such congruence in preventing *“emotive dissonance result[ing] from discrepancies between what people really feel and the images they are obliged to convey as role occupants”* (Ibarra, 1999:779). In relation to external evaluation, she comments that whilst positive feedback produced gradual changes in identity as individuals reproduced those behaviours that garnered approval, negative feedback did not consistently produce a change, particularly if the affective bonds between feedback giver and receiver were not well developed.

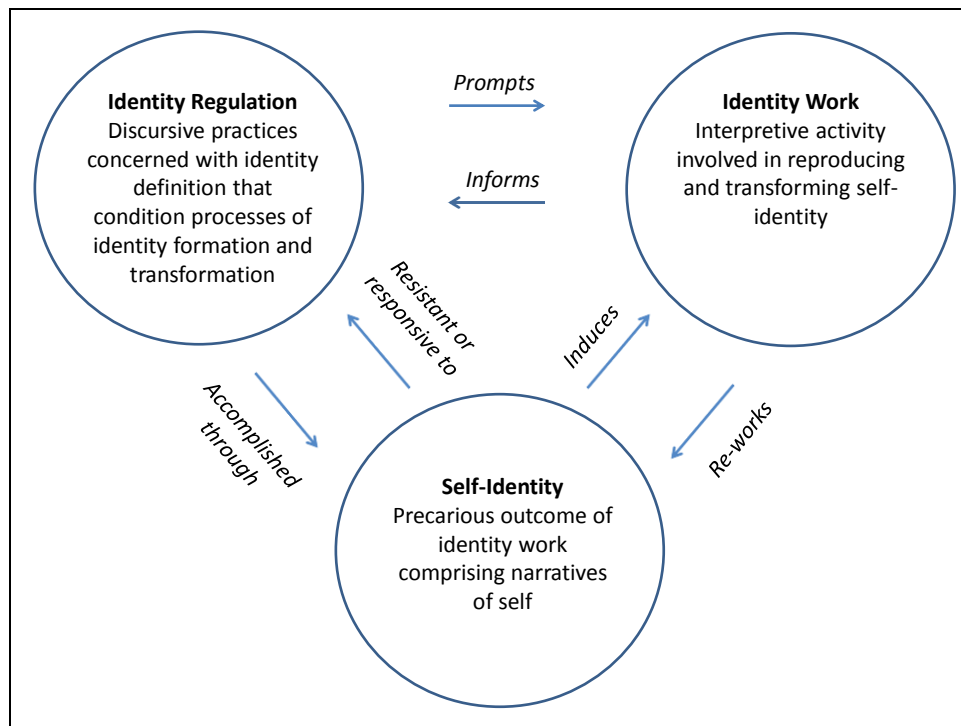
### **2.13 Constructing identities: Identity regulation in organisational settings**

This section has already made reference to the fact that identity construction occurs against a discursive background, where discourse refers to language, texts and practices (Alvesson and Kärreman, 2000). As a strategy utilised intentionally to influence identity work (particularly in directions that support the aspirations and goals of the state, organisation or institution), these discursive practices have been termed identity regulation (Alvesson and Willmott, 2002). Alvesson and Willmott (2002) detail four targets of regulatory efforts within an organisational context: the employee (defining the individual directly or relative to others); action orientations (defining values and motives through which employees construct the meaning of their

work); social relations (portraying group categorisations, affiliations and hierarchies); or the scene (establishing rules of the game specific to the larger social, organisational and economic context).

Alvesson and Willmott (2002) integrate the notion of identity regulation within a model that conceptualises an inter-play between it and two other domains. Figure 6 portrays this model and demonstrates how self-identity is reflexively constructed and re-fashioned through on-going and interpretive identity work (Giddens, 1991). Both domains, self-identity and identity work, are regulated and modulated by externally derived identity regulation that challenges understandings of self (Alvesson *et al.*, 2008). This then goes some way to addressing the structure-agency dichotomy (Halford and Leonard, 1999) by considering *“how mechanisms and practices of control... do not work ‘outside’ the individual’s quest(s) for self-definition(s), coherence(s) and meaning(s). Instead they interact, and indeed are fused with... the ‘identity work’ of organisational members”* (Alvesson and Willmott, 2002:622). In this way reflexive agency is accommodated, and outcomes of identity regulation are relational and contingent – no individual can be conceived of as a *tabula rasa*, each has their own history, values and motivations (Hall, 1996). For example, whilst social actors may have to ‘flow with the current’ of dominant subjectivities and discourses, where these are intersecting, ambiguous or in opposition there is potentially scope for individuals to hew a self that could be considered their own (Halford and Leonard, 1999; Watson, 2008). Equally, the model acknowledges that subjects are not entirely passive and may possess the resources to resist such discourses. This supports Halford and Leonard’s (1999) view of the ontological nature of the relation between

dominant discourses and identity, where an agentic role is clearly emphasised.



**Figure 6: Identity Regulation, Identity Work and Self-Identity (From Alvesson and Wilmott, 2002: 627)**

Whilst those that assume a critical stance perceive identity regulation as an entirely hegemonic action that entails oppression, subordination and reduced autonomy, others have attempted to adopt a more nuanced position that considers certain “*wisely applied*” regulatory efforts as more benign, potentially beneficial or micro-emancipatory for the individual(s) concerned (Gotsi *et al.*, 2010:785; Zanoni and Janssens, 2007). Halford and Leonard (1999) also draw on Goffman's (1990) theories of impression management, suggesting that individuals may portray identities that are in keeping with a regulatory discourse, whilst maintaining a different sense of self.

This section has summarised why the issue of identity is important to understanding the changing nature of professional work. Alvesson and Willmott's (2002) model of the interplay between self, identity work and identity regulation offers possibilities for the exploration of HCPs' responses to occupational change, that does not presuppose a deterministic or dualistic response, but rather accommodates a more nuanced approach reflecting the numerous ways in which a heterogeneous body of individuals may mediate their position. A key consideration for this thesis is now to consider how the selected theoretical lenses - professionalism as a discourse and professional identity - may be linked conceptually, that is how organisational priorities become transferred into the priorities of individuals. Halford and Leonard (1999) draw upon the works of Miller (1992) and Du Gay (1996) to rationalise the processes through which identity is conferred discursively. Both these authors utilise the ideas of the philosopher, historian and social theorist, Michel Foucault. This perspective will be discussed below.

#### **2.14 The relationship between self and society: Theorising subjectivities**

In studies such as the one proposed here (which aims to move beyond the established model of professionalism versus managerialism), Foucault's notion of governmentality has proven to be a rewarding theoretical lens (Doolin, 2002; Ferlie *et al.*, 2012; Flynn, 2002). Foucault's work can be conceptualised on three axes of relations: fields of knowledge (*savoirs*); systems of power; and forms of subjectivity<sup>6</sup> or subjectification (O'Leary, 2008). Townley (2008) identifies these as the knowledge/power/identity triad

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<sup>6</sup> Here, subjectivity refers to the ways in which an individual rationalises and comes to know their circumstances in a way that is inextricably linked with their own identity (Knights and McCabe, 2000).

that organises social action. The concept of governmentality aims to address how techniques of rule operate upon subjectivities, instrumentalising the self-regulating tendencies of social agents (Skinner, 2012). These technologies of the self involve engagement in *“operations on [individuals’] own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality”* (Brockling *et al.*, 2011; Foucault, 1991:18, 1988b). Davies and Thomas (2003) describe this approach as an exploration of the social crafting of the self, embedded within a network of power and ‘truths’. They state that individuals are subject to a polyvalent discursive field, where differing themes (for example, managerialism or professionalism) vie for attention in the process of identity constitution and reconstitution. This discursive field then:

*“produces meanings that are contradictory, contested and clashing... It is at these points of contestation that spaces are presented for alternative meanings and subjectivities and for new forms of practice. Identities are mobile sites of contradiction and disunity; nodes where various discourses temporarily intersect in particular ways...”* (Davies and Thomas, 2003:684-5).

In this way individual agency is not elided by the assumption that organisations ‘imprint’ a dominant norm upon the true identity of individuals, but rather reveals how *“identities are created through organisations”* (Davies and Thomas, 2003:685). The key point here, is that individuals are constituted through, rather than by, social relations (Knights and McCabe, 2000). The following section will consider the Foucauldian concept of governmentality in further detail.

## 2.15 Governmentality

Much of Foucault's work assumes a socio-historical perspective of the constitution of individuals' subjectivities. His later work on governmentality was a reflection of the fact that he believed he had paid undue attention to systems of domination, to the detriment of individual agency and self-governance (McKinlay *et al.*, 2012). This work has been advanced posthumously by a number of scholars, in particular the "*London governmentalsists*", Peter Miller and Nikolas Rose (McKinlay *et al.*, 2012:8). Knights (2002) provides a useful, historically oriented classification of Foucault's work, which situates the notion of governmentality in the later, postmodern period (Figure 7). This work represented a significant turn for Foucault, who utilised this 'ethical phase' (as distinct from earlier archaeological and genealogical phases) to reconsider subjectivity. Knights (2002:580-1) summarises:

*"By analogy with the artist in his/her garret, turning the self into a creative work of art would clearly disrupt those effects of individualisation that ordinarily render subjects isolated, pre-occupied with identity and vulnerable to the disciplinary demands of power. Ethics are adopted that are contingent to the localised circumstances of their application and a transformation of the individualised to a subjectivised subjectivity – that is, one created by, and responsible to, the self".*

	<b>Pre-modern</b>	<b>Modern</b>	<b>Postmodern</b>
Power	sovereign	disciplinary	governmental
Exercised through	spectacles of torture	hierarchy, normalisation, examination	responsibility
Knowledge	exclusive	partially distributed	inclusive
Effects	fear of punishment	divisive	identification
Self	struggles for honour	struggles for dignity	struggles for autonomy
Identity	subjugated	normalised	aestheticised
Resistance	limited	extensive	occurs in space between multiple identities
Subjectivity	totalised	individualised	subjectivised
Ethics	absolute	publicly regulated	localised, personal <sup>7</sup>
'Truth' (as sanctioned by dominant moral code)	function of God/nature	effect of power/consent because attached to identity	detached from identity

**Figure 7: Classification of Foucauldian Work (From Knights, 2002: 579)**

Governmentality is defined as:

*"the dual process of problematizing and acting on individual behaviours... shap[ing] and manag[ing] 'personal' conduct without violating its formally private status"* (Miller and Rose, 2008:12)

Problematization refers to the process of rendering something a problem to be addressed. As such, a starting point is to question how these problems are constructed and made visible in multiple domains by multiple agents. At

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<sup>7</sup> This reading of ethics refers to the individual's consideration, decision making and subsequent action (Barratt, 2008)



some point, the problems are expressed in terms of formalised 'knowledge', evaluated relative to certain norms and associated with more diverse socio-economic concerns (Miller and Rose, 1995). Within this it becomes almost inevitable that some aspect of conduct will be held responsible.

Two distinct components of the art of governing are described, 'rationalities' (knowledges that claim the status of truth, rendering reality conceivable and amenable to calculation and transformation) and 'technologies' (forms of intervention for operationalising rationalities and governing conduct from a distance). Rationalities and technologies have been described as "*inextricably interconnected*", co-constructing one another in a mutually dependent manner (Brockling *et al.*, 2011: 11). Considering rationalities and technologies in this fashion allows studies of governmentality to avoid overt dichotomies such as power and subjectivity, or structure and agency, and illuminate a greater vista of political programmes, social practices, re-articulations of identities and subjectivities, and knowledge production in relation to instruments of power (*ibid.*) For Foucault, power was not conceived of as a single, unidirectional or monopolistic force exercised by the state or institution, but instead, nested within social practices, discourses and relations (Flynn, 2002). As Ferlie *et al.* (2012:340) eloquently explain:

*"...power resides in mundane day to day practices, dominant languages, obedient and reformed subjects and taken for granted rationalities, such power is seen in neutral rather than critical neo Marxist terms: it can constitute a capacity to govern... without crude force, domination or exploitation".*

Governmentality therefore involves the responsabilisation of autonomous individuals, the encouragement of self-governance and the establishment of indirect control from a distance rather than overt or direct intervention; a *“regulated freedom in which the subject’s capacity for action is used as a political strategy to secure the ends of government”* (McKee, 2009:469–70). Within this neo-liberal model, the state retains its traditional governmental functions, but in addition, assumes new roles that constitute indirect and *“uncoerced application of certain values rooted in the motivation for action... premised on the construction of moral agency that accepts the consequences of its actions in a self-reflexive manner”* (Thompson, 2007). In shaping certain subjectivities and rendering individuals or collective groups responsible for a particular social risk (for example, failing healthcare productivity or an economically unviable healthcare service), the problem is transformed into one of self-governance. Lemke explains, *“the key feature of the neo-liberal rationality is the congruence it endeavours to achieve between a responsible and moral individual and an economic-rational actor”* (Lemke, 2001:201). This is the suggestion that professions need to re-legitimise their position by incorporating market criteria into their professional accountability (Fournier, 1999). In doing so, professionals are effectively aligned with particular political objectives via reconstitution of professional identity (Doolin, 2002). Consequently, encouraging individuals to pursue such a project has potential symbolic and material benefits for those individuals involved, including the perception of keeping external control at arm’s length.

The application of a governmentality perspective to contemporary social transformations within healthcare systems has been successfully demonstrated on an international stage (Ferlie *et al.*, 2012). Doolin (2002)

investigated the effects of neo-liberal management and enterprise discourses on hospital clinicians in New Zealand. A governmentality perspective permitted the author to explore the nature of power within these reforms, and the ways in which individuals responded by agreement, defiance or compromise. The governmentality lens has also been used to analyse the effects of other reforms and movements (Winch *et al.*, 2002), as this critical approach questions rationalities and encourages agents to evaluate "*truth taxonomies*" (Winch *et al.*, 2002:160). Ferlie *et al.* (2012:347) conclude that given the trend for healthcare organisations to develop towards a "*post professional dominance/post NPM configuration*" the Foucauldian perspective should be given greater empirical and theoretical credence.

A governmentality perspective therefore allows the exploration of the contours of power within reforms (Brockling *et al.*, 2011; Doolin, 2002) and critically examines the rationalities and technologies that endeavour to connect the lives of actors to the aspirations of the authorities (Rose and Miller, 2010; Winch *et al.*, 2002). Following Miller and Rose (2008), the pertinent analytical questions for such studies relate to the rationalities and technologies of government utilised in the construction of professional rights and responsibilities via certain discourses, in particular: how the state aims to exert influence over the professions; how such wishes are articulated; what sort of knowledge claims underpin schemes for intervention; what professional understandings have been acted upon; and how this may shape or reshape the way in which professionals construct and enact their identity.

In summary, the governmentality perspective offers the potential to provide an important theoretical link, bridging the void between discursive practices

(in this case the discourse of professionalism) and identity constitution. The remaining sections within the literature review now take a thematic shift, and aim to detail the nature of the productivity 'crisis' within the UK's NHS. HCPs, however, retain a central place within this literature.

## **2.16 Productivity**

The analysis of healthcare system performance has become increasingly prevalent as worldwide trends indicate that both costs and demand are rising (North and Hughes, 2012). Austere times further compound this situation, meaning that improving healthcare productivity is deemed a universal challenge (Numerato *et al.*, 2012). Despite this imperative, healthcare productivity as a concept is rife with contradictions, ambiguities and conflict and has generally been considered by HCPs as the purview of industry and management rather than clinicians (Berwick, 2005; Black, 2012; Cox, 1992; North and Hughes, 2012; Salvage, 1985).

The following sections will consider this issue of productivity primarily within the UK healthcare system, drawing upon relevant international literature where appropriate. Section 2.17 considers the nature of the productivity problem as the NHS has evolved and matured. This historical perspective provides important contextual detail for the current position. Section 2.18 unpacks the 'black box' of healthcare productivity – its definition and measurement - revealing its contested nature. Within subsequent sections (2.19-2.21), HCPs' responses and perceptions will be explored.

## **2.17 The ‘problem’ of productivity in the UK NHS**

From the inception of the NHS, the state has harboured concerns regarding the growing costs of healthcare, and has made repeated attempts to improve health service productivity (Ahmed and Cadenhead, 1998; Lapsley, 1997).

Hunter (2006:2) states:

*“If there has been a consistent thread running through the numerous changes imposed on the NHS, it has been a never-ending fascination with economic rationalism and a belief that market-style incentives are necessary in some form to temper the excesses and producer focused nature of public sector practices”.*

The following sections will embark upon a socio-historical journey exploring productivity within the context of the UK’s NHS.

### **2.17.1 The birth of the NHS**

As early as 1951, the newly founded NHS experienced its first funding crisis as expenditure exceeded the projected estimate by 39% within the first two fiscal years (Cutler, 2007). In response, the Chief Medical Officer’s report of 1952 emphasised hospital throughput as a key performance indicator, and offered strategies for improvement, including those aimed at professional practice; for example, early ambulation as a means to expedited discharge (Cutler, 2007). The Guillebaud Committee of Enquiry was commissioned in 1956 to establish why costs could not be contained (Ahmed and Cadenhead, 1998). The report however failed to identify inefficiencies, and so concluded that the financial challenges had resulted from changing demographics. It was subsequently acknowledged that the sheer magnitude of the NHS made it unwieldy to control, and so the NHS Reorganisation Act was published in 1973 (National Archives, undated), heralding strategic administrative

changes aimed at improving both the organisation and the management of healthcare services (Ahmed and Cadenhead, 1998). This reform proved to be largely cosmetic, and the hegemony of the medical profession remained effectively unchallenged.

### **2.17.2 General management and the introduction of NPM**

In 1979, the Conservative party successfully defended their position, having based their campaign on an electoral manifesto that was committed to reducing public spending. The involvement of Roy Griffiths (see section 2.7) heralded the removal of the District Management Team (administrator, medical officer and nursing officer), and their replacement by a General Manager. The rationale for this intervention was to remove the historical 'management by veto', potentially allowing more innovative service provision, and thereby improved quality and productivity (Iles, 2011). A series of top-down reforms ensued, defined under the banner of NPM and aimed at efficiency, transparency, control (costs, professions and outcomes), accountability and quality (Bezes *et al.*, 2012; McMurray, 2010). However, funding levels reached a critical point in the 1980s, with unpopular actions such as cancellations and ward closures commonplace. Organisations faced an 'efficiency trap' where they were effectively penalised for increasing their productivity (Ahmed and Cadenhead, 1998). Facing widespread condemnation, the government embarked upon a series of NHS reforms, modelled upon the concept of an internal market, under the NHS and Community Care Act (Department of Health, 1990). The policy advisors believed that the internal market, performing to state established targets and objectives, would improve productivity by incentivising organisations to reduce costs and improve quality (Ham, 2009; Secretary of State for Health,

1992). Although considerable changes within clinical practice did occur over the ensuing years, these were largely attributable to new technologies and the global interest in evidence based medicine. Generally, service redesign failed to materialise (Iles, 2011).

### **2.17.3 New Labour and the financial crisis**

With the advent of the 'New Labour' government in 1997 came comprehensive plans to reform a NHS that was perceived to be underfunded (Wanless, 2002), lacking in national standards, and devoid of levers for improving performance. The white paper, 'The new NHS Modern, Dependable' (Department of Health, 1997) and subsequent 'NHS Plan' (DH, 2000) constituted a radical modernisation programme which sought to preserve the founding principles of the NHS, but situated them within a regulatory structure of a managed market. In 2002, Sir Derek Wanless was commissioned by the Chancellor of the Exchequer to undertake a large scale analysis of funding requirements for the following two decades. In the document 'Securing Our Future Health: Taking a Long Term View' (Wanless, 2002), three potential scenarios based upon varied assumptions of NHS performance and populace health status were mooted: solid progress; slow uptake; and fully engaged.

The Labour government were committed to the notion of a market that could "*jolt the NHS into better productivity*" (Toynbee, 2007:1031). An integral part of this plan was a large increase in NHS funding designed to make healthcare spending comparable with other western European countries (Klein, 2006). In the April budget of 2002, an unprecedented rise in NHS funding was unveiled, but with the caveat that the professions and service must be

modernised (National Audit Office, 2010). The role of accounting became increasingly predominant in policy design with budgets aligned to clinical responsibilities and costs allied with efficacy and quality of care, for example, 'Payment by Results' and NHS performance frameworks (Ellwood, 2009; Lapsley, 2008). In this way the traditional public sector accounting focus increasingly moved from one of stewardship to one of productivity and performance (Broadbent and Guthrie, 1992). The influence of scientific-bureaucratic medicine (including evidence based practice (EBP) also became increasingly manifest in NHS policy during the 1990s, advocating the delivery of clinical services that were driven by evidence of both clinical and cost-effectiveness (NHS Executive, 1996). However, in practice opinions were polarised with many HCPs fearing that the EBP paradigm threatened clinical autonomy and the 'art' of medicine, and would be commandeered by managers as an exercise in standardisation that had the sole intention of curbing expense (Harrison and Checkland, 2009; Kuhlmann, 2006). Indeed there is limited evidence that this strategy successfully reduced costs (Farquhar *et al.*, 2002).

In 2004, the Gershon Review of public sector efficiency laid out clear goals for transparent and auditable efficiency gains of £20 billion, with a third of these anticipated to be originating within the NHS. The Department of Health produced a high level delivery plan in order to meet these productivity challenges, conceptualised via six main workstreams, including Productive Time (Department of Health, 2005a). Productive Time was concerned with augmenting efficiency gains at frontline service level via workforce reform, process redesign and information/communication technology (Ford, 2006).



Despite high levels of growth, a major financial crisis developed in 2005 when it became apparent that much of the additional monies had been consumed by pay agreements, capital expenditure, negligence claims, drug costs and meeting NICE recommendations. There was growing concern that the return on the investment was far from adequate (Horton, 2008). The effects of the financial injection produced a number of positive results such as improvements in waiting times, quality of care and public satisfaction (Dixon, 2012), but evidence suggested hospital activity had not increased accordingly, and consequently productivity was reported to have declined (House of Commons Committee of Public Accounts, 2011). The NHS was considered to be fulfilling the 'slow uptake' scenario predicted by Sir Derek Wanless (Wanless *et al.*, 2007). The National Audit Office (2010:9) concluded:

*"The [health] Department's design and the NHS's implementation of national initiatives were predominantly focused on increasing capacity, quality and outcomes of healthcare while maintaining financial balance, rather than on realising improvements in productivity".*

Consequently, there ensued a renewed emphasis on incentivising and supporting productivity improvement including: the Commissioning for Quality and Innovation (CQUIN) payment framework that dictated that a percentage of hospital income be contingent on quality/innovation; the use of marginal (30%) tariffs for unplanned admissions above 2008-9 baseline levels (National Audit Office, 2010); and the NHS Institute initiatives designed to improve productivity, for example, The Productive Series (NHS Institute for Innovation and Improvement, 2010).

As such, the nature of the NHS 'crisis' had shifted, from an external crisis of funding, to an internal crisis of productivity. It was also suggested that the

majority of clinicians remained disengaged from reform, or actively obstructed it (Dixon, 2012). Financial problems escalated further when the global economy was adversely affected by the collapse of the banking system. Compounding factors included mounting public expectations, development of expensive technologies/drugs, the changing nature of disease and an aging population (Department of Health, 2008). Consequently, in the NHS Chief Executive's report for 2008-2009, it was announced that unprecedented efficiency savings of up to £20 billion would have to be achieved by 2014/15 (the so-called 'Nicholson Challenge'), and improving healthcare productivity was identified as critical to this endeavour (Nicholson, 2009).

#### **2.17.4 The coalition government and the health and social care act**

The election of a coalition government in 2010 did not change the focus on productive healthcare. The 'Nicholson challenge' was widely acknowledged as extending beyond its original timeline. In a Nuffield Trust report, 'A decade of austerity? The funding pressures facing the NHS from 2010/11 to 2021/22', Roberts *et al.* (2012:6) claim that:

*"After 2014/15, to avoid cuts to the service or a fall in the quality of care patients receive, the NHS in England must either achieve unprecedented sustained increases in productivity, or funding will need to increase in real terms".*

In recognition of this position, the coalition government proposed a wide-scale set of reforms encompassed by the Health and Social Care Act (Department of Health, 2012). The reforms mandated by this legislation were, in part, premised on the alleged need to increase productivity and efficiency in the NHS (Department of Health, 2010b).

## 2.18 Defining healthcare productivity

The NHS is reportedly facing the greatest productivity crisis of its history (The Nuffield Trust, 2009). Indeed, it has been suggested that:

*“without significant improvements in NHS productivity... even higher levels of funding will be needed over the next two decades... Such an expensive service could undermine the current widespread political support for the NHS and raise questions about its long-term future”*  
(Wanless et al., 2007:xxxi-xxxii).

A similar picture is seen in other developed countries (North and Hughes, 2012).

Healthcare productivity, however, remains an elusive metric to capture.

There is a generic, global acceptance of productivity as the ratio between an output with inherent value, and the consumption of resources or units of input required to achieve that. In healthcare terms, this is the ratio between the volume of resources supplying the NHS and the quantity of healthcare subsequently provided (National Audit Office, 2010). However, converting this concept into an operationally useful metric has proved problematic (Berwick, 2005). Whilst quantitative measures have been valued in traditional production processes, it is recognised that these are not necessarily applicable to knowledge-intensive organisations (Antikainen and Lonnqvist, 2005; North and Hughes, 2012). North and Hughes (2012:195) note that healthcare productivity measurement has often reflected traditional accounting practices, with the organisation viewed as *“a rational, technical machine, and its workers as labour units... [where] [s]cientific management theory underpins many of the ‘management fads’ promising to improve efficiency and*

*productivity*". These authors suggest that, as a consequence, the alleged erosion of HCPs' position as "*labour-intensive [and] skill rich*" is associated with significant psychosocial implications, including high levels of stress, increased turnover and absenteeism, and reduced job satisfaction (North and Hughes, 2012:203).

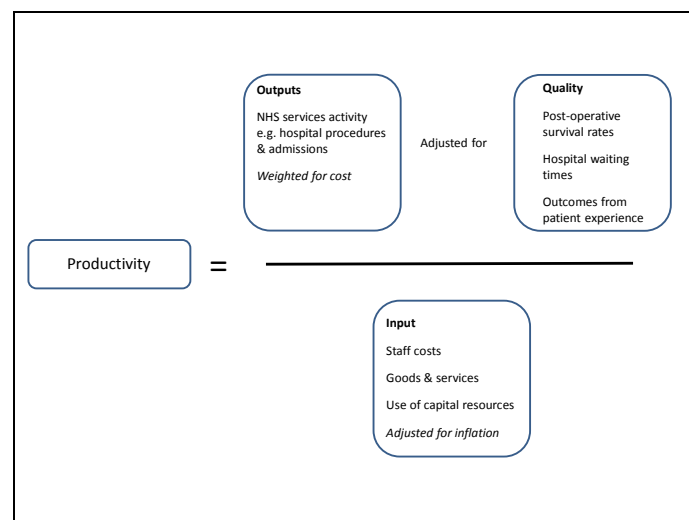
As such, a number of systems have been utilised over the years, and debate continues as to which constitutes the most representative and most economically meaningful for the NHS (Black *et al.*, 2006). The Wanless review was clear to distinguish between what was considered the two equally important components of enhanced productivity: reductions in unit costs and improvements in quality:

*"Th[e] simple definition of productivity can be extended to embrace outcomes – the value consumers derive from consumption of a product"*  
(Wanless *et al.*, 2007:216).

Quality however is often difficult to capture both "*conceptually and empirically*", and can include such factors as health outcome, access/waiting times, patient safety, patient choice/experience, professional-patient interaction *etcetera* (Wanless *et al.*, 2007:215). Arguably, the notion of 'hospital activity' may be viewed as a contentious measure of productivity, particularly given the contemporaneous drive to manage both acute and chronic conditions within the community setting (Royal College of Physicians, 2012).

A key issue is that the multifarious productivity measures invariably fail to consider the requirements of all individuals with a vested interest in how health care resources are being utilised (Smith, 2010). Black *et al.* (2006) argue

that even with quality focused approaches, the measurement of productivity remains irresolutely and inextricably contentious, and will rely on certain assumptions e.g. the contribution of healthcare services to individuals' health. Indeed, most recently, Black (2012) suggests that given improvements in mortality rates, evidence-based practice and patient satisfaction the notion of declining health-care productivity may be a myth perpetuated for political gain. Figure 8 represents the productivity tool in current use.



**Figure 8: Schemata Representing Productivity Measurement in the NHS (From National Audit Office, 2010)**

Despite the complexity of healthcare productivity, and the potential for numerous interpretations, the state remains committed to driving healthcare productivity improvement. The following section considers HCPs' responses to NHS reforms broadly predicated upon increasing efficiency and productivity.

## **2.19 Healthcare professionals' notions of NHS efficiency reforms**

The UK National Health Service (NHS) is highly professionalised. A recent workforce census revealed that the number of professionally qualified

clinical staff had reached 685,066 whole time equivalents (Health and Social Care Information Centre, 2012). Clearly, this marked colonisation of health care by professional bodies has implications for any anticipated change process. Ackroyd *et al.* (2007:10) discussed the intent of policy directives (predicated upon new public management) to:

*“induce a movement from the traditional pattern of administered services (in which professional ideas about services were dominant) to managed provision and an emphasis on efficiency (in which professional priorities may be overridden).”*

In their comparison of three UK services (health care, housing and social services), the outcomes of reform were shown to be highly variable, with health care in particular still demonstrating the influential nature of traditional, entrenched patterns of custodial administration. The authors primarily attributed this to the:

*“professional values and institutions against which reforms were directed and the extent to which different groups locked themselves into strategies either of resistance or accommodation” (Ackroyd et al., 2007:10).*

The relevance of four key issues were presented: the ability of professional groups to mediate pressures for change; the nature of the reform process itself; the perceived ramifications of change for the professionalisation projects of specific occupational groups; and the professional values that inform action, particularly the *“public service ethos”* which may constitute an uncomfortable bedfellow to strategies related to efficiency control (Ackroyd *et al.*, 2007:23). Degeling *et al.* (2003:650) concur:

*“Whether... active participation is forthcoming depends in part on how the various professions interpret the policy initiatives and on the*

*conflicts of priority that exist even among holders of common objectives. These in turn, are dependent on how the various professions conceive of clinical work”.*

Doherty (2009) explored the effects of health service reform (intended to increase productivity and improve efficiency) on the working lives of UK registered nurses in a single NHS Trust. The reform of interest was reconfiguration of work via changes to skill mix between doctors and nurses. The evidence elicited intra-occupational differentiation in opinions of skill mix change. Staff nurses and sisters discussed the notions of work intensification, and ‘losing’ the essence of nursing care as a result of undertaking delegated medico-technical tasks. Moreover, it was presented that the consequential shortfalls in fundamental aspects of basic patient care were believed to effectively diminish efficiency within the organisation. By contrast, specialist nurses’ experiences of NHS reform related to empowerment and increased autonomy as they extended their occupational jurisdiction and demonstrated productivity and efficiency gains. Other authors have also discussed the potential negative connotations for nursing professionalism as a result of cost-containment/productivity improvement measures (Dingwall and Allen, 2001). It is suggested in this work that the crusade for evidence-based intervention has been perceived by some as enforcing an increasingly restrictive licence on nursing that is apparently at odds with its professional mandate. The concomitant disparity is presented as a *“chronic source of dissatisfaction”* (Dingwall & Allen, 2001:65). Similar sentiments have been expressed by others (Maddock and Morgan, 1998).

Som (2009) investigated the perceptions of employees of a UK NHS Trust regarding the introduction of clinical governance strategies, a system through which NHS organisations were to be held accountable for safeguarding high quality care, and which considered resource use as an integral element of quality (Sally and Donaldson, 1998). This work revealed professionals' confusion regarding the clinical governance framework, described by the author as perpetuating the *"quantity versus quality dilemma"* that it was designed to address (Som, 2009:301). Opinion varied from the perception of performance targets and quality targets as essentially paradoxical (*"you can have either a good service or a quick service. I find it difficult to see how you could have both"*), to being compatible yet problematic (*"we are advancing our clinical governance agenda in a way that our strategy calls for, at the same time we are also advancing our performance agenda in a way that the government requires us to and that's not an easy place to be located in. We have to deal with these inconsistencies"*) (Som, 2009:307). In a similar way to that described by Dingwall and Allen (2001), Som (2009) suggests that clinical governance appeals to the professional mandate of quality and clinical excellence, yet restricts professional licence by attempting to side-line clinical decision making via a management framework.

An interesting reform predicated upon improving efficiency and productivity, is that of the ED key performance standard for Acute NHS Hospital Trusts, introduced in 2005, mandating that 98% of patients be treated and discharged/admitted within 4 hours of arrival<sup>8</sup>. Indicative of the target culture, it was expected to improve clinical outcome and experience

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<sup>8</sup> Reduced to 95% in 2010. In 2011, a range of quality indicators was introduced to replace the target, however, most hospitals continue to operate to the 2010 95% target as a key performance indicator for commissioners of their services.



for the patient, although critics warned of the potential for negative consequences such as gaming, effort substitution, or distortion of clinical priorities (Weber *et al.*, 2011). Weber *et al.* (2011) note that few qualitative studies have explored how healthcare organisations respond to targets in general or the 4-hour target in particular. Their study however, whilst interviewing both ED managers, doctors and nurses, only recruited departmental ‘leaders’. Perhaps of greater interest is the small study conducted by Mortimore and Cooper (2007) who considered the perceptions of ‘shop-floor’ nurses with regards to the 4-hour target. Whilst these nurses considered the target to be successful in terms of improving throughput, there were considerable reservations regarding the imposed nature of the target, the significant increase in workload pressure and, like Som (2009), concerns regarding the reconciliation of quantity with quality.

These studies highlight the contingent nature of any reform or technology introduced under the guise of improving healthcare efficiency or productivity. As might be anticipated, the studies identify the centrality of HCPs and their concerns regarding conflicting professional and economic priorities. Perhaps more surprising is the professional ‘confusion’ with regard to the reforms, noted by Som (2009). This then raises the question: How do HCPs understand and conceptualise this notion of healthcare productivity?

## **2.20 How do healthcare professionals conceptualise productivity?**

The literature reveals a dearth of evidence regarding the nature of HCPs’ beliefs pertaining to the concepts of workplace productivity and efficiency. This is significant as it is postulated that better collaboration to improve

productivity in health care could occur if professionals' perceptions and views of their productivity could be elucidated (Arakelian *et al.*, 2011, 2008; Cattaneo *et al.*, 2012; McNeese-Smith, 2001). McNeese-Smith (2001:8) suggests that the disparity in conceptions of productivity between management and clinicians (particularly in terms of values and a common lexicon) invariably results in a *"struggle between polarities including those caused by administrative demands, edicts and redesign strategies, and clinician retaliation"*. Furthermore, Arakelian *et al.* (2008:1423) state, *"[d]ifferences in how efficiency is understood may constitute an obstacle to supervisors' efforts to promote it"*. Sandberg (2000) proposes an interpretative approach rather than a rationalistic epistemology for understanding workplace performance. This author presents a body of literature that demonstrates that attributes used in accomplishing work are context-dependent, and this context dependence is acquired via professionals' ways of experiencing that work. In Sandberg's own empirical work, *"workers' knowledge, skills and attributes used in accomplishing work are preceded by and based upon their conceptions of work... [and] why some people perform... better than others is related to variation in ways of conceiving that work"* (Sandberg, 2000:20-21). This supports the premise that the way in which professionals deal with the phenomenon of productivity/efficiency within their clinical work is related to how they understand it.

A small number of studies were identified that explored HCPs' concepts of productivity (Arakelian *et al.*, 2011, 2008; Cattaneo *et al.*, 2012; McNeese-Smith, 2001; Nayeri *et al.*, 2006, 2005). All of these studies were conducted outside the United Kingdom, and three of the six were uni-professional (nursing). One study was excluded (Linna *et al.*, 2010) as it considered the

perceptions of Finnish public service employees but did not differentiate between healthcare staff and others.

Arakelian *et al.* (2008) and (2011) studied multi-professional operating room and surgical team efficiency respectively, in a Swedish University hospital. The authors of these studies describe the synonymous use of the terms 'efficiency' and 'productivity'. This is a common approach in papers concerning productivity (Holcomb *et al.*, 2002; Mullen, 2003). Using a phenomenographic methodology they established two clear strands dependent upon the nature of the study context (Figure 9).

<b>Team Organization</b>	<b>Non-Team Organization</b>
Staff doing their best and doing what they have to do to achieve good workflow.	Staff having the right qualifications. Knowing what to do, and being able to prevent problems.
Working with joy, changing one's work tempo, saving energy and adjusting it to different situations is the basis of an efficient workday full of harmony.	Staff enjoying work by seeing the meaning of it.
Team members interacting well together, utilizing the members' work ability/capacity in the best way, working with the right tasks at the right time.	Planning and having good control and overview, creating smooth patient flow.
Getting desirable results with the least resources.	Each professional performing the correct task.
Working with preserved quality of care as quickly as possible.	Completing a work assignment within the given time frame.
Achieving long term benefits for patients.	Producing as much as possible per time unit.
Efficiency is a concept that should be related to an individual's prerequisites and experience and a group's resources.	

**Figure 9: Comparison of a team & non-team organisation in understanding of operating room efficiency (From Arakelian *et al.*, 2011)**

Interviewing clinicians and managers, the authors reported that subjects expressed more than one way of viewing efficiency, with both individual-orientated and organisation-orientated perspectives. Arakelian *et al.* (2011)

suggest that despite having varied individual perceptions, staff working within a team may be more likely to express productivity/efficiency from an organisational standpoint. In a study without an organised team, productivity/efficiency was perceived more quantitatively and individually, with the patient and quality of care infrequently alluded to (Arakelian *et al.*, 2008). The authors acknowledge the need for further qualitative research regarding team organisation and members' perceptions of productivity and efficiency. In both studies, recruitment was based upon diverse professional groups and variation in years of experience. Whilst research methods and subsequent data analysis were well explicated, issues of intersubjectivity and reflexivity were poorly addressed. Furthermore, in the 2011 study, the sample was small (n=11), therefore limiting the credibility of the findings.

In McNeese-Smith's (2001) study of acute care nurses in an American county/university affiliated hospital, concepts of productivity and non-productivity were primarily related to themes of quantity and quality, but personal factors and organisational factors were also discussed (Figures 10 and 11).

<b>Productivity</b>	Factors related to quantity of work	<ul style="list-style-type: none"> <li>• Working hard</li> <li>• Finishing everything</li> <li>• Doing extra</li> <li>• Collaborative teamwork, pulling together (no conflict)</li> <li>• Influence of organisational systems (things running smoothly, manageable workload, workers valued)</li> </ul>
	Factors related to quality of work	<ul style="list-style-type: none"> <li>• Processes of care (holistic, technically complex, appropriate referral, new skill acquisition)</li> <li>• Work outcomes (receiving thanks / compliments, supporting the team, doing a good job)</li> <li>• Teaching others &amp; making innovative suggestions</li> </ul>
	Personal factors	<ul style="list-style-type: none"> <li>• Experience</li> <li>• Knowledge (training, keeping updated)</li> <li>• Attitude (knowing responsibilities, risk of discipline, self-esteem, professional values)</li> <li>• Organisational skills (time management, accuracy, minimal distractions)</li> <li>• Physically / mentally prepared for work</li> </ul>

**Figure 10: Staff Nurse Views of Productivity & Influential Factors (From McNeese-Smith, 2001)**

Non-productivity	Organisational	<ul style="list-style-type: none"> <li>• Overloaded / disorganised</li> <li>• Lack of teamwork</li> <li>• Complex patients</li> <li>• Reduced patient load</li> <li>• Having to teach new staff / students</li> <li>• Systems failures</li> <li>• Work related stressors (criticism, death, moral / ethical dilemmas, assignation of unpopular tasks)</li> </ul>
	Personal factors	<ul style="list-style-type: none"> <li>• Physically or mentally unfit for work</li> </ul>

**Figure 11: Staff Nurse Views of Non-Productivity & Influential Factors (From McNeese-Smith, 2001)**

The McNeese-Smith (2001) study included a purposive sample of 30 staff nurses selected from across 6 specialities. Whilst the author was clear to point out the divergent opinions of clinicians and management, this was assumed as managers were not included in the study. Although the study was well executed and achieved saturation of the data, no discussion was raised regarding reflexivity. One key finding, related to the relatively small number of nurses who discussed the relevance of systems changes (13%) and teamwork (10%) as important in promoting productivity. A greater proportion of nurses (27%) saw their co-workers as potential threats to productive practice (administering poor care or leaving tasks undone). The author suggests that for these nurses, system redesign would constitute a threat to their immanent sense of productivity, with success or failure being predicated on the extent of nurse involvement, support and education.

The work of Nayeri *et al.* (2005, 2006) in an Iranian University Hospital also themed nurses' and managers' perceptions of productivity in terms of quality or quantity, with quality (i.e. outcome not output) assuming primacy (Nayeri *et al.*, 2005). The key influential factors were believed to be managerial (leadership, support, motivation, recognition) and human resources (staffing, staff expertise / experience, work co-ordination / teamwork). The authors suggest that an awareness of staff viewpoints permits managers and policy makers to create or promote conditions conducive to attaining productivity gains (Nayeri *et al.*, 2006). These studies involved rigorous application of research methods and achieved data saturation. Whilst commencing with purposive sampling, the authors proceeded to theoretical sampling as codes and categories emerged. The sample population was diverse including nurses, managers and educators; however nurses with less than five years' experience, or who worked part-time were excluded. This potentially ignores a significant section of the study population. The authors produced a reflexive account, with issues of credibility, transferability, dependability and confirmability addressed.

Cattaneo *et al.* (2012) conducted a phenomenographic study designed to investigate how members of an Italian surgical team experienced efficiency in their daily work. Twenty-two multi-professional participants were selected from a cardiac surgery team, as the authors believed that this surgical speciality offered relative stability in terms of the case histories that participants would draw upon. The study findings revealed a multi-dimensional approach to efficient (productive) work, as represented in Figure 12. The most frequently cited domain was that of fluid workflow; however this might be anticipated in a surgical specialism that is

characterised by a series of distinct chronological stages. The authors concluded that a fluid workflow was the cardinal factor in perceptions of efficiency, and that the first three domains (Figure 12) were integral to this. Clinical effectiveness and quality care then resulted from this fluid workflow. The authors describe optimal resource management (within and without the operating room) as the 'pivot point' – they concluded that whilst emphasis on waste reduction did not directly influence fluidity or effectiveness, it constituted an essential criteria for the organisation in releasing assets in order to achieve its overarching goal of delivering a quality service. This last assumption is somewhat debatable however, as it could be argued that by reducing wasteful steps in a process, fluidity could be improved. Cattaneo *et al.*'s work (2012) bears a number of similarities to that of Arakelian *et al.* (2008, 2011), leading the authors to surmise that increasing surgical standardisation and internationalisation may produce an operating room experience that transcends individual organisations. This study does however present a number of methodological problems, in particular sample recruitment (all participants were selected by a member of the management team) and the failure to consider any aspects of reflexivity or inter-subjectivity.



1. Know-how: experience, skills and professionalism
2. Team work: harmony and synergy
3. Management of the situation: all under control
4. Fluidity of workflow: everything goes well
5. Clinical effectiveness: obtain a good result
6. Management of resources: optimisation
7. Allocation of resources beyond operating room boundaries

**Figure 12: Domains of efficient work (From Cattaneo *et al.*, 2012)**

Other studies have explored HCPs' perceptions of waste (Goff *et al.*, 2013). Using innovative methods of auto-photography and photo-elicitation, 21 multi-disciplinary HCPs in an American tertiary hospital captured visual representations of healthcare waste, and then discussed these images during in-depth interviews. Four categories and subcategories (in parentheses) were identified: Time (searching, waiting, transporting, excess processing); materials (overutilisation, excess inventory); energy; and talent. Interestingly, of the four categories, talent/skill was the least frequently identified. Indeed, notions of 'operational' waste predominated over 'clinical' waste, and issues such as medical errors were not alluded to at all. The authors suggest that this emphasis on operational waste might be explained by the fact that participants may have felt less inclined to photograph examples of waste that they had personally contributed to. Alternatively, these more 'abstract' forms of waste might have been more difficult to capture photographically. North and Hughes (2012) note that defining waste related to talent/skill can be a contentious issue, particularly where waste is attributed to staff apparently overqualified for the tasks assigned to them. For example, they refer to the

trend for 'non-nursing tasks' to be delegated to non-registered, unregulated staff, in particular healthcare assistants assuming responsibility for observational and monitoring tasks. It could be argued that rather than constituting wasteful use of registered nurses' time, these activities are in fact important opportunities for therapeutic interaction with patients (Shields and Watson, 2008).

This small collection of studies has served to demonstrate the multidimensional nature of productive healthcare as perceived by HCPs. This multidimensionality is diverse and encompasses quantitative/qualitative, organisational/clinical and team/individual elements. It is suggested that the nature of these dimensions (and perceived importance of each) is influenced by the context, particularly team orientation and nature of the work. A number of questions remain unanswered however. Methodologically, all the studies alluded to (with the exception of Goff *et al.*, 2013) rely upon interview data alone. The omission of other methods, such as observation and document analysis, seems incongruous considering the importance ascribed to contextual issues. Fundamentally, none of these studies reflect the perceptions of UK HCPs in the current climate of austerity and a political context that calls for increased healthcare productivity, nor do they consider the implications for professionalism. The following section will consider one such contextual issue, namely the implementation of productivity improvement strategies based upon the technology of Lean Thinking (LT).

## **2.21 Healthcare professionals' notions of productivity improvement – The case of Lean Thinking**

A number of contemporary policy documents and reports have reflected the policy imperative to improve healthcare productivity (Appleby *et al.*, 2010; Department of Health, 2009, 2008, 2010b, 2010a; House of Commons Committee of Public Accounts, 2011, 2011; House of Commons Health Committee, 2010; Hurst and Williams, 2012; National Audit Office, 2010; NHS Confederation, 2006; Wanless *et al.*, 2007) and this has been specifically addressed in the DH's programme: 'Quality, Innovation, Productivity and Prevention' (QIPP) (DH, 2010a). The publication of a clinicians' guide set the agenda as one that all healthcare staff had a role in delivering (Department of Health, 2010a; Royal Pharmaceutical Society, 2012).

A number of business process improvement methodologies, such as LT and other private sector management technologies, have become increasingly utilised in the re-organisation of clinical services (Radnor, 2010). These technologies have been implemented in an effort to address the "*efficiency agenda*" faced by the NHS (Radnor *et al.*, 2011). In a Futures Debate, (NHS Confederation, 2008) acknowledged LT as a disruptive innovation, i.e. one that is "*most likely to have a significant impact on the way services work over the next ten to fifteen years*". LT is a process improvement technology and management philosophy derived from the manufacturing industry (see appendices). Evidence to date suggests that LT (and associated initiatives such as the Productive Series<sup>9</sup>) has had a significant impact, however Radnor (2010:11) points out that achievements have been gained via precarious use

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<sup>9</sup> The Productive Series is a strategy originally introduced by the NHS Institute for Innovation and Improvement, intended to improve productivity by implementation of LT principles in clinical settings.

of simple tools rather than sound application of the Lean philosophy, consequently *“the real test [will] come once the low hanging fruit has been picked”*. In order to implement LT as a philosophy, there is a requirement for a shift in organisational behaviour, culture, and thinking (Papadopoulos *et al.*, 2011). As such, frontline staff essentially represent gatekeepers for this process.

The variability in extent and success of LT implementation within healthcare highlights the relevance of existing socio-cultural and organisational contexts (Waring and Bishop, 2010). Waring & Bishop (2010) investigated the implementation of LT within an operating department. They revealed that despite apparent efficiency improvements, professionals expressed cynicism and opposition. Notions expressed included: doubts regarding the motives of managers and expertise of champions; epistemic concerns regarding the legitimacy of evidence/knowledge on which service transformation was predicated; the perceived detrimental sequelae for clinical practice; and dissatisfaction regarding jurisdictional conflicts. A particular contention was the perceived mismatch between macro- (management) and micro- (clinician) level values. A number of clinicians expressed concern regarding the standardisation of work, and the potential to de-skill and limit future career progression. Waring & Bishop (2010:1339) state that after some initial engagement with LT, health care professionals came to regard it as *“another bureaucratic... task that required superficial compliance”*. The authors conclude that the paucity of sociocultural research regarding LT in healthcare is significant as *“making healthcare services Lean is likely to be a highly contested process, as it becomes reinterpreted and reshaped by different social actors to ensure that it fits with their prevailing vision or aspirations for clinical practice”* (Waring

& Bishop, 2010:1339). Joosten *et al.* (2009) present similar sentiments. They argue that implementation of LT inherently triggers further sociotechnical and sociocultural dynamics, and advocate research to identify which factors mediate these effects and how.

In a more recent study, Radnor *et al.* (2011) reported on four multi-level case studies involving implementation of LT within UK NHS Trusts. They equate the current state of LT implementation within healthcare to that of the automotive industry in the late 1980s, where LT efforts were localised and lacking in impact. One of the explanations proffered is that staff perceptions remain focused on LT as a managerial tool to eradicate waste rather than embracing the opportunity to create an efficient, innovative and safe environment.

Radnor (2010) discusses the sectoral specific barriers to implementation of business process improvement methodologies in healthcare. Echoing the empirical work of Waring & Bishop (2010) and Radnor *et al.* (2011), she describes the division between macro- and micro-level values as the cause of conflict between “*the culture of efficiency and the culture of caring*” (Radnor, 2010:52). This paradox between macro-level economic tensions (to which managers are broadly aligned) and micro-level pursuit of quality of care (to which clinicians are broadly aligned) reflect the challenges faced by occupational professionalism from organisational professionalism. It is suggested that only by understanding key stakeholders’ perceptions and positions regarding waste, value (clinical, operational and experiential) and process change can healthcare leaders deconstruct this barrier promoting greater collaboration between managers and professionals (Caldwell *et al.*,

2005; Young and McClean, 2008). Both the healthcare and industry literatures have paid little attention to workers' / professionals' perceptions (Holden, 2011; Losonci *et al.*, 2011). Sawhney and Chason (2005:78) assert that *"for a successful lean transition, it is thus necessary to first understand the people... expectations... and to ensure the success of the human element"*.

## **2.22 Literature Review: Summary**

Professionalism is changing, not least of all because of neo-liberal policies associated with new public management. The fields of the sociology of the professions, organisational sociology and identity formation highlight that implementation of healthcare reform is not a simple process of resistance or subordination. Many authors have called for a less binary perspective and suggest that contemporary social research adopts a more nuanced approach. In particular, there is an identified need to explore how professionals mediate their position in response to neoliberal strategies, in such a way that does not polarise or reify occupational/organisational or professional/managerial (Noordegraaf, 2011; Numerato *et al.*, 2012; Tonkens *et al.*, 2013), and instead adopts a dialectical perspective that considers the structure/agency dualism, capturing manifestations of professional autonomy within the wider context of policy (Gleeson and Knights, 2006).

The call for improved healthcare productivity in order to secure the long-term future of the NHS is a prime example of a neoliberal policy directive. It has been demonstrated that no UK studies have yet considered HCP identity regulation in the context of productivity improvement in the UK's NHS. Furthermore, UK HCPs' perceptions of productive healthcare and productivity have remained unexplored, despite a national programme

directed at its improvement. This represents a clear lacuna in sociological and healthcare management scholarship. It is a significant gap in the body of knowledge, as it is proposed that productivity and process improvement strategies such as LT or The Productive Series will fail to reach their full potential unless they conceptualise productive professional work in a way that is commensurate with that of HCPs.

Consequently, the research objective for this study is to draw upon all three sociological fields highlighted above, and explore the implications of austerity for professional work. Specifically, the focus of the study relates to the drive for improved productivity for UK HCPs. The overarching aim of the research is to explore to what extent the call for improved healthcare productivity contributes to the extant discourse of new professionalism and, in turn, how professionals come to understand and respond to this discourse. How does the 'creeping spread' of managerialist and bureaucratic logics affect employees personally in terms of their identities or senses of self?

### **2.23 Research objectives and aims**

Therefore, the research objectives are to investigate:

1. What are the macro, meso and micro level influences that frame the call for increased productivity and productive roles for UK HCPs?
2. How do HCPs negotiate and rationalise productive healthcare, and what identities do they craft in response to this call for productivity?

3. What is the governance structure for productive healthcare within the case study setting and what implications does it have for professional identity?



## Chapter 3: Methodology and Methods

*“There is no greater fallacy than the belief that aims and purposes are one thing, while methods and tactics are another”*

*(Goldman, 1924)*

### 3.1 Introduction

This chapter will present the plan and principles of inquiry. In making explicit the methodological approach adopted, the reader is better equipped to appraise the study findings:

*“[t]he inferential warrant of each research methodology rests on basic ontological and epistemological beliefs. These allow researchers to chart their course into and through their research projects. They also suggest legitimate and illegitimate uses for findings as claims supporting knowledge or action.”* Giacomini (2010:146)

This chapter opens with a detailed account of the methodological and philosophical assumptions of the study. It demonstrates that ethnography, as the selected approach, was an appropriate way with which to address the research questions developed and defined within the previous chapter. A critique of the methodology is offered, in particular consideration of the relationship between the researcher and the field of research. The subsequent sections acknowledge the imperative to provide a clear and complete description of the empirical techniques utilised in the collection and analysis of data (Rudestam and Newton, 2007), and offer the rationale for the specific tools selected. The chapter will conclude with a discussion of issues relating to research ethics.

## 3.2 Methodology

### 3.2.1 The qualitative research paradigm

This study sought to explore HCPs' understandings and experiences of productivity (and productivity improvement) within the context of an Emergency Department (ED). A qualitative methodology was selected for this purpose. The qualitative research paradigm is predicated by particular assumptions regarding ontology, epistemology and methodology (Avis, 2003). Ontologically, qualitative research acknowledges multiple social realities, epistemologically it places emphasis on the subjective or 'emic' perspective, and methodologically it rejects the hypothetico-deductive precepts of positivism in favour of inductive, retroductive or abductive logic (Blaikie, 2010; Creswell, 2007) (Figure 13).

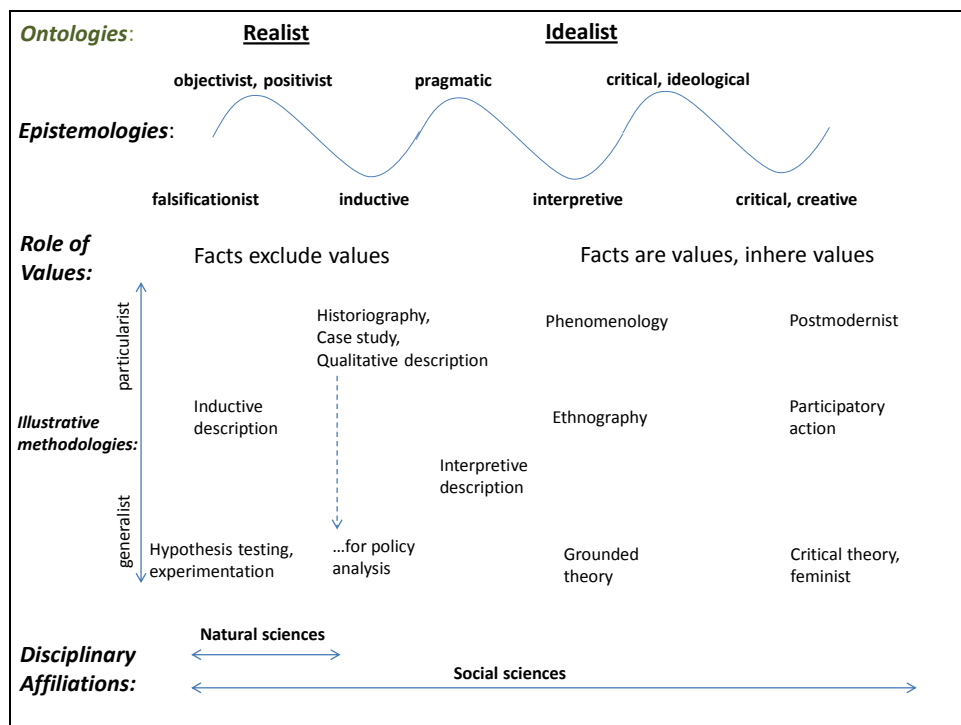


Figure 13: Schemata of Health Research Traditions (From Giacomini, 2010:130)

Qualitative research constitutes a method of inquiry that aims to understand, describe and interpret how individuals make sense of both life experiences and the social world that they occupy (Holloway and Wheeler, 2010), and raises open questions regarding phenomena within their contextual setting (Carter and Little, 2007). By immersing themselves within the participants' world, the researcher is able to elicit rich data regarding the 'emic' perspective (people's knowledge, views, understandings, perceptions, experiences, discourses, interactions *etcetera*), and via analysis and reflection generate their own interpretation or 'etic' perspective (Harris, 1976; Mason, 2002a). Utilising qualitative research for this study allowed exploration of the social world of the ED, and the professional culture and identity therein. Specifically, qualitative (ethnographic) methods allowed the exploration of professionals' perceptions of productivity, to a greater depth and sophistication than could be achieved by a quantitative approach.

### **3.2.2 Ethnography**

Ethnography may be viewed as a composite of three features: principles that guide the production of data; the research method; and the final written account (Waring, 2013). These features effect a *"recasting [of] everyday understandings and practices that are taken for granted... turning the familiar into the strange"* (Savage, 2006:384). Ethnography is increasingly recognised as a valuable methodology in healthcare research, including the understanding of healthcare organisations (Savage, 2000). In the organisational setting, ethnography can provide a nuanced understanding – capturing the *"winks, sighs, head shaking and gossip"* (Dixon-Woods, 2003:326) - and a comparison between what people say and what they actually do.

The field of interpretive anthropology has developed a genre of ethnography that aims to establish this intimate, nuanced and inter-subjective understanding of a culture, group of people, or a social setting (Prentice, 2010). Interpretive anthropologist Clifford Geertz maintained:

*"[b]elieving, with Max Weber, that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be therefore not an experimental science in search of law but an interpretive one in search of meaning" (Geertz, 1973:5).*

An interpretivist epistemology (Figure 13) stems from an idealist ontology that considers the phenomena of research to comprise our ideas about things, and that what people believe to be true is constructed as individuals interact with one another over time and within specific contexts (LeCompte and Schensul, 1999).

Consequently, this epistemological position is one that views social life as a world of ideas (Giacomini, 2010; Hammersley and Atkinson, 2007).

Researchers become an inherent part of these social worlds and therefore are unable to adopt an objective position, or refrain from influencing the field of study. As such, differing perspectives will lead to varied interpretations of phenomena, with individuals each constructing their own, equally valid, viewpoint (O'Reilly, 2012). In this manner, such research presents the researcher's constructs of participants' constructs. Consequently, interpretive research characteristically portrays findings as contextualised and open to further interpretation (Giacomini, 2010). The idealist/interpretivist position also maintains that facts inhere values, and therefore no element of the research process can be considered value-neutral.

Prentice (2010) describes a number of fundamental principles of anthropology that should underpin ethnographic research. The first is that ethnographic fieldwork is critical to theory generation, involving participative investigation of social activity with the intention of cultivating the 'native's' viewpoint. This requires the researcher to act as a human conduit and data gathering tool, establishing social structures, rules and norms of a given society and observing participants' daily lives within that framework. The ultimate aim is to establish how participants interpret, understand and represent aspects of their lives through inductive/abductive conceptualisations. (Hirsch and Gellner, 2001:7) describe this process as:

*"a curious kind of cross-eyed vision, one eye roving ceaselessly around the general context, any part of which may suddenly reveal itself to be relevant, the other eye focusing tightly, even obsessively, on the research topic."*

The second principle is that researchers appreciate research as an inherently social enterprise in which 'facts' emerge over time rather than simply existing and awaiting discovery. Anthropologists research iteratively: observing, participating, interviewing, interpreting and reflecting. The final principle suggested by Prentice is that the key to comprehending sociocultural phenomena is context. Human beliefs and behaviours are shaped by factors such as social and institutional expectations, and power dynamics. Consequently, in aiming to understand participants' ideas, beliefs and practices, the researcher must study and analyse these within the relevant context. Van Maanen (1979:520) remarks that researchers:

*"know little about what a given piece of observed behaviour means until they have developed a description of the context in which the behaviour*

*takes place and attempted to see that behaviour from the position of its originator."*

### **3.2.3 Underpinning philosophy**

Whilst Hammersley (1992) notes the tendency towards an anti-philosophical position in ethnography, both he and Aull-Davies (2002) assert that the establishment of a sound philosophical basis for ethnographic research cannot be forsaken. Historical support for interpretivism within social science research can be discovered in a number of classical works, particularly those of Max Weber. Weber believed that the elementary unit of sociological analysis should be the individual actor (Scott, 2000), as only human beings (not structures) are capable of sentient, meaningful action. Consequently he proposed that social action (those actions that are meaningfully oriented to other humans) be the focus of sociological study (Porter, 1998). By rejecting the suggestion that unavoidable forces determine human actions, Weber acknowledged individuals' choice based on their unique perceptions/understanding of specific situations. As such, he defined the sociological challenge as understanding the sequence of motivation that precedes a particular course of action, and thus the causal explanation of that course of action. Weber termed this 'interpretive' understanding or *"verstehen... an understanding of what is going on in the actor's head, and this in turn involves an understanding of the logical and symbolic systems – the culture – within which the actor lives"* (Benton and Craib, 2001:79). It is clear from this quote that whilst Weber awards primacy of social action to the individual, he still roots this in social structure. This can perhaps be construed as one of the earliest endeavours to reconcile structure and agency, and is a position that King (1999) advocates for interpretivists. Weber did indeed acknowledge the

existence of classes, bureaucracies *etcetera*, although he did not concede that such structures could exist independently of the constituent individuals (Haralambos and Holborn, 1995). This stance has invited criticism from some authors who consider his work on social action an uncomfortable bedfellow to his views on certain social institutions (Haralambos & Holborn, 1995). Critics of interpretivism point to the preoccupation with subjectivity, primacy of human agency, relativism and apparent lack of rigour (Denscombe, 2010). Lack of objectivity renders social research incapable of generating grand theories or universal truths, and this has resulted in some criticism of the tradition (Craib, 1992). Returning once again to Weber may supply a solution to this problem. Whilst being renowned for his concept of *verstehen*, it is worth revisiting a quote from *Economy and Society*:  
*“Sociology... is a science concerning itself with the interpretive understanding of social action and thereby with a causal explanation of its course and consequences”* (Weber, 1978:4). This highlights that Weber did not distinguish understanding as distinct from explanation, but as two critical parts of the same methodology (Ekström, 1992). For this purpose, Weber advocates ‘*rational interpretation*’ – i.e. “*reconstructing a context of meaning for the purpose of understanding why persons act as they do*” (Ekström, 1992:112). Reed (2008:102) also advocates a “*layered interpretivism ... as a route to sociological explanation*”. Like Weber he considers culture the crux for explanation as it provides the manner in which subjects render their experience intelligible, and also provides a setting via which more objective social structures come to have an effect on action.

Of particular interest is the condemnation regarding the uni-dimensional perspective, i.e. “[a] *thinned out approach to social structure*” that results in

structure being “*erased or seen as epiphenomenal of agency*” (Nairn, 2009:191). Critics believe that the interpretive approach, whilst providing rich phenomenological analysis of the social world, overemphasises subjectivity with the potential for obscuring more fundamental, structural factors (Lipscomb, 2006; Nairn, 2009; Wainwright and Forbes, 2000). Archer (1995:10) proclaims, “*there is no ‘isolated’ microworld – no lebenswelt [lifeworld] ‘insulated’ from the socio-cultural system in the sense of being uncontrolled by it, nor a hermetically sealed domain whose day-to-day doings are guaranteed to be of no systemic import.*” Nyström *et al.* (2003) utilised a phenomenological/hermeneutic approach to investigate non-caring encounters within an emergency department. Attitudes and behaviours of nursing staff were attributed to shortfalls in care, whilst alternative concepts were conflated as nursing characteristics rather than constraining structural issues that had ramifications for resultant nursing behaviour. Nairn (2009:195) states, “[T]here is no sense in this paper [Nyström *et al.* (2003)] that structures have any real existence independent of the people that inhabit them and so we are left with... a set of superficial narratives that fail to understand the real social effects on the behaviour and attitudes of their respondents”. The perceived relative erasure of structure, particularly constraining factors, could generate cultures of blame and criticism, whereby individuals are deemed ‘responsible’ for inadequacies in care/service rather than entrenched structural factors. Advocates of the interpretivist tradition would contest this argument (King, 1999). Despite refuting the concept of a pre-existing and autonomous structure (and therefore the concept of objective causality), they would proclaim that this does not then infer rejection of the concept of social causality or restriction overall. Most interpretivists would however view those restrictions/constraints as the constructs of actors’ beliefs and practices,



and award ontological priority to agency and meaning when exploring how individuals internalise and rationalise such constraints (King, 1999).

The over privileging of agency has been accused of engendering “*epistemological relativism*” (Wainwright & Forbes, 2000:268) and “*judgemental relativism*” (Bergin *et al.*, 2008); that is the contention that systems of knowledge possessed by different societal groups are incommensurable, and the inability to ascertain which knowledge most approximates the truth. Bhaskar (1989) further accuses the interpretive tradition of both ‘linguistic fallacy’ (failing to appreciate that there is more to reality than that articulated via the discourse of agents) and ‘epistemic fallacy’ (the failure to recognise that whilst interpretive approaches reflect a significant impression of what the social world entails, one cannot assume that this is all that exists). Nairn (2009) however, does not deny the value of interpretive, microsocial research, and indeed acknowledges that it is of considerable value in humanist domains such as the caring professions. He does however encourage researchers to state their intent if they propose to focus on micro-interactions, and also to engage with structural ideas more vehemently in order to contemplate how the different ontological realms influence each other. For King (1999:220), the interpretive tradition does not function with a doctrine of a “*monadic individual separated from the social context*”. Interestingly, in his conclusion, King (1999:223) appears to raise a half-hearted white flag to the notion of structure – “*in employing the interpretive approach and focusing on the specific interactions of individuals, the sociologist is going to have to assume certain background conditions which are not reduced to their micro dimensions. This background might usefully be called ‘structure’ but with the strong proviso that this structure amounts to the relations of other people in different times and places and*

*never refers to any metaphysical entity which exists above and beyond all individuals or is more than the sum of all individuals and their interactions."*

For the purpose of this study, the researcher acknowledges that no methodological stance will ever constitute a 'bomb-proof' position. The cardinal issue of the structure-and-agency debate is to assume a theoretical position that will give sufficient credence to both elements. In adopting the stance advocated by King (1999) or Reed (2008), (i.e. an interpretivist position that is more 'structure-friendly') this ethnography will assume a suitably integrative position. It is believed that this structurally-cognisant interpretive approach will provide an appropriate framework for the pursuit of sociological knowledge pertaining to professionals and productivity in the ED.

#### **3.2.4 A critique of ethnography**

Ethnographers have been criticised for paying insufficient attention to the social processes that interact with and influence the data (Brewer, 1994). Hammersley and Atkinson (2007) suggest that rather than endeavouring to mitigate the effects of the ethnographer, researchers should instead be reflexive in trying to understand data and findings contextually. This reflexive turn acknowledges the limitations of an 'authentic reality' as represented in the ethnographic account. As such the researcher must ensure transparency and be explicit regarding the context in which the data was produced. Brewer (1994) asserts that these critiques of ethnography should be used to reconstruct 'good' ethnographic practice rather than deconstructing ethnography as a genre. To this end he provides an

ethnographic 'toolbox' which offered important guiding principles in designing, conducting and writing this study.

In being part of the world under study, and producing findings that are a product of relationships within the field, it is essential that the researcher critically reflects upon thoughts and actions, engaging in "*explicit, self-aware analysis of their own role*" (Allen, 2010; Finlay, 2002:531) by the addition of "*embedded self-portraits*" (Fetterman, 2010:128). Holloway & Wheeler (2010) describe this reflexivity as a form of self-monitoring, including awareness of interactions between the researcher, the researched and the research.

However, reflexivity is not only concerned with the researcher's influence on the kind of knowledge produced, but also on how that knowledge is generated (Guillemin and Gillam, 2004). The validity of research methods and the subsequent interpretation of data collected must be made transparent via "*a careful retracing and reconstruction of the route by which you think you reached them*" (Mason, 2002a:194). This approach acknowledges that factors such as the researcher's values, knowledge, experiences, gender, ethnicity, class, or dis/ability prevent them from being entirely neutral or silent in the construction of knowledge (Woodward, 2008).

### **3.2.5 Hanging out, hanging about or just hanging?**

In negotiating and maintaining my access to Rushton's ED, I undertook a near continuous reflexive account of my own position, inter-subjective reflections, social critique and changes that occurred over time (Finlay, 2002; Marshall *et al.*, 2010). The endeavour was to question how my interpretations of experiences in the field had been made manifest (Hertz, 1997).

In the pre-research phase, I reflected on my own beliefs, values and understandings of the study, and critically questioned my motives for considering healthcare productivity a topic of research (Section 1.1). This critical exploration was important in order to allow me to unravel my own understandings of a highly complex subject. It allowed me not only to understand how participant's views may differ from my own, but also how their articulations may emerge in fits and starts, and may develop over the course of time. It is important to acknowledge that, at first, I found the process of reflexive practice somewhat difficult and ambiguous. Reading the reflexive accounts of others, offered an opportunity to garner a deeper appreciation of the craft and relevance of reflexivity, allowing me to:

*“strike a balance, striving for enhanced self-awareness but eschewing navel gazing” (Finlay, 2002:541).*

In designing the study I had considered my place in terms of the insider/outsider – hanging out/hanging about (Woodward, 2008) – debate, and had explored the relative merits of either familiarity and affiliation, or detachment and lack of bias. Following the work of Bonner and Tolhurst (2002) I concluded that a standpoint broadly oriented towards insider status would potentially promote allegiance with study participants, greater sensitivity and empathy to their preoccupations, familiarity with technical discourse, and a greater appreciation of those environments and situations that were likely to be fertile for eliciting data. I was however aware that the insider perspective may equally sacrifice some of the sensitivity to the field of study or critical distance that a researcher with no prior experience or preconceptions may find productive (Dwyer and Buckle, 2009; Gerrish, 1997; Holloway and Wheeler, 2010).

Prior to commencing the fieldwork I undertook various sensitisation activities to allow me to familiarise myself with Rushton ED and the staff. The demanding and unpredictable nature of ED has led some researchers to advocate the importance of becoming "*a familiar face*" prior to commencing field studies (Bailey, 2009). After engaging with the clinical gatekeeper, I began to assist in the delivery of relevant teaching and training activities. Whilst this was an excellent way to meet a wide range of HCPs, and to develop my understanding of the ED as a system, it did raise questions about the inter-subjective relationships between myself and prospective study participants. In adopting the role as 'teacher/trainer' it could be argued that I had already established a power relationship, even before entering the field as a researcher. In founding such a power relationship I may have inadvertently influenced which participants volunteered for the more detailed and individualised forms of data collection such as interviews and focus groups (and what they subsequently elected to reveal), or even the informal discussions during the course of observation work. Once the data collection commenced, I elected to discontinue the teaching commitments.

For the first four weeks of data collection, I committed myself to information giving and recruitment. This involved repeated attendances at morning and evening staff briefings, sisters' meetings and doctors' academic meetings. In these sessions I presented my 'ethnographic self' as a fellow HCP (Coffey, 1999). Burns *et al.* (2010), note that the socially constructed meaning of 'professional identity' is suggestive of desirable researcher traits such as compassion, ability to listen and confidentiality. Whilst I did not offer my specific professional role, many assumed that I was a nurse. I noted subsequently that it was much easier to recruit nurses to the interview

components of the study and wondered if in part this had been influenced by a (presumed) shared background and understanding (Burns *et al.*, 2012).

Whilst undertaking my fieldwork, I elected not to wear ED uniform. This was a pragmatic and ethical decision based on the fact that the ED was a busy and complex environment. By wearing a uniform I did not want to mislead patients or staff that I was there in the capacity of 'clinician'. Consequently I wore clothing that complied with Trust health and safety requirements (thereby intimating cultural competence), and an identity badge/swipe card which stated my designation as 'Researcher' and provided me with access to all areas of the ED. This decision however, did little to promote my desired 'insider' status, indeed it may have led ED HCPs to perceive me as a manager (particularly given the study's focus of productivity), thereby establishing further power relationships. Consideration of power relationships is important as it is suggested that participants who perceive themselves to be in lower hierarchical ranks are more likely to view outside observers with suspicion (Burns *et al.*, 2012). In general, I made considerable effort to pre-empt and allay participants' reservations by dispelling any suggestions that the study concerned time-and-motion type activities. HCPs were assured that the focus of the study concerned their thoughts, perceptions, and daily challenges that they faced, and not an evaluation of their work. Some clearly remained sceptical, as will be discussed in section 3.8.1.

Whilst I had spent some time considering the effects of my position upon others, I had not fully considered the effects upon myself. Murphy (2005:56) notes a bias towards positive emotions associated with ethnography in the

literature, whilst feelings of “*anger, boredom, confusion, disgust, self-doubt, depression, frustration and embarrassment*” are relatively ignored. During the first few weeks of ‘hanging about’, whilst I endeavoured to develop relationships with participants (and make the transition to ‘hanging out’), I felt extremely uncomfortable – peripheral, a ‘misfit’. These feelings were amplified as the ED was facing unprecedented demands and HCPs were extremely busy. Indeed rather than describing this role as hanging about, the sense of alienation made me feel more like I was just ‘hanging’ – caught between two pillars – attempting to reconcile both allegiance to my profession and allegiance to my research. This discomfort (and its potential effect on data collection) is reflected in an excerpt from the field notes:

*“It’s obviously been a busy and stressful night. There is a 10 hour wait for beds and there has been a paediatric death. A disoriented patient is wandering round the department and I can hear someone else shouting out. News comes in that there are not enough nurses to cover the shifts, and because it has been so busy overnight, no stocking up has been completed... Resources are obviously very stretched, and I sit here thinking – I **understand** how difficult this all is, so how on earth can I ask people to give up time for an interview?”*

I endeavoured to take on small housekeeping or administrative roles in order to ease the burden on ED HCPs. At first, many staff were reluctant and gave me the impression that they could not expect me to take on menial tasks. Over time I assured them that I was happy to help in any way I could (non-clinically), and gradually they began to allow me to assist. But did I do these tasks for them, for the data, or for me? In some ways, my intention was an altruistic desire to reduce the load on a staff group which was patently under

considerable pressure. Whilst I had assumed that I was familiar with the types of stressors faced by ED staff – after all, my own clinical field had meant that I was used to critical illness and trauma, medical emergencies, death and dying – I was totally unprepared for the true nature of ED work. My own clinical experiences had invariably been conducted in relatively controlled environments, but what struck me in ED was the chaos and unpredictable demands. I noted in my field diary that, at times, I was awe struck by the work of the ED staff and suspected that I looked like “*a rabbit in headlights*” as I watched scenes unfold before me. It would be naïve to assume that ingratiating myself in this way had no effect on the data that I collected. On a superficial level, certain tasks took me to parts of the ED, or members of ED personnel that I might not otherwise have encountered. However, more fundamentally, undertaking such roles helped me to forge deeper relationships with ED HCPs. This may have predisposed them to be more forthcoming, allowing me to elicit greater volumes and different types of data. To a large extent however, my motives for taking on these tasks were largely associated with the desire to mitigate the feelings of marginalisation that I found so profoundly debilitating. On one particular occasion, my desire to ‘hang out’ rather than just ‘hang’ caused a potential ethical concern. I was observing work in the resuscitation area when the emergency phone rang to warn the team of the imminent arrival of a patient who was in need of specialist tracheostomy equipment. The staff nurses on duty were not familiar with this type of tracheostomy system. Not only did I know what the system was, I also knew where in the Trust it could be procured. Consequently, I asked a nurse to make a telephone call to the relevant department and I set off to collect the equipment. When I returned, the team members were incredibly appreciative. The resuscitation area was now very



busy and all the staff nurses were engaged in tasks. One nurse was caring for a patient who was requiring ventilatory assistance. She had taken a set of arterial blood gases but was struggling to interpret them. As I had 'revealed my hand' (i.e. exposed my critical care background, and shown willing to help out), she approached me and asked me to help her analyse the results. I was concerned however that this would overstep the boundaries of my ethical approval, and so instead suggested that she wait until a senior member of the ED staff was available. I felt guilty that I had 'misled' this nurse, and elected to be more attentive to the underlying motives and effects of my participant observation. My supervisor and I subsequently discussed my discomfort at feeling marginalised. I began to appreciate that not only would this discomfort diminish with time as I forged stronger relationships with the study participants, but also that it could potentially offer some methodological integrity (Dwyer and Buckle, 2009). Of particular value was Woodward's (2008) perspective that:

*"[t]he insider/outsider dichotomy... [is] based on far too crude a polarisation. The research process can never be totally 'inside' or completely 'outside', but involves an interrogation of situatedness ..."*  
(Woodward, 2008:17).

Dwyer and Buckle (2009:61) also reject the binary distinction between these two states, instead suggesting that as qualitative researchers, we occupy the *"space between, with the costs and benefits this status affords"*. A reflexive acceptance and consideration of this middle ground subsequently allowed me to draw on a multi-layered professionalism (Burns *et al.*, 2012) and embrace this liminal space. In allaying my anxieties regarding just 'hanging' I was able to recognise the situatedness of the inside/outside positions. After

episodes of observation and interviews I spent time documenting my thoughts and feelings regarding this situatedness and subsequently used these detailed notes to contextualise my data during analysis.

### **3.3 Study design**

#### **3.3.1 Study setting**

The study design was a single-centred, ethnographic case study conducted within the ED of a large NHS Trust between November 2011 and July 2012 following approval from the University Ethics Committee (see appendices) and the Trust Research and Development Department. The ED was selected as the field of study as it represented a busy hospital unit with multi-professional representation and contemporary experience of dealing with productivity pressures. As such, this setting offered a suitable context within which to study the phenomena of interest, i.e. productivity and process improvement. Full details of the study setting are provided in the next chapter. Preliminary pilot work in this field was undertaken by one of the study supervisors (Dr S. Timmons) during 2010 as an initial scoping exercise to assess feasibility, and the researcher also conducted sensitising visits during the six months before the study commenced.

#### **3.3.2 Participants**

Participants were recruited from current ED employees: nurses; doctors; and ED assistants (including assistant practitioners and clinical support workers). Whilst ED assistants (EDAs) are not typically considered a professional group, it was acknowledged that this section of the workforce was critical to service delivery. Inclusion of the EDA group ensured that their voice (which might otherwise have been marginalised) was represented within the study.

Exclusion criteria included: office-based staff; volunteers; students; and employees unable or unwilling to provide consent. The initial approach was made via distribution of Participant Information Sheets (PIS) that provided full details of the study and incorporated a reply slip to capture expression of interest. The clinical gatekeeper's secretary sent these information sheets electronically to all relevant ED staff on behalf of the research team. It should be noted that the gatekeeper was also an ED consultant, and this may have influenced individuals' decisions to participate or abstain. The principal investigator (PI) also spent the first 4 weeks of the study delivering information via early morning staff meetings, academic teaching sessions, sisters' meetings and general one-to-one discussion. Information sheets and posters regarding the study were also made available in clinical domains, meeting rooms and rest areas.

### **3.3.3 Sampling and recruitment**

Qualitative research has been accused of producing non-generalisable, anecdotal accounts (Murphy and Dingwall, 2003). Many would claim that aspirations of generalisability within qualitative work are inappropriate, and that particularisation via a nuanced understanding of unique cases should be the real goal, rather than a "*single, unequivocal social reality or truth*" (Creswell, 2007; Mays and Pope, 2000). Others however, maintain that as the "*hallmark of science*" generalisability should be sought (Mason, 2002a; Murphy and Dingwall, 2003; Seale, 1999). Within the quantitative research paradigm, generalisability is pursued via probabilistic sampling methods. This form of sampling, whilst not impossible in qualitative work, is impractical (Murphy and Dingwall, 2003). Consequently, nonprobability sampling is warranted, where the researcher pragmatically opts for depth at the expense of breadth.

Hammersley (1992:86) describes "*empirical generalisation*" as a way in which ethnographers can claim general relevance. In empirical generalisation the ethnographer claims that the sample selected for study (in this case, the ED) is typical of a larger population. This may be validated via collection of information regarding the aggregate in order to establish representativeness of the sample, or introduction of survey methods, either via collaboration with other researchers or the use of mixed methods. An alternative, more pragmatic perspective on generalisation (and the position adopted in this study) is to produce thick descriptions based upon the premise that their relative merit can be judged by readers who may wish to utilise those accounts in understanding situations of interest (Hammersley and Atkinson, 2007).

As well as being considered representative of UK EDs, the case study site was also selected for pragmatic reasons, for example: ease of access (managerial and clinical gatekeepers had already expressed interest in the study); proximity to the researcher's home (permitting prolonged duration of observation); and recent experience of a productivity driven change programme. It is acknowledged that selection of further field sites for study would have improved the generalisability of findings; however this was not possible given the time restrictions and the labour intensive nature of ethnographic study.

Whilst selecting the case for investigation is a critical form of sampling within ethnography, equally important is sampling within cases (Hammersley & Atkinson, 2007). This was essential in this work as the selected case for investigation (ED HCPs) was too large to study exhaustively

in its entirety. Consideration was given to sampling issues related to time (covering all varieties of shifts and weekdays/weekends), people (multi-professional representation, range of experience) and context (clinical areas, staff rooms, teaching/meeting rooms). In the initial stages of the ethnography a “*big net approach*” was adopted to allow the researcher to accommodate to the environment and the participants (Fetterman, 2010:35). Over time, this approach became more focused, with data collection proceeding in specific geographical areas or with specific ED HCPs.

In undertaking the interviews, a purposive sampling strategy was adopted to ensure that a heterogeneous range of professional groups, grades and levels of experience were included in the focus of the study (Holloway & Wheeler, 2010). This approach ensured representation and also increased the potential for reflecting different perspectives (Creswell, 2007). A total of 26 interviews (Figure 14) were conducted allowing meaningful comparisons to be made in relation to the research questions (Mason, 2002a). Holloway & Wheeler (2010) suggest that between 14 and 20 data units are considered sufficient within a heterogeneous sample. Two groups were harder to recruit to: the doctors and the EDAs. Both of these occupational groups were smaller in number, and therefore did not have the capacity to ‘cover’ in the way that the nursing group often did. In addition, the EDAs were often away from the department running errands or transferring patients and so were generally less available. Many of the nursing staff elected to undertake the interviews in their own time, either staying after a shift had finished or arriving early.

The focus group was generated by a convenience sampling strategy, and included an experienced EDA and three nurses. Whilst this meant that the

doctors were unrepresented, purposive sampling was (at that time) unachievable within the pressured environment of the ED.

Profession	Number	Management role
Nurse > 5 years NHS experience	13	10/13
Nurse < 5 years NHS experience	4	1/4
Doctor > 5 years NHS experience	3	2/3
Doctor < 5 years NHS experience	2	0/2
Non-registered staff > 5 years NHS experience	3	1/3
Non-registered staff < 5 years NHS experience	1	0/1
TOTAL	26	14/26

Figure 14: Interview participants by profession and length of NHS experience

### 3.4 Data collection

In the ethnographic tradition, data was collected via a variety of methods (O'Reilly, 2012). These are elucidated in the following sections.

#### 3.4.1 Participant observation

Participant observation represents a process whereby exposure to and involvement with study participants offers the researcher opportunity to understand daily lives and activities (Schensul *et al.*, 1999). An epistemological position is assumed that suggests observation is essential to generating meaningful knowledge of the social world because not all knowledge is “*articulable, recountable or constructable in an interview*” (Mason,

2002a:85). In this way, 'hidden' practices, behaviours, relationships and interactions relevant to productivity had the potential to be revealed (Allen, 2010). Furthermore, observation is said to permit data generation without risking the "*endless hall of faulty mirrors*" effect created by lengthier chains of transformation (Gudmundsdottir, 1996), with Dingwall (1997:63) claiming that "*where interviewers construct data, observers find it.*"

Gold (1958) describes 4 typologies of participant observer roles. At the two extremes are the 'complete participant' and 'complete observer'. Both roles often involve covert observation – the complete participant as an undisclosed researcher actively involved in the field of study, and the complete observer effectively removed/concealed from the participants with no direct interaction within the social field. Both these typologies were rejected for this study as they were not consistent with my ethical or epistemological position. The remaining typologies are both overt methods of participatory observation. The participant-as-observer is an inherent part of the group being studied; that is they have a legitimate reason (other than being a researcher) for their presence in the field. Conversely, the observer-as-participant has minimal involvement within the field, and whilst they may interact within the social setting, they are clearly there in the capacity of researcher. Over the course of the study, both these roles were assumed. For the majority of the time, my role was predominantly observer-as-participant; however, there were instances during certain meetings and training sessions where I was called upon to participate by virtue of my perceived expertise in the field of productivity and productivity improvement, or because of my experience in data collection. The differences in these roles and the

implications for the data collected were considered in the reflexive accounts that I collected over the course of the study.

Participant observation was the initial mode of data collection undertaken, commencing in December 2011. Approximately one shift per week was observed to minimise disruption to the ED service. A wide range of shifts (weekday/weekend/bank holiday and day/night) were observed in all areas of the ED in order to ensure full representation. Episodes of field observations were generally limited to 4 hours to minimise deterioration in the quality of observation and field notes (Allen, 2010, Bonner & Tolhurst, 2002). In total, 120 hours of participant observation were completed during this ethnographic study, including 'shop-floor' observation, clinician shadowing (but **not** directly observing clinical encounters), rest breaks, meetings and training events.

Consent for the observational work was secured on an iterative basis, obtained verbally immediately prior to each period of observation. No individual declined to be observed. This negotiation and renegotiation of non-written consent over time as the ethnographer-host relationship and trust develops is both common and validated practice (Adler and Adler, 2002; British Sociological Association, 2002; Denscombe, 2010; Moore and Savage, 2002; Murphy and Dingwall, 2007).

Mason (2002a:89) describes the risk of executing "*unfocused and vague*" observation, and recommends establishing a procedure for linking research questions to selective field observations in much the same way that an interview schedule is prepared (Figure 15). Foci of observation included:



space; actors; activities; artefacts; events; timings; goals; feelings/expressions and utterances (Holloway & Wheeler, 2010). Observation progressed from descriptive, to focused, to selective over the course of the study with observatory gaze directed in a way that addressed the research objectives. Field notes were collected in writing, including data, provisional analysis (embedded researcher reflections and analytic memos) and reflections on issues of reflexivity. Note taking was congruent with the field setting and was not undertaken in environments where participants would consider it inappropriate or threatening (Hammersley & Atkinson, 2007). Where it was not possible to record field notes contemporaneously, they were completed at the earliest opportunity to ensure all relevant data was captured.

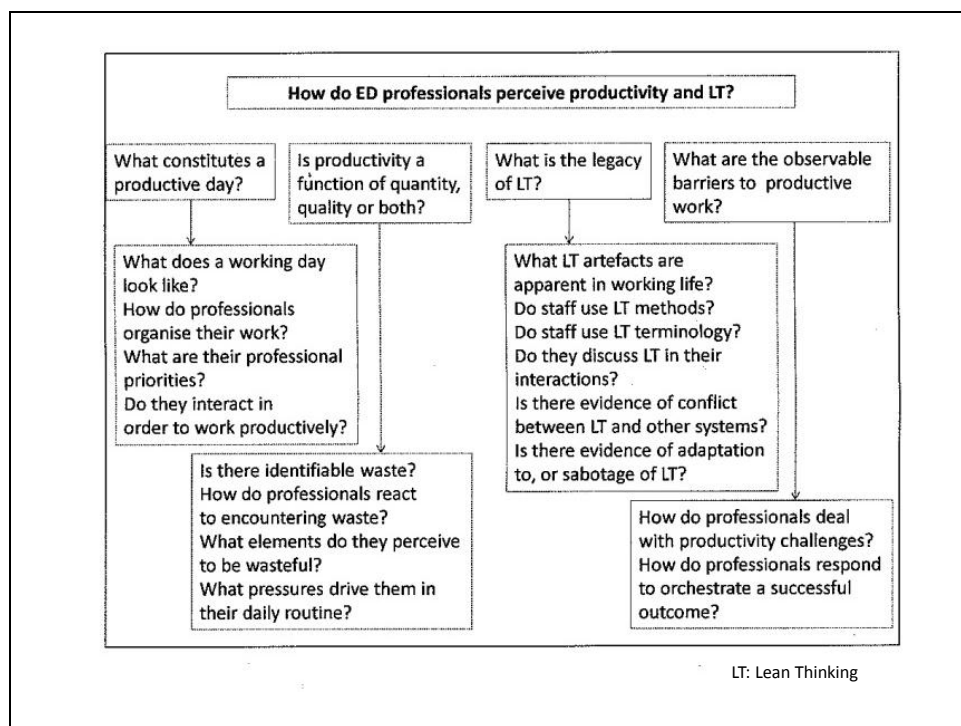


Figure 15: Schemata produced to guide observation

### 3.4.2 Qualitative interviews

Qualitative interviews are “*conversations with a purpose*” and are appropriate for research questions that concern gaining insight into participants’ interpretation of events or phenomena (Mason, 2002a:62). They can be a valuable supplement to observational field work, allowing the researcher opportunity to compare what is seen and heard in a naturalistic setting to what is expressed in a more formal interaction. They also have the potential to provide a greater breadth of coverage than is feasibly possible with observation, and are effective in encouraging participants to reconstruct historical as well as contemporaneous events (Bryman, 2004). Ontologically, interview methodology assumes that participants’ knowledge, perceptions, interpretations, experiences *etcetera*, are meaningful components of the social reality under investigation. Epistemologically it assumes that the nature of the social can be accessed via discursive activity, and that knowledge can subsequently be constructed via interpretation of what has been said (Mason, 2002b). The interview process constitutes social interaction, and as such, the interviewer and participant become collaborators in the construction of the data (Kelly, 2010). Murphy and Dingwall (2003) describe qualitative interviews as the opportunity to view the world from the perspective of the participant, or to utilise Weber’s term, a means of ‘*verstehen*’.

The optimal conditions for creating the construction of meaningful knowledge were considered prior to the study. Mason (2002b) recommends charging the participants with recounting or narrating situations and events, thereby grounding the dialogue in relevant contexts. This relies on posing situational rather than abstract questions. For example, in this study, rather than asking ‘What is productive practice?’ participants were asked to reflect

upon issues such as 'What makes you feel productive at work?' or 'Describe a day when you felt productive'. This strategy is based on the premise that individuals make sense of the social by founding it in everyday encounters.

Qualitative interviews can be represented along a continuum of control, with naturalistic, informal talk at one extreme of the spectrum, and a clear focus and pre-established approach at the other. In deciding where to locate this study, it was essential to consider the current state of available knowledge. As the understanding of professionals' notions of productivity was relatively under-researched, it was appropriate to adopt a more open approach via semi-structured interviews (Murphy & Dingwall, 2003). In rejecting the use of an inflexible framework of categories, there was greater opportunity to explore participants' frame of reference, following leads and examining alternative dimensions (Schensul *et al.*, 1999).

Whilst the relationship between researcher and participant should be one based on mutual respect, the researcher (by virtue of the fact that they will subsequently dictate the representation of the interaction) wields considerable power. Consequently, the issue of inter-subjectivity must be an important consideration in both the generation and analysis of data (Holloway & Wheeler, 2010). Murphy & Dingwall (2003:96) state: "*However sensitive and non-judgmental our interview techniques may be, they cannot be expected to neutralise informants' awareness of the ways in which their behaviour could be judged and found wanting.*" This is of particular significance when exploring an issue such as productivity which has personal, professional and political connotations. Consequently, analysis considered what participants were endeavouring to do with their talk, whilst considering the intricacy,

instability and vacillation that is typical of participants' understandings (Murphy & Dingwall, 2003).

Twenty-six interviews of HCPs were conducted within private rooms within the ED from January 2012. Whilst the initial intention had been to interview 30 members of staff, data saturation was achieved and the study team collectively agreed to stop recruitment. An interview guide was generated to prompt exploration of relevant themes (Figure 16). The interview guide was pre-tested amongst non-ED HCPs to ensure that questions were unambiguous and fit for purpose. The guide was however intended as a prompt, and was adapted according to the nature of the individual respondent, their experiences/interests, and their replies. Before interviewing the most senior staff, I explored the literature on interviewing 'elites' in order to develop strategies for managing the interview and eliciting relevant data (Richards, 1996). Interviews ranged from 20 minutes to 1 hour with the average lasting 35 minutes. Timing was a critical issue, as the nature of the environment meant that HCPs could not be released from clinical work for long periods of time. On occasions, interviews were interrupted by pagers or phones, or cut short when the individual was 'pulled back' to the field. This meant that as a researcher I always had one eye on the clock and was aware that, at times, I did not achieve the depth or breadth of information that I desired because of the temporal constraints. This is ironic given that it was the phenomenon of productivity under investigation.

Interviews were digitally recorded in order to minimise note-taking and improve interaction between myself and the respondent. All participants consented to audio-recording, however one individual clearly moderated

their responses whilst the recorder was switched on. This posed an ethical dilemma, as the participant revealed further data once the recording was stopped. I reflected on the incident after the event:

*The interview was quite difficult. I had got to know the individual beforehand by virtue of observational work. They had been really welcoming and facilitatory, keen to oblige. Consequently I had set a lot of store by the interview and fully expected it to be quite revelatory. To some extent it was, but there was also a sense of the individual being somewhat reserved, and possibly even obstructive. There were marked hesitations and frequent requests for me to justify my motivations for asking specific questions. This made me feel very uncomfortable at times. However, as soon as the voice recorder was stopped the dialogue continued, with the individual using statements such as: 'I can say this now the recorder is off'; 'what's on there (recorder) anyone can listen to, this is just me saying this to you'; and 'I don't have to worry about being diplomatic now'. It was clear from these statements that the utterances had been off the record, and were not for use as data. I was frustrated as the thoughts were expressed articulately and passionately, and supported the beliefs of other participants interviewed earlier in the process who, for whatever reason, had chosen to be less 'diplomatic'. How did this affect intersubjectivity? I think I probably probed more during the interview because I knew that there was more to be got. I wonder if the individual picked up on my discomfort and frustration, and if in fact this compounded the situation?*

The views expressed 'off the record' by this participant were not included in the final body of data subjected to analysis. The views did not represent a deviant case, but would have added richness to the data collected from other participants.

Theme	Example questions
How do HCPs understand and value productivity?	<p>What does a productive shift look like?</p> <p>How do you know if you have been productive?</p> <p>Does productivity feel relevant to you as a HCP? Is it new? Have perceptions changed? What was the catalyst?</p> <p>What factors confound attempts at productive work?</p> <p>Are there risks associated with chasing productivity?</p> <p>How would you measure productivity?</p>
How do HCPs perceive the management/political position on productivity?	<p>How do you think productivity is viewed by Trust management/government?</p> <p>What productivity measures do you think they would value?</p> <p>How do they measure your productivity?</p>
How do HCPs view productivity improvement?	<p>What are your experiences of productivity improvement?</p> <p>What did you think when you heard about the change programme? Do you feel the same now? Were you involved?</p> <p>Was it viewed as a threat/opportunity?</p> <p>Did it change roles?</p> <p>Does healthcare productivity need improving?</p> <p>How would you improve healthcare productivity?</p>

Figure 16: Interview schedule - Themes and sample questions

Reflexive notes were made immediately after the interviews concluded, documenting thoughts and feelings, with these then forming an integral part of the data analysis. Furthermore, I elected to listen to each recording at least once before transcription, and wrote further reflexive notes afterwards. All recordings were transcribed as soon as possible after the event, with personal identifiers removed.

### **3.4.3 Documents**

The methodological position for the analysis of documents within this study was to explore the development of productivity discourse in both national and local policy, and the construction of professional responsibilities therein. The literature review had indicated that concepts of efficiency, productivity and resource management/allocation were not new to NHS policy (Lapsley and Schofield, 2009), but around the early years of the 21<sup>st</sup> century, healthcare productivity had become a much more widely mobilised concept within policy and professional literature. This was evident both in terms of increasing frequency and potency – many documents were dedicated solely to this issue of productivity. This watershed appeared to be marked by a synergy of factors including the unprecedented investment in the NHS, the onset of the fiscal crisis, the ‘Nicholson Challenge’ and the improved accuracy and sophistication of national efforts to collect healthcare output data (Street, 2009). Consequently, public policy documents, influential reports and minutes of House of Commons Select Committee meetings published from this turning point were selected by their direct reference to NHS productivity, efficiency or value for money as a major theme. Whilst The King’s Fund and Nuffield Trust reports do not originate from the NHS it is acknowledged that as authoritative, independent think-tanks, both



organisations are influential in shaping policy and transforming services. Such an approach was also consistent with the conceptual framework as governmentality acknowledges the existence of multiple sources and agents.

Local documents<sup>10</sup> were procured using the same methodology and approximate timeframe. All local documents were publicly available (usually via the Trust internet pages, or in general circulation within the ED or Trust) and included: reports; minutes of board meetings; video podcasts; job advertisements; training manuals; newsletters; newspaper articles and posters. As both national and local documents were publicly accessible, data collection and analysis commenced in October 2011, before formal entry to the study site. Once in the field I continued to collect relevant documents as they became available.

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<sup>10</sup> Local documents are identified and described within the subsequent chapters, but are not formally referenced in order to preserve the anonymity of the case study site and participants.

Document	Publication Date	Publisher/Author
What is Productivity?	2006	NHS Confederation
Our Future Health Secured	2007	The King's Fund (Wanless <i>et al.</i> , 2007)
High Quality Care For All. NHS Next Stage Review Final Report	2008	DH
NHS 2010-2015: from good to great. Preventative, people-centred, productive	2009	DH
The NHS Quality, Innovation, Productivity and Prevention Challenge: an introduction for clinicians.	2010a	DH
Equity and excellence: Liberating the NHS.	2010b	DH
Value for money in the NHS	2010	House of Commons Health Committee (HoCHC)
Improving NHS productivity. More with the same not more of the same.	2010	The King's Fund (Appleby <i>et al.</i> , 2010)
Management of NHS hospital productivity	2010	National Audit Office (NAO)
Management of NHS hospital productivity (26 <sup>th</sup> report of session 2010-11)	2011	House of Commons Committee of Public Accounts (HoCCPA)
Can NHS hospitals do more with less?	2012	Nuffield Trust (Hurst and Williams, 2012)

**Figure 17: Key National Productivity Documents**

### 3.4.4 Focus groups

The nature of the focus group is the emphasis upon participant interaction in response to a specific theme (Bryman, 2004), where *“the aim is to understand the social dynamic and interaction between the participants through the collection of verbal and observational data”* (Redmond and Curtis, 2009). The plurality of voices means that a diverse range of views can be elicited, expressed, challenged or corroborated (Barbour, 2010). This process of complex social interaction and discussion reflects the manner in which meaning and knowledge is constructed in everyday life, and is particularly relevant to the investigation of socialised HCPs.

One focus group was conducted in the final months of the study. Whilst 6 HCPs were recruited, 2 were subsequently unable to attend because of workplace pressures. Redmond and Curtis (2009) suggest that limiting the number of participants to ten or less facilitates equitable sharing of information whilst ensuring that it is still manageable for the moderator. The purpose of the focus group was to present initial findings to ED staff, with the intention of promoting discussion and generating further data. Furthermore, by conducting this group towards the end of the study, it offered the researcher opportunity to herald the final stages of the data collection and commence negotiation of exit from the field.

The focus group was conducted within the ED and lasted approximately one hour. The researcher assumed the role of moderator, permitting conversation to flow freely, but intervening when difficulties arose, participants became marginalised or opportunities were missed. Stimulus material was utilised depicting an overview of interim findings or raising further questions. The

focus group was a prime example of how individuals' ideas regarding productivity developed over time and with discussion. One participant became so engaged in the debate that she seemed reluctant to let the session close at the end of the hour, and asked me to accompany her into the department in order that she could show me examples of some of the issues she had discussed. Focus group data was digitally recorded and transcribed at a later date with all identifiers removed. Reflexive field notes were made to aid data analysis.

### **3.5 Recording and managing the data**

Interviews and encounters recorded in the field notes were transcribed verbatim by the researcher in order to ensure full and meaningful data. Details on the front sheet included date, time and place of data collection, plus a participant code number. All data generated was managed according to the Data Protection Act, 1998. Hard copies of data were kept in a locked cabinet according to the University of Nottingham Code of Research Conduct and Research Ethics (University of Nottingham, 2010). Computer stored data was held securely and password protected. Access was restricted to the researcher and the research supervisors.

### **3.6 Data analysis**

Ethnographic studies characteristically generate a wealth of data, including field notes, reflexive accounts, digital recordings, interview transcripts and documents. The challenge for the researcher is to deal with it efficiently and effectively. Analysis as a process implies the craft of interpretation or sense making, and reflects the ontological and epistemological position of the researcher. Qualitative data analysis commonly proceeds on an *“iterative,*

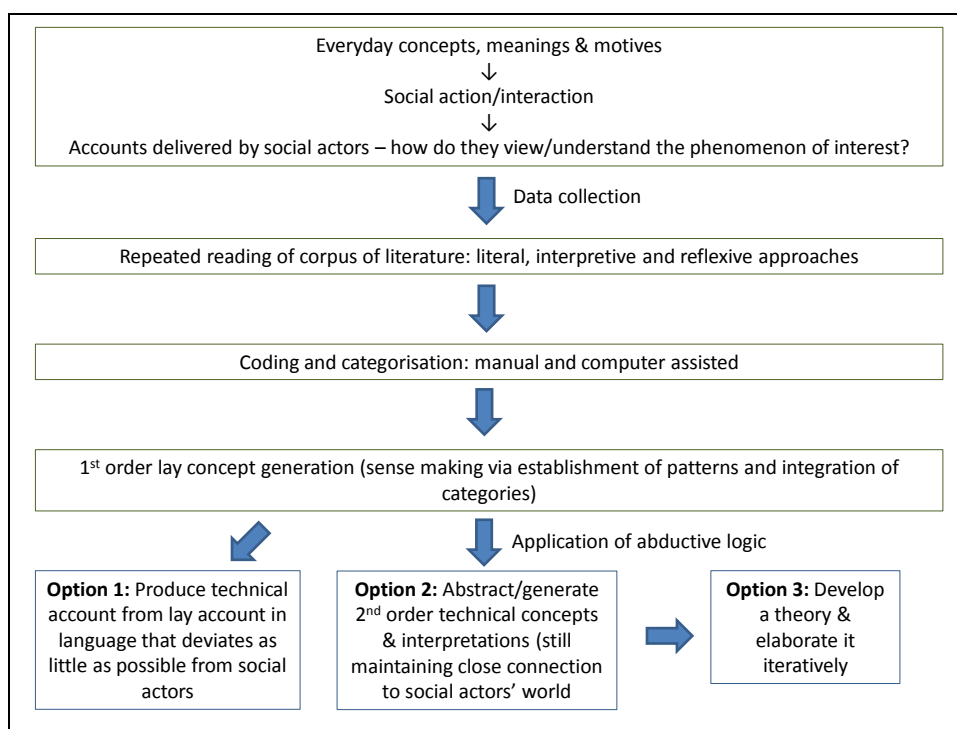
*recursive and dynamic*" basis, establishing a non-linear and dialectical relationship with data collection (Gibbs, 2002:2; Hammersley and Atkinson, 2007).

The ultimate outcome of qualitative analysis is variable. In ethnographic studies, data analysis is directed towards the generation of a comprehensive record of the research field and of participants' interpretations of their world (Murphy *et al.*, 1998). For some cases the endeavour is to produce thick description and an interpretive account, in others it is also to build or test a theory (Tesch, 1990). In order to generate theory however, researchers must establish a research strategy or logic of enquiry (Blaikie, 2007). For the purpose of this study, an abductive research strategy was employed. This is in keeping with an idealist ontology and is based on the work of Schutz (1963), Weber (1964), and Winch (1964) (Figure 18).

The abductive research strategy (Blaikie, 2010) answers research questions by providing understanding rather than explanations. Abduction is predicated on the construction of theory that is derived from social actors' meanings, interpretations, accounts, motives and intentions experienced within the context of everyday life. The mutual or 'insider' knowledge that this research strategy aims to uncover is that which is usually unspoken but which is central to social actors' interactions (Blaikie, 2010). The first stage of the abductive strategy therefore is to establish this knowledge in actors' own words, before abstracting technical accounts that remain 'loyal' and closely connected to the original accounts (Option 1, Figure 18). At this point the researcher should ensure that the actors still recognise their social world within the representations. This triangulation process allows the researcher

to ensure that they have adequately represented the social world. Within this study, triangulation was undertaken by presenting emerging ideas and concepts back to a number of key informants. Some researchers may elect to end the process here, but for this work ideas and concepts were continually refined in the attempt to develop more substantive theory (Options 2 and 3, Figure 18).

Whilst Figure 18 suggests that the abductive research strategy is a linear process, this is in fact misleading. Abduction is an inherently iterative process characterised by alternating periods of data collection and analysis/reflection. In this way, theory and research are *“intimately intertwined... Research becomes a dialogue between data and theory mediated by the researcher”* (Blaikie, 2010:156).



**Figure 18: Representation of Abductive Research Strategy (Blaikie, 2007, Mason, 2002a, (Priest *et al.*, 2002)**

The analysis of documentary data was undertaken separately, *in advance* of the analysis of observation and interview data. This documentary analysis proceeded according to a tradition attributed to Foucault – the ontological and epistemological belief that discourses constitute subjects and objects, and are therefore the system of action through which government of social life can be orchestrated and understood (Alvesson and Kärreman, 2000; Rose and Miller, 2010; Willig, 2008). Once texts had been identified the relevant documents were coded by thorough and repeated reading for both implicit and explicit constructions of productivity. Of primary interest were those discursive practices around productivity that made visible certain regimes of power via the authority of particular rationalities or ‘truths’ (Campbell and Arnold, 2004). Attention was paid both to recurring themes and any inconsistencies or deviations from dominant discourses. Procedural guidelines established by Willig (2008) were used as a framework, attending to discursive constructions, discourses, action orientations, subject positions, opportunities for action and subjectivities. This analysis generated a particular theory (individualised responsabilisation for productivity, as a mode of new professionalism) which, in the abductive style, was then ‘re-applied’ to the study field, in order to test and develop it iteratively.

Interpretive reading and systematic categorical indexing of the observational and interview data was then undertaken. All data was read through repeatedly, what Bazeley (2013:101) refers to as “*read, reflect, and connect*”. Copious notes were applied to paper manuscripts in order to develop general ideas and concepts. Coding was applied on a line-by-line basis, identifying themes and relating to *a priori* issues highlighted by the analysis of documents and the original research questions. The researcher remained

vigilant for apparently discrepant information, in order to ensure that valuable data was not dismissed (Holloway & Wheeler, 2010). Coding was crudely based on two phases: an initial, broad brush approach and a second stage committed to refining and interpretation. Over the course of the study, codes and themes were constantly developed and re-appraised relative to the new data being acquired. In this study, the themes emerged as a result of systematic coding, categorisation and a process of analysis (Saldaña, 2013). The final themes, developed from the data in its entirety, underpin the thesis: productivity and new professionalism; domains of productivity; problematics for productivity; and resolving ethical tensions.

A computer assisted qualitative data analysis system was used with the intention of complementing and assisting the manual indexing. NVivo 10 was pragmatically selected due to ease of access and availability of training. NVivo supports qualitative data analysis by managing and organising data/ideas, running queries, producing graphical depictions of conceptual models and generating reports (Bergin, 2011). The choice to code manually as well as electronically was an endeavour by the researcher to remain 'hands on' with the data and preserve theoretical sensitivity (Murphy *et al.*, 1998). Indexing and analysis of data was reviewed by the study supervisors on a monthly basis.

### **3.7 Ethnographic writing**

As previously discussed, ethnography is as much an output as methodology and methods. Consequently, I spent some time considering how I might represent this work in a way that was scientifically/theoretically robust, and yet preserved inherent reflexivity. Van Maanen's (2011) text, 'Tales of the



field' was particularly influential in guiding my choice. Van Maanen maintains that method discussions of ethnography should explicitly consider the representational style. Citing James Clifford (1983:120) he wonders how:

*"a garrulous, overdetermined, cross-cultural encounter, shot through with power relations and personal cross purposes [is] circumscribed as an adequate version of a more-or-less discrete 'other world', composed by an individual author?"*

Consequently, Van Maanen endeavours to explore traditional narrative conventions used to produce ethnography: realist tales and confessional tales. Realist tales are precise and rational studies of a culture, with little attention paid to the role of the fieldworker in the production of the account. Conversely, confessional tales focus predominantly on the fieldworker, rather than the culture under scrutiny. As a novice ethnographer, I believed that the more traditional realist route was one that I could most easily navigate successfully and which would address the research questions. However, in order to justify my role within the construction of knowledge, it was essential to 'borrow' from the tradition of confessional tales.

Selecting the elements to present within the written account was emotional work. Whilst I believed that I had a clear story to tell (driven by the original research questions), I had also encountered numerous other sub-plots or tangential stories. Acknowledging that some of these were to be 'left behind' was difficult. Not only had I invested considerable emotional labour in excavating these stories, I also felt beholden to the study participants who had been generous and frank enough to share their experiences. One individual in particular, Peter, had left a distinct impression on me. A reserved, softly-spoken, very reflective and insightful HCP, Peter had

participated in all aspects of the study. He later confessed that it had taken considerable nerve to volunteer. His accounts resonated strongly with me, as I believed we shared the same professional ethos. Whilst this thesis contains many of his experiences and beliefs, there are equally many others that are not addressed. However, for the sake of clarity and cohesion within this thesis, Peter's other stories must be represented in another work.

In an endeavour to represent my participants' 'true' voices, I have used numerous direct quotations from both interview transcripts and informal discourse captured during periods of observation. In order to situate those voices I have utilised the abbreviations shown in Figure 19.

JDoc/SDoc	Junior doctor/senior doctor
SN/SSN/CN	Staff nurse/senior staff nurse/charge nurse
EDA	Emergency department assistant
ENP/ANP	Emergency nurse practitioner/advanced nurse practitioner
AP	Assistant practitioner
CSW	Clinical support worker
-obs	Data collected during observation rather than interview

**Figure 19: Abbreviations used to attribute direct quotes**

### **3.8 Ethical considerations**

In designing, conducting, analysing, interpreting and disseminating research, there is a plethora of ethical challenges to consider (Murphy and Dingwall, 2001). These include consequentialist approaches (have participants been protected from harm?) and deontological approaches (have participants' rights been preserved?). Ethicists translate these into a set of guiding principles (Murphy & Dingwall, 2001) which will be discussed below. For the purposes of this study The British Sociological Association Statement of Ethical Practice (British Sociological Association, 2002), The Department of Health Research Governance Framework for Health and Social Care (Department of Health, 2005b) and The University of Nottingham Code of Research Conduct and Research Ethics (University of Nottingham, 2010) were adhered to.

#### **3.8.1 Non-maleficence and beneficence**

Whilst ethnography does not incur the same potential for physical harm that biomedical experimentation may confer, it would be naïve to assume that it is free of risk. Participants may become upset, worried or offended during the course of the fieldwork (Hammersley & Atkinson, 2007). Furthermore, they may become reliant upon the relationship that is forged with the researcher. Although these issues were deemed improbable in the context of this study (the nature of the investigation was not anticipated to be overtly emotive), the researcher remained cognisant of the complex nature of relationships that might develop during the period of study. The role of reflexive analysis of the ethnographic 'self' (Gerrish, 1997; Mason, 2002a) in mitigating such issues has already been discussed. Furthermore, an agreed

referral process was established in consultation with the study supervisors, to deal with any such issues should they have arisen.

At times it was necessary to discontinue periods of planned data collection in order to protect the wellbeing of ED staff. This was usually related to last minute cancellations of interviews in order to avoid overstretching a workforce that was already struggling to cope with demands. On one occasion however, the decision was made to discontinue observation because of the threat of physical harm to both researcher and ED staff:

*“At this point I have to abandon my observation. There is an extremely complex psychiatric patient in the department who is paranoid, delusional and becoming increasingly aggressive in his tone. I am observing from behind the nurses’ station. The patient is wandering around zone 3 – the team have elected not to place him in one of the observation rooms normally reserved for psychiatric patients because of his labile state. The patient catches my eye on a number of occasions. I am acutely aware that I am not in uniform, and therefore look different to the other members of staff. I feel anxious, concerned that my presence (as an individual who is merely watching and writing) may actually compound his paranoia and further disrupt his fragile state. I inform the nurse in charge of my plans to leave and move to the resource room down the corridor to write my notes.”*

This example highlights the importance of reflexivity *in action*, identifying and responding to ethical challenges as they arise.

Findings from this study have been presented at a number of conferences and published journals, as well as within this thesis. Stark and Hedgecoe

(2010) highlight dissemination as a particularly vulnerable time for participants. Endeavours were made to preserve anonymity and confidentiality, e.g. removing identifiers, using pseudonyms, altering non-important details. However, it is debateable as to whether anonymity and confidentiality are genuinely achievable in qualitative research where field notes and interview transcripts are more easily attributable to specific participants. Where participants inadvertently revealed their identity by virtue of stating something that could only be attributed to them (for example, describing a specific role that only they held), the data was not utilised without permission. Study participants were given opportunity to view published work as the research team displayed copies of conference posters within the ED once data collection was complete.

Whilst the information sheet and consent form (see appendices) clearly stated that all information collected during the course of the research would be kept strictly confidential, a significant number of study participants remained anxious regarding anonymity and confidentiality, and sought repeated assurances particularly during the course of the interviews. One participant revealed that a senior member of staff had discouraged her from participating, and another had been told to 'be careful' about what she divulged. It was difficult to ascertain whether this was a general feeling, or whether it had been specifically directed at one or two individuals who might have been considered outspoken or cavalier. In consultation with the clinical gatekeeper and study supervision team, a further email was sent to all ED staff reminding them that confidentiality was a priority.

Although patients did not constitute any direct part of this ethnographic work, the fact that the study was to be conducted within a healthcare setting could not be overlooked. Posters were designed and displayed in all waiting areas informing patients and families/carers that a study was in progress but that they would not be involved in any way. Whilst the researcher (as a Health and Care Professions Council state registered physiotherapist) was legally, professionally and morally bound to adhere to the correct policies and practice guidelines, no negligent or incompetent practice was observed over the course of the study.

### **3.8.2 Autonomy**

Respecting the values, rights and decisions of research participants is of paramount ethical concern. Within the qualitative paradigm, the focus has historically concerned the issues of covert research and absence of informed consent. In this study, the researcher's aims were overtly disclosed and consent was attained prior to periods of observation and interview, as previously discussed. The researcher ensured that potential participants were not only fully aware of the study but also had sufficient time to consider the implications of participation.

Signed consent forms were gained for interview/focus group work. Although it is recognised that these do not guarantee the participant's understanding of the study (Moore and Savage, 2002), Murphy and Dingwall (2001) comment that they serve as a salutary reminder of the nature of the researcher/participant relationship. The researcher worked through the consent form systematically with research participants, and answered any questions concerning study participation. One copy of the form was retained

by the participant, and one by the researcher. All study participants (interview/observations/focus groups) were informed that:

*“Healthcare productivity is a major focus of interest. The NHS has tried many methods to improve productivity, yet most fail to reach their full potential. There is virtually no research that explains how UK healthcare professionals perceive productive or efficient practice. We believe that understanding your views will better inform productivity improvement strategies of the future” (PIS).*

The research relationship may be perceived as inherently exploitative, generating imbalances of power between researcher and participant (Watts, 2008). In particular, within any research of healthcare settings and staff there is the potential for institutional vulnerability; that is individuals feeling compelled to participate because of the environment that they have been approached in (Stark & Hedgecoe, 2010). In this study, the researcher ensured that HCPs were assured that participation was voluntary, and their decision to enrol (or not) would in no way affect their employment or income. This power imbalance also extends to the issue of interpretive authority. Some authors have argued *“that the only legitimate role for researchers is to **reproduce** participants’ perspectives: to go beyond this usurps the right of people to define their own reality”* (Murphy & Dingwall, 2001:345, emphasis in original). Whilst this is a complex issue, it is hoped that adequate representation of the participants’ voice (via numerous data excerpts) and transparency regarding the researcher’s process of interpretation can go some way to promoting fair representation.

### **3.8.3 Justice**

Justice implies that the research is conducted in a fair and even-handed manner. In practice this relates to 'fair-dealing' ensuring equality in the treatment of participants regardless of ethnicity, age, gender, disability or sexual orientation (Holloway & Wheeler, 2010, Department of Health, 2005b). In this study, no financial incentives were offered to participate, although tea, coffee or soft drinks were made available to interview/focus group participants.

### **3.9 Methodology and methods: Summary**

This chapter has served a number of purposes. Firstly it has provided an account of the philosophical framework that has underpinned the design, execution and final representation of this study. Secondly, the study design and methods of data collection have been presented in detail to ensure transparency and potentially facilitate replication of the study in another context. The selection of multiple methods has permitted data triangulation, whilst also adding considerable depth and breadth to the findings. By reflexive exploration of my own 'situatedness' I hope that I have permitted the reader an appreciation of my influence in both the data collection and the origination and development of ideas and theories. As an experienced HCP involved in research within a healthcare context, exposure of this 'situatedness' is critical.

What remains unspoken in this chapter is the consideration of potential limitations of the methodological approach. Some of these have been alluded to such as the difficulty in recruiting junior doctors for interviews and focus groups, and the fact that the ethnography was limited to a single case study



site. Theoretical and methodological limitations will be discussed in greater detail in the concluding chapter.

The next four chapters will consider the study findings in detail, exploring the social construction of healthcare productivity and the implications for professional identity.

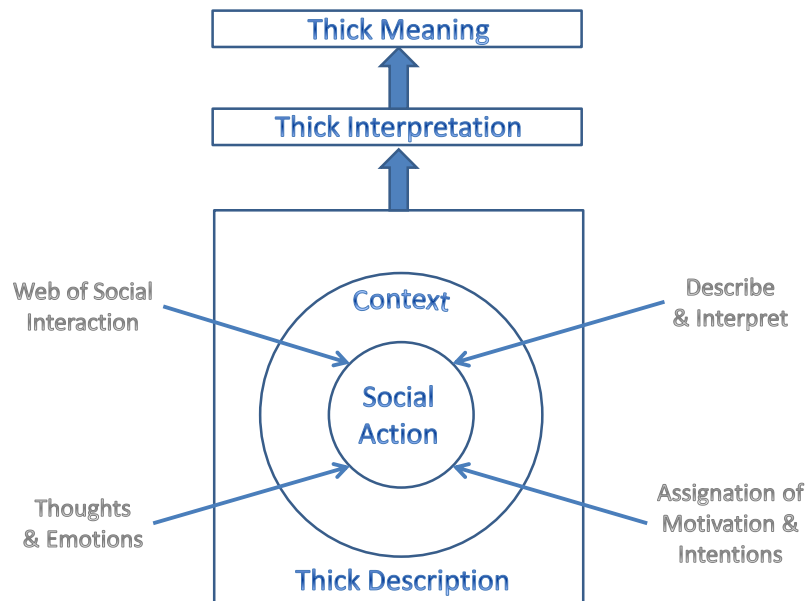
## Chapter 4: Setting the scene: Professionals, productive work and the ED

*"Sitting in the Emergency Ward was like sitting on a bench in the Louvre: a human tapestry, ever unraveling under my eyes... [it] was a place unlimited in time: I'd leave it, and it would go on without me until I returned. An immense, humbling eternity of disease" (Shem, 1998:203)*

### 4.1 Introduction

This chapter is the first of four presenting empirical data from the study. The aim of this initial chapter is to 'set the scene' and provide the reader with a clear view of the organisational and professional context of productive work in the ED. Using thick description an image is created of the ED, the professionals, the process of care, the working day and the nature of the productivity challenges.

Ponterotto (2006) provides a synopsis of key works in order to describe the 'essence' of thick description (Figure 20). It is this synopsis that frames the thick description constructed within this chapter.



**Figure 20 Theoretical Framework for the Production of Thick Description**

This chapter is structured using two main sections. The first presents the study site, an ED within a University teaching hospital in the UK. The department is depicted in terms of its practitioners, patients, challenges and geography. Whilst the aim of this study is not to generalise, the provision of such detail allows readers to relate findings to other contexts.

The second section maps the contours of productive healthcare within the ED, in particular the HCPs and the organisational context within which they provide that care. Using a series of 'ED snapshots', the intention is to create a collection that portrays for the reader a sense of both structure and agency, of the efforts made to optimise productive healthcare as well as the challenges faced. The 'snapshots' are derived from the ethnographic fieldwork in the ED and include profiles of patient journeys, reflections on meetings and clinical shifts, and professionals' own accounts. Within each snapshot is some reflection of

the issues at play, the relevance to productivity and productive work, and the interplay of the organisational and the professional.

## **4.2 The Study Field**

### **4.2.1 Emergency Medicine as a Specialism**

The 'speciality' of emergency medicine emerged within the UK as a response to calls for better care for seriously ill and injured patients (Bache, 2005). Accident and Emergency (A&E) departments were established but no provision was made for senior specialist career posts, despite acknowledgements that a unique skill set was required to run such units. Although the Casualty Surgeons Association was inaugurated as a professional body in 1967 with the explicit aim of improving the standard of emergency care, poor leadership and inadequate staffing levels persisted. Casualty work was not considered to be a medical speciality and consequently A&E work was generally perceived to be an unattractive option (Sakr and Wardrope, 2000). This prompted a widespread investigation leading to the appointment of 30 A&E consultants as an experimental pilot, growing to 105 by 1976. In 1990 the Casualty Surgeons Association became the British Association for Emergency Medicine (reflecting a more holistic approach) and later still, the College of Emergency Medicine, the current authoritative body for Emergency Medicine in the UK and Republic of Ireland (Guly, 2005). Consequently, the speciality of Emergency Medicine can be described as relatively new in comparison to long established specialisms such as surgery (Royal College of Surgeons England established 1843) or general medicine (Royal College of Physicians founded 1518). As such it is suggested that Emergency Medicine may

not always command the same respect or recognition as longer established specialisms.

#### **4.2.2 The 4-hour target**

A range of healthcare related targets, operational standards and performance measures have proliferated globally (Weber *et al.*, 2011). During the 1990s, emergency services faced increasing political and public criticism regarding long ED waiting times. Consequently, the dramatic changes proposed in the NHS Plan (Department of Health, 2000) included the introduction of the 4-hour target, which declared that by 2004 no patient should wait for more than 4 hours from arrival to admission/transfer/discharge. Whilst the operational standard for this target was originally 100%, this was reduced in 2004 to accommodate 2% of the patient population deemed to be 'clinical exclusions' (Department of Health, 2003). Achievement of the target was linked to financial incentives, paid on a staged basis. In 2011, the target was 'de-emphasised' and reduced to 95% following requests by professional bodies, and actively supported by the Royal College of Nursing (Cooke, 2013). The professional rationale was that many patients would derive clinical benefit from a longer ED stay where more complex investigations and first line treatments could be initiated.

#### **4.2.3 The crisis in emergency care**

In the last few years, EDs throughout the UK have experienced spiralling pressures (Royce, 2013). Concerns have been expressed that without widespread efforts to stabilise the emergency care system, imminent systemic failure is highly probable in the winter of 2013 (Foundation Trust Network, 2013). The challenges faced by EDs are

described as the most visible sign of pressure across the health system as a whole (Royal College Physicians, 2013). In this way, the ED effectively becomes conceptualised as the health system barometer. The primary reasons for the pressure on EDs – *“the biggest operational problem facing the NHS”* (Hunt, 2009) – are represented in Figure 21.

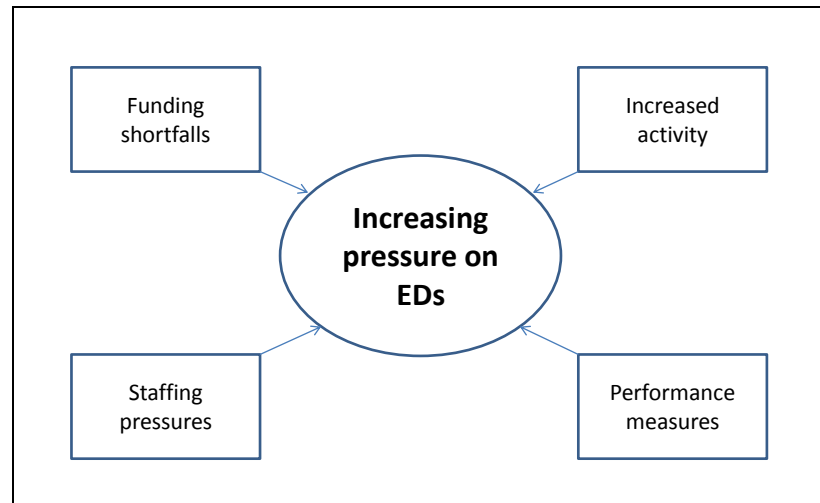


Figure 21: Pressures faced by EDs (From Foundation Trust Network, 2013)

This situation has prompted an urgent review of emergency care and a drive to devise ED recovery plans (NHS England, 2013).

## 4.3 The Study Site

### 4.3.1 The Trust

Rushton NHS Trust<sup>11</sup> is one of the biggest teaching trusts in the UK. Providing acute and specialist services to 2.5 million people, it has an annual budget in excess of £700 million and over 13,000 employees. Spread over 3 sites, the Trust manages 87 wards and approximately 1,700 beds. Since 2009 the Trust has been actively working towards achieving Foundation status.

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<sup>11</sup> 'Rushton NHS Trust' is a pseudonym

Performance improvement has been an integral part of the Trust's agenda. It was an early participant in the NHS Institute for Improvement and Innovation programme, 'Releasing Time to Care – the Productive Ward' and in 2009 launched its own bespoke whole hospital change programme (Committed to Care) based on Lean methodology. The Trust promoted this programme as an opportunity to improve the experience of both its employees and service users, and maintained that equal credence be given to the elements of quality, safety, productivity and consistency. A primary objective of the programme was to inculcate a culture of continuous improvement achieved, in part, by employee engagement and direct involvement. The first Committed to Care project commenced in the Trust's Emergency Department as a direct result of failure to consistently achieve nationally mandated ED performance targets (Figure 22).

Cumulative Performance	ED 4 Hour Wait Target	Total Time in ED	Time to Initial Assessment
2008-2010	97.4% (standard 98%)	N/A	N/A
2010-2011	96.7% (standard 95%)	N/A	N/A
2011-2012	93.9% (standard 95%)	4 hours 27 mins (standard 4 Hours)	29 mins (standard 16 mins)

**Figure 22: Rushton ED Performance against National Standards March 2008-March**

**2012**

Running parallel to the Committed to Care programme was a second stream (Committed to You) that endeavoured to embed core Trust values and behaviours in hospital staff. This parallel programme involved public, patient and staff consultation and resulted in the

establishment of core values on which all staff received on-going mandatory training (Figure 23).

Thoughtful patient care	Caring and helpful
	Safe and vigilant
	Clinically excellent
Continuous improvement	Accountable and reliable
	Best use of time and resources
	Innovation for patients

**Figure 23: Rushton NHS Trust Committed to Care Values and Behaviours**

### 4.3.2 The Emergency Department (ED)

The emergency department at Rushton is one of the largest and busiest in Europe. The department's medical team comprises 17 consultants, 1 clinical fellow, 8 specialist trainees and 26 core trainees<sup>12</sup>. There are 133 adult nurses, 33 paediatric nurses, 14 emergency nurse practitioners<sup>13</sup>, 7 advanced nurse practitioners (5 in training), 3 assistant practitioners<sup>14</sup>, 55 emergency department assistants<sup>15</sup>, 1 hospital play specialist and 10 clinical support workers. For the period April 2011 to the March 2012, the department received 157,089 attendees (119,360 adult and 37,459 paediatric), averaging 430 patients per day. The attendee figures for the last five years show a year on year increase of approximately 5%.

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<sup>12</sup> Under 'Modernising Medical Careers', following completion of Foundation level training, doctors undertake speciality training. This may be split into either two or three years of core training, followed by higher specialty training at ST3 level.

<sup>13</sup> Specialist nurse role

<sup>14</sup> Non-registered practitioners who have trained to develop specific clinical skills. Often work as 'buddies' to the ENPs

<sup>15</sup> Non-registered practitioners



### **4.3.3 Managing Demand**

The continued rise in patient attendance (in a department already working at maximum capacity) was a critical factor precipitating the introduction of the 'Committed To Care' programme at Rushton ED, aimed at improving productivity and quality of care. From 2009 ED staff participated in a number of projects involving new ways of working, facilitated by Trust service improvement personnel, seconded ED staff and an externally contracted business consultancy specialising in LT methodology. The Trust financed these personnel for a period of 18 months and their work was complemented by an £800,000 major departmental re-build, abolishing the traditional waiting area, improving the reception and creating new assessment areas with dedicated entrances for both adults and children. The project was co-ordinated from an open-access office and resource area situated within the heart of the department. This 'hub' office displayed key findings and project details aimed at both informing and engaging ED employees, and was used for meetings and training as a quiet and creative space away from clinical activity. All staff were invited to submit 'quick wins', ideas that could be easily implemented that would have positive outcomes for the delivery of care. The major changes (and therefore those that were most likely to release significant savings) were designed and implemented by project teams formed by ED staff. Rapid improvement events were conducted where these teams reviewed areas and processes and designed a number of sub-projects subsequently delivered and disseminated by 'change champions' (designated ED staff). All sub-projects were introduced via an iterative process of trial and re-design. A total of 8 trials took place during 2010 involving processual changes to the management of patient flow, development of

an initial assessment unit and associated operational guidelines, and changes to staff roles. Seconded ED staff and Trust service improvement leads returned to their original posts at the end of 2010. However, in Spring 2012 (during the study period), the ED change programme was resurrected with the offer of an opportunity to apply for a project lead secondment to be involved in *“improving the way we work... be at the forefront of developing safe, high quality and efficient care by focusing on clinical outcomes, patient experience, patient pathways, staff experience [and] value for money and efficient use of resources”* [Rushton internal advertisement]. Whilst this proposal was framed by quality based issues, it arrived at a time when there had once again been significant difficulties meeting the 4 hour emergency access target. A member of the change programme described additional drivers as: exploring issues of sustainable change (in LT terms, ‘striving for perfection’); service re-evaluation; and opportunity to explore the wider picture of the patient journey (including the flow through the hospital and how patients navigate their way into the service).

In April 2012, Rushton became a recognised trauma centre, receiving patients sustaining serious, multiple injuries from across the region. As the ‘front-door’ to the Trust, this meant that the ED was expected to experience a considerable increase in such patients, with projections (based on Trauma Audit and Research Network [TARN] data) suggesting a rise from 300 (2009 figures) to 900 in 2015. It has been speculated that the actual number of additional trauma patients expected to present via the ED will be even higher than this, but many of these will have sustained less life threatening injuries than those currently recognised by TARN.

#### **4.3.4 Meeting the Staff**

Nurses form the greatest proportion of the ED staff group. The majority range from Band 5 to Band 7, with those from Band 6 and above holding some managerial authority and able to act as 'nurse in charge' of the department. This duty is a co-ordination role overseeing the daily management of the unit, responding to problems and managing the nurses, the EDAs and, to some extent, the doctors. Within the adult service the nurse in charge is a non-clinical role, however within paediatrics the nurse retains some clinical responsibility. All nurses may find themselves allocated to work in any area of the ED. The Band 7 nurses assume the role traditionally referred to as 'sister' or 'charge nurse'. Whilst these staff still retain a clinical role, they have far greater managerial responsibilities. The nursing team is overseen by a dedicated ED matron (Band 8a).

Medical staff join a 6 year training programme in emergency medicine, with a number of the allocations provided by Rushton NHS Trust. Core training (CT1-3) involves placements within the ED (both adult and paediatric), shared with experience in acute medicine, anaesthesia and critical care. Upon completion of core training and acquisition of relevant competences, doctors may apply for a specialist training (ST4-6) post, where they will be required to take a lead role in the management of acutely ill or traumatised patients. Consultants are available within the department from 08.00 until 22.30 from Monday to Friday, 9 hours per day during the weekend and 24 hours on call. The medical team is overseen by the Head of Service (ED Consultant).

In addition to the large cohort of nurses and doctors, Rushton ED also utilises other practitioners to deliver a service. These include Emergency Nurse Practitioners (ENPs) and Emergency Physiotherapy Practitioners (EPPs) whose remit is to manage many of the patients who attend with minor injuries. Advanced Nurse Practitioners (ANPs), are nurses who have undertaken a specialist training programme and work alongside the doctors to see a wide variety of patients. Emergency Department Assistants (EDAs) are non-registered staff who undertake a number of duties including portering, housekeeping, administrative activities, admitting patients at reception, personal care and observations. Some of these assistants have extended their scope of practice via relevant training and have subsequently developed the Clinical Support Worker (CSW) and Assistant Practitioner (AP) roles which involve activities such as taking bloods, inserting intravenous cannulae for administration of drugs or fluids, and delivering certain treatments. Rushton ED also has dedicated Education and Research teams staffed by both permanent and seconded nursing staff.

A number of services are also co-located within the ED: an alcohol and drug liaison service; cardiac nurse specialists and Rushton Emergency Medical Service (a primary care facility).

#### **4.3.5 Geographical Configuration**

Since the re-design of the ED, the department has been compartmentalised with the intention of improving flow and performance. Most patients arrive via the main entrance and report to the reception area (Figure 24). At this juncture, the episode of care formally commences with registration of the patient's details via the ED

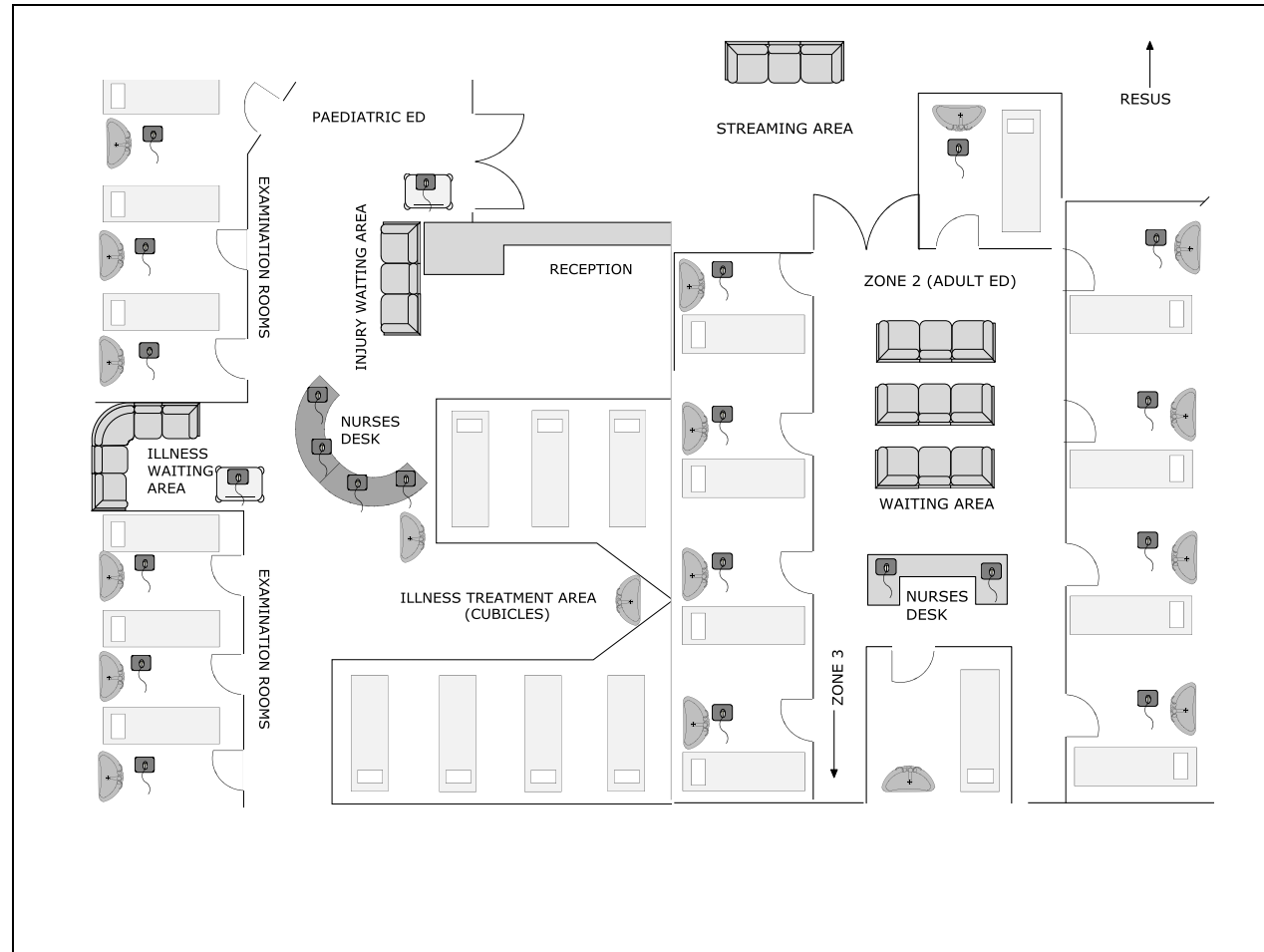
Information System (EDIS), a widely utilised administrative and clinical tool used for tracking and charting the patient journey, managing workload, and data retrieval. Once registered, the patient is 'streamed' by a nurse, categorised<sup>16</sup>, and directed to an appropriate area within the ED (Figure 27). Three main zones are located in the adult area. Zone 2 is a 'minors' area with 10 examination rooms designed for patients often referred to as 'the walking wounded' (Figure 24). These patients are clinically stable and able to wait in a chair to be seen. They will be reviewed either by a doctor or an ENP/EPP depending on the nature of their illness or injury. Zone 3 receives 'majors' patients – those who are demonstrating physiological compromise but whose condition is not deemed life-threatening (Figure 25). Zone 3 has 13 trolley cubicles, with 4 of these designated as the Initial Assessment Unit (IAU). IAU is operated by senior nurse decision makers who can assess patients and establish an early decision plan. IAU beds also have monitoring systems and are equipped in such a way as to optimise assessment time, i.e. necessary items are at hand. The IAU also has a number of computers on wheels (known as 'cows') which allow the professionals to input data and make notes at the patient's trolley. Zone 1 (resus) is a 9 bedded resuscitation unit receiving those with life-threatening illness and major trauma (Figure 26). These beds are fully monitored and equipped to a high specification. Three of the bays are significantly larger and designated to trauma and paediatric cases. Patients are usually admitted to Zone 1 from an ambulance, but may also be transferred from Zones 2 or 3 if escalation of care is required. Whilst

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<sup>16</sup> 1: red phone, 2: priority, 3: doctors majors, 4: ENP priority, 5: senior review, 6: doctors minors, 7: ENP, 8: Rushton emergency medical service, 9: GP referral

zone 2 and 3 are geographically distinct they are not separated by doors or corridors. In comparison, Zone 1 is located at the far end of the ED and is bounded by corridors and doorways.

The paediatric area (Figure 24) is similarly compartmentalised, with a designated injury waiting area (and associated examination / treatment rooms) and an illness area (including waiting area, treatment rooms and monitored cubicles). In a similar fashion to the adult zones 2 and 3, the injury and illness areas merge into each other with porous boundaries.



**Figure 24 Rushton ED Paediatric ED, Reception Area and Zone 2 ('Minors')**

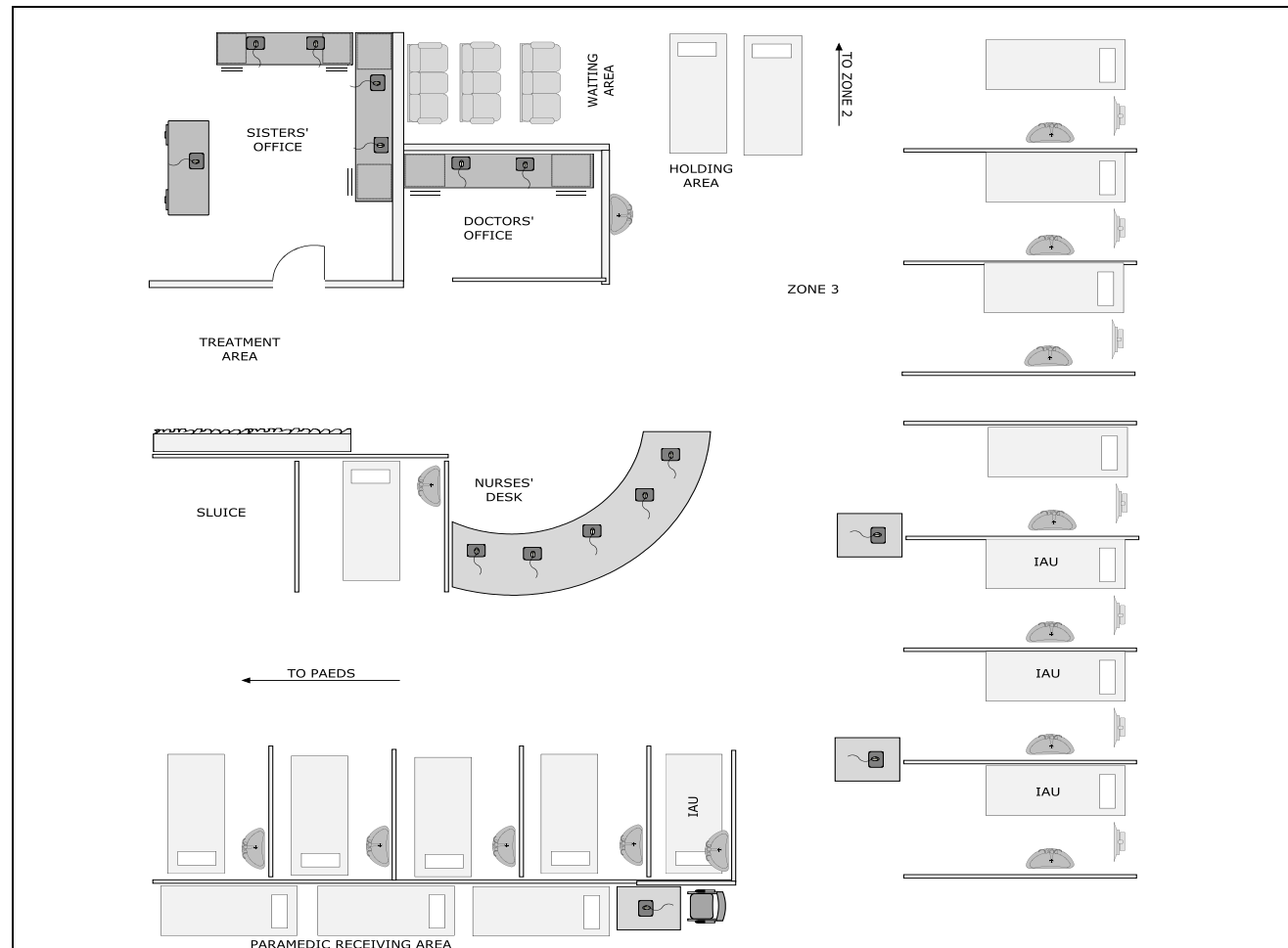
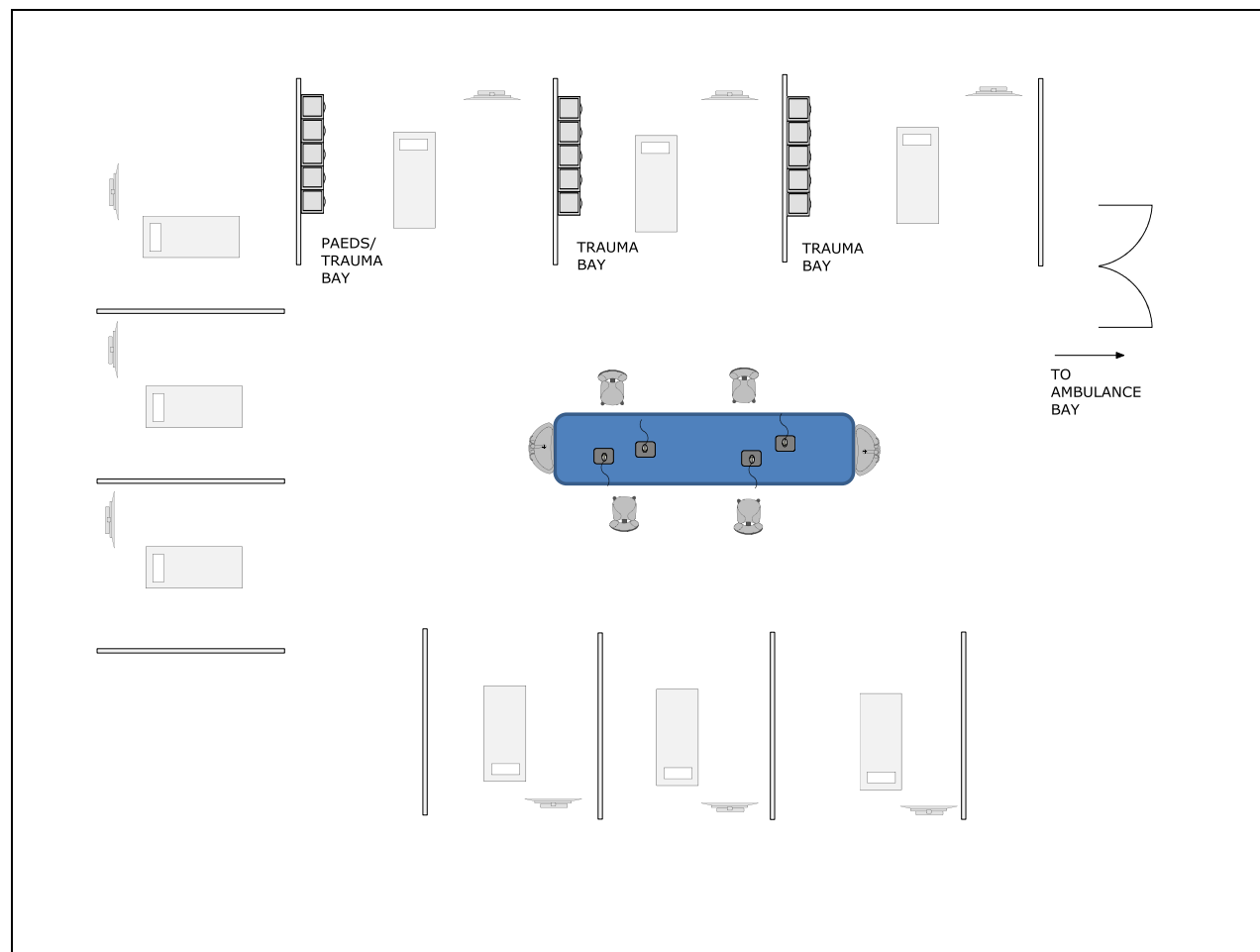


Figure 25 Rushton ED Zone 3 ('Majors')





**Figure 26 Rushton ED Zone 1 Resuscitation Unit ('Resus')**

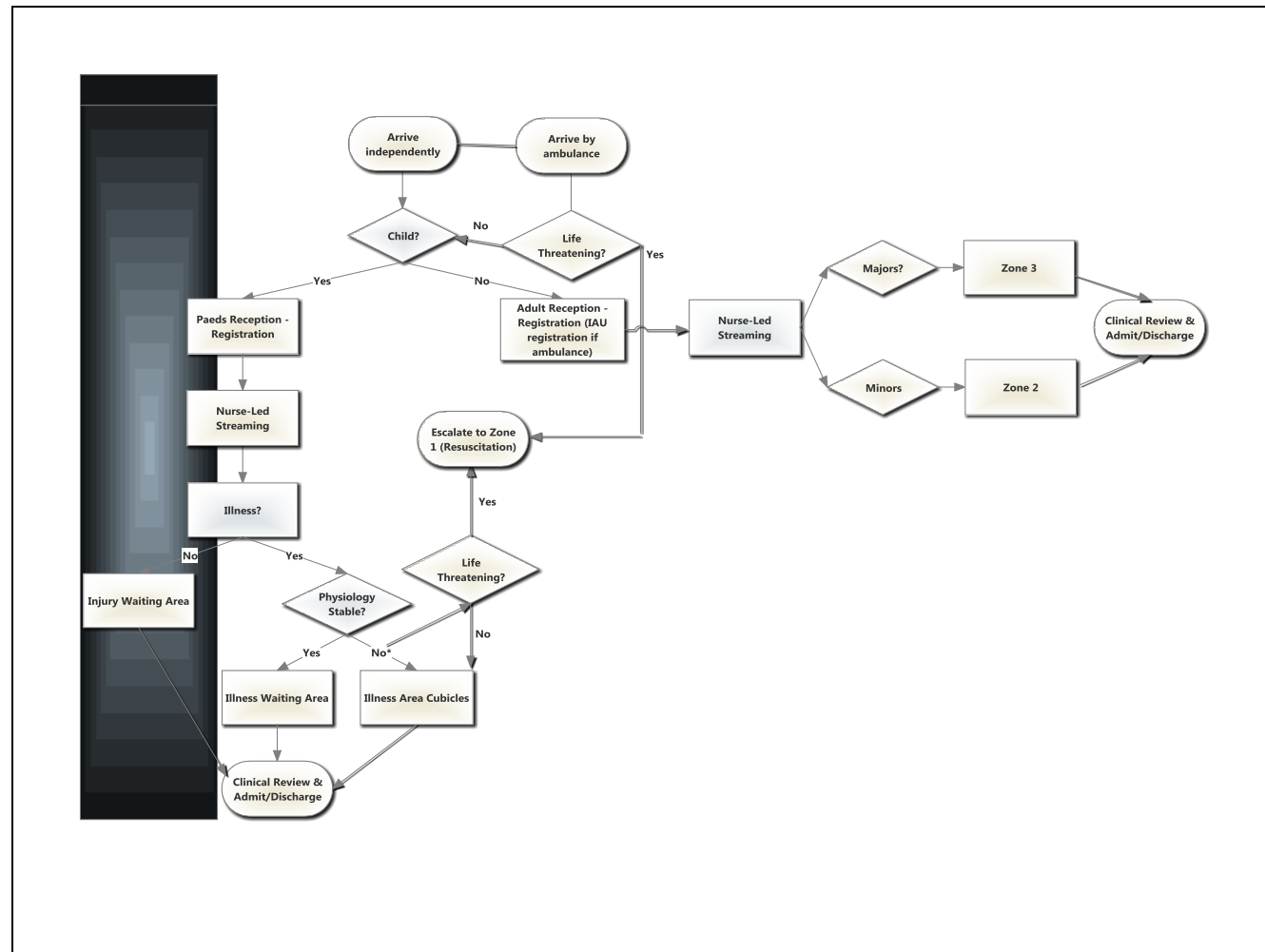


Figure 27 Process Map of Patient Journey

## **4.4 The Process of Productive Healthcare – ED Snapshots**

Creating a representative account of a frenetic department dealing with the mundane to the extreme is challenging. It requires not only an accurate portrayal of the organisation of that work, but also an approach that elucidates the other factors at play, i.e. those upon which the organisation of productive work is contingent. The following ED snapshots are intended to address this issue, allowing the reader a sense of the lived experience for an ED professional charged with productive healthcare. The aim of this section is to illustrate the culture of productive work in the context of Rushton ED – the ideas, customs and social behaviours - and, via these snapshots<sup>17</sup>, reflect some of the local challenges and drivers. The key questions for this scene setting were: what constitutes a productive day; how do the professionals organise their work; what are their professional priorities; how do they interact to work productively; what pressures drive them in their daily routines; how do they deal with productivity challenges; and how do they respond to these in order to orchestrate a successful outcome? In addressing these questions, a clear theme emerged, namely the importance of generating flow. This theme will be discussed in the following section.

### **4.4.1 Generating Flow**

Demand for emergency medical services is increasing throughout the developed world. Rushton's annual increase of approximately 5% is

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<sup>17</sup> Some of the snapshots are accounts created from patient journeys discussed by HCPs during periods of observation. These do not arise from direct patient observation, however general departmental observations are used to contextualise the accounts. It should be noted that these snapshots are intended to offer an insight into ED productivity via processes, division of labour, and the associated external networks involved in patient care, and not patient care per se. Consequently in addition to changing all names, in some cases gender, age, condition and mode of injury have also been altered.

consistent with global trends of 3-6% per annum (Lowthian *et al.*, 2012). Reasons for increased demand include rising healthcare complexity, inadequate access to or inadequate use of primary care services, public expectation (fuelled by the media and internet), seasonal influences (influenza, norovirus), demographics (in particular, an aging population), technical advances (permitting rapid diagnosis and turnaround of patients with conditions that would have previously required hospital admission) and social reasons such as homelessness and substance abuse (Hoot and Aronsky, 2008; Jayaprakash *et al.*, 2009; Wuerz *et al.*, 2000). Rushton staff also expressed other locally relevant factors such as paramedic preference, closure of walk-in centres and the relocation of a nearby ED. A consequence of this increased demand is the role it may play in ED crowding, a phenomenon associated with increased waiting times, reduced patient and staff satisfaction, greater likelihood of breaches of privacy and confidentiality, increased untoward or 'sentinel' events, impaired ability to deliver patient centred care, reduced physician productivity, increased acts of aggression, poorer clinical outcomes, patient elopement and increased costs (Derlet and Richards, 2000; Hoot and Aronsky, 2008; Moskop *et al.*, 2009).

Compounding the problem of volume/complexity is also that of variance. The unpredictable nature of ED attendance often confounds best efforts to deal with increased demand. Some have proposed the influence of the lunar cycle, major sporting events or even 'payday' on ED attendance (Reich *et al.*, 1994). Others suggest complex mathematical models such as poisson or linear regression or time series methods forecasting (Au-Yeung *et al.*, 2009; Jones *et al.*, 2008; McCarthy *et al.*, 2008), however Wargon *et al.* (2009) state

that whilst these may be of use for long-term planning they are not suitable for making day-to-day adjustments to staffing numbers or skill mix. Consequently, Rushton ED staff often relied on informal local 'knowledge' to predict or justify surges in demand:

*"As long as I've known I've always said there's a 10:30 or 11:00 bus and that's when people arrive" (ANP1).*

Rushton ED staff responded to this challenge of demand by aiming to generate constant flow through the department. Stasis, or waiting time, was considered as unacceptable waste:

*"Waiting points are wasted time. If there isn't anyone doing an intervention or interacting with that patient it's wasted time, and reducing that down is really the key to getting more productivity" (ANP1).*

Waiting might relate to treatment or clinical intervention, equipment availability, results or assistance:

*"Minor injury patients could wait indefinitely to be seen. That's just criminal really and that had to stop and something had to be done about it" (SN5).*

*"If things flow well, if you need something to hand and you're given it and if everything happens in a nice organised manner then you just feel that the department has got the most out of you" (SDoc1).*

Organising work to optimise patient flow was undertaken in a number of ways, as illustrated by the following ED snapshots.

### **ED SNAPSHOT 1: JOHN, ANKLE INJURY**

John has sustained an ankle injury playing football. Unable to bear weight through the leg, John's friend has brought him to the ED. John queues for a while waiting to give his details to the EDA at reception. Standing rather precariously on one leg, he hops forward as his turn approaches. The EDA ascertains some basic details regarding his injury. His details are checked against the hospital database and the current event is logged via EDIS (Emergency Department Information System). This is the moment that 'the clock starts' on the 4 hour target. John is asked to take a seat in a small area adjacent to reception containing approximately ten chairs. It is a bank holiday weekend and the department is extremely busy. Most of those accompanying the ED attendees are standing as there are insufficient chairs. A young man arrives in a wheelchair with his parents. He is grey, has considerable cuts and bruises to his face and looks extremely unwell. He too joins the group of patients awaiting attention. The other patients waiting are clearly concerned about him and engage his parents in conversation. There are no ED staff visible other than the EDAs behind their screen at the reception desk. The father leaves to find someone to attend to his son. The other patients continue to look anxious and steal glances at the young man. A 'streaming' nurse (one who undertakes a basic assessment and directs the patient to the appropriate part of the department) is working from the adjacent office. Another nurse has obviously been drafted in to help as twenty minutes later John is attended to, but not within the office. Instead a nurse squats down next to his chair, takes a brief history and offers John analgesia. The streaming nurse then asks John to take a seat in Zone 2. John has been allocated to see the ENP but the department is busy and he has a further wait. He sits watching the news on continuous loop on a wall

mounted TV and is clearly uncomfortable. There is no way in which he can elevate his leg and he has to move repeatedly to allow people to pass. The air in zone 2 is one of frustration with some patients and friends/family complaining about the wait. The waiting area is surrounded by 10 examination rooms, but only a few appear to be in use reflecting the small number of nursing and medical staff available in zone 2. A nurse states with exasperation that some zone 2 staff have been 'pulled' to Zone 1 (resus) because a major trauma case has been admitted. Occasionally someone asks the nurse who stands behind a desk at the back of the area, 'How long till I'm seen?' The nurse is apologetic and cannot give a definitive answer but consults EDIS to see how many people are in the queue. After approximately 60 minutes the ENP calls John and escorts him to an examination room. She conducts a systematic examination of John's ankle and requests an x-ray. Both the ENPs notes are documented and radiography referral made electronically. EDIS is updated in order that John's care can be tracked. An EDA then takes John to the radiography department adjacent to the ED. After 30 minutes John returns to Zone 2. On his return, John's x-ray is reviewed on the computer by the ENP who reassures him that there is no fracture. She recommends that he use crutches for the next 3 days and advises him regarding analgesia, ice application and physiotherapy. An assistant practitioner then measures John for crutches, educates him regarding their use on stairs and provides John with an information leaflet. John is discharged 150 minutes after his arrival. John's GP is informed of the incident and subsequent care by a letter generated from EDIS and organised by an EDA.

## **ED SNAPSHOT 2: JOSHUA, BREATHING DIFFICULTIES**

Joshua is a 20 month old boy who arrives at ED with mum. An EDA manning the paediatric reception takes Joshua's details as mum explains that Joshua has been experiencing breathing difficulties having recently been treated for a chest infection by his GP. The GP has arranged for Joshua to be seen by a paediatric medical registrar in ED and has rung ahead to register Joshua as 'GP expect'. The EDA ensures that he can see Joshua who is bundled up in mum's arms. Mum takes Joshua through into the entrance of the paediatric ED where they are immediately greeted by Pam, the nurse who is fulfilling the 'front door' role this shift. Pam is trained to Advanced Paediatric Life Support level, a pre-requisite for fulfilling this role she explains. Her duty is to direct patients to either the 'injury' or 'illness' area, and prioritise their care in the case of 'illness'. She gently removes Joshua's blanket and ensures that his breathing is adequate and that he is responsive. Pam checks Joshua's history including recent medications and performs a set of observations, recording these using the 'cow' (computer on wheels). Pam elects to bypass the illness waiting area as Joshua's oxygen saturations are a little low and instead takes him directly to a cubicle in the illness area. Here a nurse ensures that Joshua is given oxygen and that his oxygen saturations are continuously monitored.

## **ED SNAPSHOT 3: EDITH, CHEST PAIN**


Edith is an elderly nursing home resident who has been complaining of sudden onset chest pain. Paramedics have brought Edith to Rushton ED where she is taken straight to the Initial Assessment Unit (IAU). An EDA within IAU enters the patient details via EDIS and checks for any alerts (e.g.



diabetic register, previous MRSA, frequent ED attendance), and after a short wait the paramedic crew give a verbal handover to the receiving nurse. Edith is categorised as a '2' (priority) and moved into a IAU cubicle where there is a dedicated machine for performing observations, a computer and other pieces of equipment that the nurses are likely to require (e.g. printers for the identification wristbands and demographic labels). During the next 30 minutes a nurse, CSW and EDA systematically take a history and set of observations, administer oxygen via a facemask, perform an electrocardiogram (ECG), insert an intravenous cannula, and take bloods ensuring that they are sent to the labs. In and around the cubicle are posters and documents intended to prompt the clinical staff in the event of life threatening illness, for example emergency assessment algorithms, and recommendations for 'best practice' tests and treatment options (Figure 28). Throughout this 30 minute period there is almost always someone in the cubicle with Edith. After a further 20 minutes the doctor arrives to examine Edith. She checks the ECG and observations, and can see via EDIS that the appropriate bloods have been sent (Figure 29). The doctor requests a chest x-ray and urine dip and prescribes some analgesia and other medications. These requests are logged via EDIS and marked as completed by the nurse as appropriate. The doctor is happy that Edith is not at risk of deterioration and as her chest pain has resolved she is moved out of IAU. The IAU nurse hands Edith over to one of the 'red team' nurses in zone 3, explaining her condition and course of treatment to date. The nurse is identifiable as a red team member by the scarlet lanyard she wears over her uniform. Edith is moved to another cubicle. An EDA escorts Edith to the adjacent radiography department where she receives her chest x-ray. When she returns, her doctor reviews this and discusses the ECG with a senior doctor and a cardiac

specialist nurse who is also resident in the department. The doctor then checks the computer for results from the blood tests. Unfortunately the bloods have not yet been processed and so the doctor documents (via EDIS) that there has been a delay. Once the results are available the doctor agrees with her senior that Edith's condition requires hospital admission for observation and stabilisation. Edith's nurse rings the medical admission unit (MAU) to request a bed but is warned that there are significant delays because the ward is 'rammed'. EDIS is updated accordingly. The department is now very busy with patients waiting to be admitted via IAU. Consequently Edith is moved out of her cubicle and waits in a central area on a trolley alongside five other patients. There is a patient wandering around the department who is clearly intoxicated. He repeatedly stumbles and falls. The patients on trolleys in the central area watch and some look distressed. A security guard is present in the department and comes to the help of the staff who are clearly frustrated with the man's antics. During this time the 'red team' nurses and EDAs continue to provide personal and clinical care to Edith including regular observations, even though they are clearly busy with ever increasing numbers of patients in the department. At 180 minutes after her admission, Edith's status turns to red on EDIS and the hospital's duty nurse manager contacts the nurse in charge to enquire about progress as there are concerns that Edith will 'breach' the 4 hour target. The red team nurse looks frustrated as she is trying to deal with her burgeoning workload, but contacts MAU again. Negotiations are made and after some discussion it is agreed that Edith can be brought to the ward. The nurse informs the EDA and together they hurriedly prepare for the transfer ensuring that all documentation is correct and the necessary transfer equipment is available.

They keep a close eye on the clock to ensure that Edith is transferred before 'hitting' the 4 hour target.



ED INITIAL ASSESSMENT TOOL  
 TARGET TIME 20 MINS

## Cardiac sounding chest pain

Crushing or heavy chest pain +/-

Radiation to jaw / neck / left arm  
 SOB  
 Nausea / vomiting  
 Sweating / clamminess / pallor

If patient still has pain, perform IMMEDIATE ECG, alert Senior Doctor & move to resus

Does the patient have new LBBB or ST elevation? If YES:

- Uncomplicated STEMI** - doctor must arrange for URGENT 999 transfer to Cardiac Centre for PRIMARY ANGIOPLASTY. Ring \_\_\_\_\_ with patient details and ETA. Give IV MORPHINE, ASPIRIN 300mg and PRASUGREL 60 mg orally. Heparin and clopidogrel are not required at this point. **DO NOT DELAY.**
- Complicated MI / significant co-morbidities** - doctor should first discuss with cardiology SpR at \_\_\_\_\_ via switch

- 1) If now pain free do ECG within 15mins of arrival with prompt doctor review. If abnormal request old notes to compare with old ECG/ check old EDIS entries. Move to Resus for monitoring if new LBBB / ST elevation / new AF / ST depression.
- 2) Record vital signs: BP, HR, RR, SpO<sub>2</sub>, GCS, Temp, BM  
Commence Observation Chart/ Early Warning Score - follow ED Escalation Plan
- 3) Document time of worst pain
- 4) Fully undress, apply a gown and wrist band
- 5) Take bloods: FBC, UE, and if >6 hr since worst pain trop I
- 6) Cannulate and complete VIPS if abnormal ECG only
- 7) If patient SOB/ low saturations ask for doctor to examine and arrange CXR from IAU
- 8) Document if morphine / antiemetic / aspirin given by the crew. If not already given, consider Aspirin 300mg stat
- 9) Record weight ready for enoxaparin
- 10) Inform CCU Nurse

NOTE: If NOT cardiac sounding chest pain, please liaise with Senior Doctor ASAP for plan of care and appropriate investigations

Any tasks NOT completed within IAU should be handed over verbally to the team and placed on NURSE ORDERS

Figure 28 Initial Assessment Tool

**iSOFT - Emergency Department Information System - EMERGENCY DEPARTMENT**

File Edit Main Reports Commands Window Help

**Order Entry**

Order Details:

Order: OBS OBSERVATIONS

Date Ordered: Time Ordered: 09:32

Ordered by: 0000000

Order Results:

Date Assigned: Time Assigned:

Assigned To:

Result Details:

Date Completed: Time Completed: 09:46

Completed by: 0000000

Reason:

☒ Ordered ☒ Assigned ☒ Completed

**CURRENT ORDERS**

Order Description	Date/Time Ordered
OBSERVATIONS	2012 09:32
VENEPUNCTURE	2012 09:32
ANALGESIA	2012 09:32
CANNULA	2012 09:32
URINALYSIS	2012 09:32
BRADEN SCORE	2012 09:33
OBSERVATIONS	2012

Add Order Edit Order Edit Results Assign Orders Complete Orders Delete Order Close

Figure 29 EDIS Nurse Orders Screen

**iSOFT - Emergency Department Information System - EMERGENCY DEPARTMENT**

File Edit Main Reports Commands Window Help

Area: \*\*\*All Areas\*\*\* Go to: Clerical Window

Tracking Screen as at 2012 12:04

Tr Cat	Surname	Forename	Episode	Status	Alert	Sex	Age	Arrival Time	Target Time	4 Hr Target	Loc	Seen By	Order Results	Nurse	DI	M I P	E C G	Nurse Orders	Bed Request Date and Time	Ward	Be
2			12000117055	LTCs	I	M	51	08:48		180	BTA	ABROU						VEN AN SOC	2012 11:52	PHOW	
2			12000117067	LTCs	I	F	43	09:25		159	G4	DV124						VEN FC CG BR	2012 11:52	MSSL	
2			12000117090	LTCs	R	M	19	09:58		126	RED 6	DAHWA						VEN FC CG BR	2012 11:44	PHOW	
2			12000117103	LTCs	I	M	11	10:18		106	P2	DLEVE						VEN FC CG BR	2012 10:28	CAU	
2			12000117063	LTCs	R	F	78	08:41		201	BTA	EHATT						VEN FC CG BR	2012 10:09	SAM	
2			12000117058	LTCs	I	M	52	08:54		190	BTA	AA160						VEN FC CG BR	2012 10:18	SAM	
2			12000117070	LTCs	I	F	56	09:31		153	A-XR	EHATT						VEN FC CG BR		PB3	
2			12000117074	LTCs	I	M	50	09:38		146	G5	AA160						VEN FC CG BR		PB3	
2			12000117077	LTCs	I	F	47	09:43		141	G8	ABROU						VEN FC CG BR		PSUR	
2			12000117082	LTCs	I	M	57	09:48		136	G3	HEH69						VEN FC CG BR		PMED	
2			12000117132	LTCs	I	M	14	11:18		46	PNV	DLEVE						VEN FC CG BR			
2			12000117075	LTCs	I	F	28	09:39		145	G7	DV124						VEN FC CG BR	2012 11:56	MSSL	
2			12000116775	LTCs	I	F	56	+14:36		126	YTA	CH166						VEN FC CG BR	2012 17:02	HOME DIA	
2			12000117056	LTCs	I	M	21	08:52		192	GTA	ABROU						VEN FC CG BR	2012 10:18	MSSL DIA	
2			12000117061	LTCs	R	M	31	09:08		176	YTA	EHATT						VEN FC CG BR			
2			12000117069	LTCs	I	F	41	09:27		157	B3	AA160						VEN FC CG BR	2012 11:13	HOME	
2			12000117073	LTCs	I	F	25	09:37		147	B2	AAHMA						VEN FC CG BR		PHOW	
2			12000117086	LTCs	I	M	19	09:54		130	YTA	Z1240						VEN FC CG BR			
2			12000117092	LTCs	I	M	22	10:01		123	Y7	Z1240						VEN FC CG BR			
2			12000117096	LTCs	I	F	39	10:07		117	Y4	HBKAU						VEN FC CG BR			
2			12000117104	LTCs	I	F	38	10:19		105	RED 8	DSHEA						VEN FC CG BR			
2			12000117117	LTCs	I	M	1	10:40		84	PNV	BDUNN						VEN FC CG BR			
2			12000117085	LTCs	I	M	40	09:19		165	YTA	HBKAU						VEN FC CG BR			
2			12000117071	LTCs	I	F	47	09:33		151	YTA	MMH41						VEN FC CG BR			
2			12000117088	LTCs	I	M	46	10:10		114	YTA	MDVEP						VEN FC CG BR			
2			12000117099	LTCs	I	F	18	10:11		113	A-XR	MDVEP						VEN FC CG BR			
2			12000117118	LTCs	I	M	12	10:40		84	PNV	BDUNN						VEN FC CG BR			
2			12000117119	LTCs	I	M	12	10:42		82	PNV	BDUNN						VEN FC CG BR			

Status: L=Linked, S=Seen, C=Clerked, A=Admitted, T=Triaged, X=Transferred, R=Consultation (Red=Requested), Investigation (Red=Requested)

86 Pts listed above

Consultations = 2

1 Up Expand Down

Triaged Pts ☒ Admitted Pts ☐ All Pts ☐  
Clerked Pts ☒ Awaiting Admit. ☐ Discharged Pts ☐  
Seen Pts ☒ Transferred Pts ☐ Daily List ☐  
MP Pts ☐ Short Stay ☐

Request List Care Plan Browser Discharge Instruct Worksheet Prior Reqs  
Digital Images Vitals Handover Bed Request Alerts Print  
Auto Refresh Orders Results Register Patient Close

Figure 30 EDIS Tracking Screen

#### **ED SNAPSHOT 4: NIGHTWORK**

Handover tonight opens with acknowledgement that the 'pressures' have been continuous for the last 24 hours. The nurse in charge explains that these pressures involve waits for hospital beds in excess of 11 hours, and massive demand for ED services – zone 1 (resus) has been 5 patients over its capacity. Out in zone 3 there is a very different atmosphere to the one I have previously encountered. The perfect analogy is a trading floor, utterly frenetic, with constant activity, noise and continuous updates, response, reassessment and feedback loops. The nurse in charge presides over this scene, moving staff, patients and resources around the department to ensure that she has *"the right people, in the right place, at the right time"* (SSN-obs). There is also the noticeable presence of security guards as there are a number of intoxicated patients in the department, and I convince myself that there is a pervading smell of alcohol. Despite the volume of patients, the nurses and doctors appear to work quickly and efficiently.

One of the intoxicated patients has 'fallen' and a number of staff, including a security guard leave their duties and move over to where he lies in a main thoroughfare. The nurse in charge addresses the patient somewhat brusquely. The patient does not respond. Other staff speak to him, equally firmly. He opens his eyes but does not get up. The ED staff move away after a while, returning to their patients, and leave the patient lying on the floor with the security guard in attendance. My first instinct is to feel shocked at the behaviour of the professionals, but then I realise that what I have witnessed has been the combination of a rapid assessment of the patient's condition followed by a decision predicated, in part, on prior experience of this individual. These professionals have acted in this way in order to

prioritise care for sicker patients. My conclusions are confirmed when a nurse explains that this man is a 'frequent flyer' (recurrent ED attender) who is known to seek attention by falling to the floor. When I look back, the security guard is telling him to *"Be a good lad. Get up, and make life easier for yourself"*. The patient meekly stands and moves to a chair in his cubicle.

### **ED SNAPSHOT 5: KATY, POLYTRAUMA**

The nursing team leader in zone 1 (resuscitation area – 'resus') receives a 'red phone' call informing her of the imminent arrival of a 16 year old girl who is known to have been thrown from her horse sustaining suspected long bone fractures and spinal injuries. The patient, Katy, is due to arrive by ambulance in 15 minutes. The resus area is fully occupied and so the nurse in charge of ED arrives to help move more stable patients through the system. ED nurses from zones 2 and 3 are also re-deployed to resus. After some time they are joined by the 'silver on-call', a nurse manager who offers her assistance in terms of 'unblocking' beds in the hospital. As staff make the necessary arrangements to move patients out of resus, they refer to them by bed number or condition, *"9 is my confused chap"* (SDoc-obs). The doctor appears keen to assure me that this is not lack of compassion but a reflection of the speed and dynamism embodied by the department. During this time the nurse in charge alerts the ED and trauma team (as per the designated Trauma Team Activation Guideline) and prepares the area. Each of the 9 resus bays is equipped with advanced monitoring systems and a diverse array of equipment. Within the dedicated trauma bay to which Katy is to be admitted is a large, pre-printed information board (referred to as the 'MIST' board) visible from most positions within the bay. The nurse fills in as much

as possible, details such as name, mechanism of injury, injuries sustained or expected, vital signs and observations, treatment and 'ABCDE' (a standard acronym for the systematic assessment of airway, breathing, circulation, disability or neurological function, exposure). Before Katy arrives a large team of people gather and 'check in', including ED staff, anaesthetists, and trauma/orthopaedic surgeons. Roles are allocated to individuals, for example nominating one person as scribe<sup>18</sup>. There is an air of excitement and expectation as the HCPs busy themselves with preparatory tasks such as collecting drugs and bags of fluid, and starting the warming device. When Katy arrives through the swing doors she is wearing a cervical collar and has blocks either side of her head to prevent movement. She has already had an intravenous cannula inserted by the paramedics and a bag of fluid is attached. The team gather around Katy's trolley and the mood changes instantly. One of the nurses 'starts the clock'; this fulfils a different role to that of timing via EDIS. In this situation starting the clock concerns monitoring physiological deadlines. There is near silence in the trauma bay as the paramedics rapidly provide a synopsis of the accident, findings of their initial assessment, and management to date. A registrar explains, *"It's essential. If everyone was talking you could miss something critical"* (SDoc-obs). This silence is directly contrasted to the cacophony of sound elsewhere in resus as unattended monitors alarm from the other bays. A staff nurse throws a cursory glance at these monitors, but when she sees that the alarms are error messages, she chooses to ignore them; all attention is directed to the trauma bays. Katy is periodically groaning and crying and the nurse moves to comfort and reassure her. Katy's mum and brother arrive and they are

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<sup>18</sup> Responsible for documenting vital signs on a 5-15 minute cycle and maintaining a chronological record of events

permitted to stay within the resus bay with Katy in order to calm her. The anaesthetist moves to stand at Katy's head as his priority is to ensure a patent airway and adequate ventilation. He adjusts Katy's oxygen mask and checks the monitor. He appears to be satisfied with the observations and looks up, making eye contact with the ED doctors. He continues to chat to Katy, ascertaining relevant information, but also ensuring that her Glasgow Coma Score<sup>19</sup> remains consistent. One of the nurses cuts through Katy's clothing to attach monitoring and allow the ED registrar to begin the primary assessment. At this point the orthopaedic team stand at the foot of the bed and await findings. There is a red line marked on the floor behind which all team members must stand unless actively involved with the patient. An EDA loads Katy's details onto EDIS whilst a radiographer arrives and commences x-rays, working around the other members of the team. Bloods are taken and sent almost immediately. The nurse administers further analgesia in response to a request by the doctor. A delay occurs in requesting the blood tests electronically as the system appears to have temporarily crashed. The registrar, frustrated, resorts to making the requests the 'old-fashioned' way, hand-writing forms and ringing departments. In the half hour prior to Katy's admission, 2 other trauma patients were brought in following a road traffic accident. These patients are in adjacent bays to Katy. This results in approximately twenty-five individuals in an area of about 30m<sup>2</sup> but as everyone has a clearly defined role, this does not appear to cause any problems. As Katy's assessment proceeds and it becomes apparent that her injuries are not life threatening, professionals start to drift away leaving two orthopaedic surgeons, an anaesthetist, an operating department practitioner (ODP) and ED staff. After approximately forty minutes of constant activity

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<sup>19</sup> Neurological assessment of level of consciousness



the anaesthetist, ODP, ED nurse and registrar accompany Katy to the CT scanner located in the adjacent radiography department.

### **ED SNAPSHOT 6: THE REGULAR ATTENDERS PROJECT**

Whilst attending a mandatory training day I meet Jay, a senior ED staff nurse. He talks passionately about a project in which he is involved that aims to deal with the complex group of patients referred to as 'regular attenders'. He clearly views this project as a professional, economic and moral imperative. I seek Jay out on two further occasions to discuss this project in greater detail.

Jay explains that for some time the department has collected data regarding those patients who attend on more than 3 occasions in any one calendar month. The project was initially directed at those individuals with substance abuse problems, but has recently been extended to cover others including those with learning disabilities or long term conditions. The project aims to identify these repeat attenders and then work on an inter-agency basis to produce strategies to better manage their complex needs. Where possible, ED admissions are prevented, and when ED services are accessed, plans are in place to ensure that the patient is managed in the most appropriate way, both in terms of what is right for the patient and what is the most efficient use of ED resources.

Jay shows me how 'alerts' stored in EDIS inform ED staff that there is a specific care plan in place for certain regular attenders. This may include specific information about what to do, and what not to do for a given patient.

Jay explains that this ensures extremely complex patients can be managed productively so that they do not create 'bottlenecks' in the system which would detract from other patients requiring attention. For Jay, this project is clearly a labour of love (he hints that much of what is being done is on a good-will basis rather than a funded service).

Next time we meet, Jay tells me the story of one such repeat attender. He describes a young woman who has been known to social services because of family circumstances since she was in her late teens, but *"because of the fact that she was a little bit too old to get the proper help, she was 17, she kind of fell through the cracks of social care and then she started to drink, so she started to present to ED"*. Jay explains that they conducted many case conferences, even including the patient when she was sober. The project team co-ordinated with the homeless healthcare team, primary care, social services, the Salvation Army, a regional charity specialising in the help of homeless people and even representatives from local churches to put provisions in place:

*"All of the agencies were involved and in a relatively joined up way... But she ended up last year, I'd said last year I felt she wouldn't make December and then she made December, but she died a couple of weeks ago. And so to me... it's always about trying to stop people getting to the stage in which they, you know because they're very much there but for the grace of god people aren't they? You don't know you're not going to end up like that. To me getting involved in the project, it was trying to make a difference. But it's not just the cash, the cash is a big thing, as you know, one of them [regular attender] was costing the NHS £9,000 a month in ED attendances... But it's about what's your quality of life like*

*if every other day you're down in the ED, and there is no quality of life, and, and I think if you can't see the humanity of the people on the trolley then you need to leave the job, this is how I feel about it."*

## **4.5 Discussion**

These snapshots have demonstrated the ways in which professionals organise their work in order to optimise a steady flow of patients through the ED, minimising disruption and 'bottlenecks' whilst still responding to the inherent complexity of emergency medicine. A number of strategies were evident, including utilisation of space, developing professional roles, and prioritisation. These will be discussed in turn.

### **4.5.1 Utilisation of Space**

The way in which professionals utilise space is one key factor in generating patient flow. Many of these methods were legacies of the change programme, for example the compartmentalisation of the department and subsequent team working, intended to divide the workload into similar and manageable 'groups' e.g. illness and injury in paediatrics, and majors, minors and resus in adults. Nugus (2007) describes the ED sub-compartmental structure as a representation of the organisational imperative to move patients through the ED quickly and therefore create capacity for future patients. Whilst some of the change projects received mixed support, the implementation of the IAU was almost unanimously perceived as beneficial. The demarcation of a dedicated space, and provision of supporting technology within that space, allowed HCPs (in particular the nurses and CSWs/EDAs/APs) to provide hub treatment, i.e. treatment that proceeded directly around the patient. This is exemplified in snapshot 3 where, for the

first half hour Edith receives constant attention, care and assessment in order that upon the arrival of the doctor, critical information is already at hand to inform differential diagnoses.

The use of space to organise productive professional work was not always legitimately defined. Borrowing a term from Franck and Stevens (2007), I labelled these 'loose spaces' – departmental areas that were used for purposes other than those originally intended. In snapshot 1 we see how John receives his initial 'streaming' and potential first clinical intervention (analgesia) in a waiting area. From experience I surmised that this was an impromptu use of space predicated on high volumes and necessity, but some loose spaces were organised and planned in advance and were part of a regular schedule. Perhaps the most interesting of these was the use of 'booking in space' used to make initial safety assessments of sick children as seen in snapshot 2 with Joshua. In this account, both the EDA manning reception, and the nurse fulfilling the front door role use what is essentially corridor or transition space to discreetly ascertain Joshua's condition. This organisation of work was one that paediatric staff were highly committed to having previously used it to identify very sick, even moribund, infants at a very early stage permitting more rapid intervention. Technology had been adapted in order to optimise the use of these loose spaces, for example the computer on wheels (cow) that Pam used during her assessment of Joshua. This use of liminal space has been previously discussed by others in the healthcare context. Iedema *et al.* (2006) describe an ethnographic study of a hospital corridor, identifying it as a marginal space that is transmuted into a place of intense clinical productivity.

These 'loose spaces' were not always successful however, and sometimes became sites of stagnation rather than flow. This was particularly evident when pressures external to the ED (particularly hospital bed occupancy) became influential. This is portrayed in snapshot 3 where Edith is moved from a cubicle into a central area within Zone 3 whilst a ward bed is made available. Under these circumstances loose spaces caused great frustration and anxiety for HCPs as it contributed to their workload, jeopardised patient safety and dignity, and at times, impeded their passage:

*"A lot of the obstacles we hit are external to this department. We can only do so much and we get to a stage where we can't go any further you know, when we're bed-blocked, when we're backing up in here... You know you do as much as you can and obviously if you've got a group of people sitting in the middle of the department needing looking after then that affects the people coming through the door, affecting everyone all the way up to the doctors because there's people in the middle who are poorly who need looking after. So that's frustrating, yeah, it would be nice to have that constant flow, but it's not always possible" (SDoc1).*

#### **4.5.2 Defining and Developing Professional Roles**

The redefinition of professional roles was also critical in generating patient flow. This is reflected across the snapshots with nurses assuming roles normally fulfilled by doctors and physiotherapists, and non-registered staff extending their scope of practice to include clinical interventions. These roles were highly valued, particularly by nursing and non-registered staff who viewed them as not only a way to improve productivity but also opportunity to extend occupational jurisdiction (Abbott, 1988):

*“Nurses particularly have been empowered, so they are more respected especially in our department, they are taken seriously, we are very respected. Nursing roles have developed as they have gone to ENP, ANP and the EDAs have been developed into CSWs” (SN2).*

Guidelines and protocols had been designed in order to support more general role development, for example a range of 14 IATs (immediate assessment tools) that provided standardised approaches for nurses managing clinical conditions (Figure 28). HCPs acknowledged the role of such guidelines in aiding productivity, and for some professional groups they also provided professionalisation opportunities:

*“If you’ve got fairly clear pathways, is it always what is traditionally a clinician [doctor] that needs to make those decisions? ...we have a gynaecology or pregnant PV bleed pathway<sup>20</sup>, and I think that is probably a very empowering pathway as it allows any nurse, band 6 or above, to actually make decisions about managing this group of patients” (ANP1).*

HCPs also discussed the importance of having the ‘right team’, and appropriate mix of skills and abilities (including security personnel, paramedics, physiotherapists, other nurse specialists *etcetera*) and sometimes just professionals who worked in a manner that complemented their own:

*“If you have got two staff nurses who have worked together professionally and know each other’s workings they know how each other works, they know their skills, their communication will be good and they*

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<sup>20</sup> A pathway that permitted direct referral by the nurse to the on-call obstetric and gynaecology team

*will be very productive. They will have a system that will flow, it doesn't matter whether one is junior or one senior it will still flow. You could have four in a team with no communication, no organisation it will be a mess and nothing will be achieved."* (SSN3).

An integral role in generating flow was that of the Nurse in Charge. This role was often alluded to as one that *"makes the department flow"* (SSN-obs) and required continual problematisation of ED status as well as performing department rounds, attending organisational bed meetings and negotiating/mediating between the ED and the other departments within the Trust. The role of nurse in charge was a finely calculated act, endeavouring to move patients and staff in such a way as to balance clinical and organisational needs. Many acknowledged the bargaining power that the 4-hour emergency access target had conferred on this role:

*"It's given ED a huge, huge amount of power over that time to actually unblock into the hospital, and there's been, I think the focus of the bed blocking and getting patients out of ED has really shifted and that is now the hospital's problem, not ED's problem, and that is I think a very big thing. Because before... if they said we haven't got a bed for 2 hours then fine, they [patients] just sat down here. Whereas now that is escalated incredibly rapidly"* (ANP1).

The nurse in charge held the responsibility of 'senior decision maker' and was influential in organising the work of all HCPs including the medical staff. A key priority was to ensure that doctors had registered a diagnosis via EDIS. The formulation of a diagnosis is significant as it represents an organisation of past/present medical history and investigation results in a

symbolically recognisable form that a treatment plan can then be attached to and therefore *“give[s] ED clinical work a sense of forward motion”* (Nugus, 2007:131).

Technology was essential in complementing both the utilisation of space and role definition/development. For many ED HCPs, EDIS was described as essential to productive healthcare:

*“If I’m working in a team it [being productive] is being able to look at the computer, look at the tracking screen on EDIS and see that they’ve been seen quite quickly by the doctor. If there are any orders on there of things that need to be done, that they’ve been done, that if there’s a particular intervention that we need to do, if somebody needs morphine, if somebody needs a drip, or if somebody needs sliding scale insulin, I feel satisfied if I’ve done that”* (SSN4).

Consequently, EDIS was seen to provide a visual representation of ‘flow’, allowing staff to gauge *“how well we are performing as a department”* (ANP1). This representation allowed HCPs to initiate the episode of care, track its progress and identify or document delays (such as the patient screen changing colour from green, through amber, to red depending on time spent in the ED). HCPs were vigilant in documenting any disruption of flow via EDIS, indeed this was such common practice that a senior staff nurse stated that when notes were audited there were often occasions when references to delays almost exceeded the volume of clinical information documented. EDIS was also used as an aid to expediting flow and was the principal tool used by the nurse in charge to monitor the department, a virtual panopticon (Timmons, 2003).



### 4.5.3 Prioritisation

HCPs identified prioritisation of treatment as essential in maintaining departmental flow, by allocating time and resources to patients demonstrating the greatest need. In some situations, these prioritisation decisions were dictated by an explicit framework. Examples of this included the ED categorisation system that defined the patient in snapshot 6 as a 'red phone' patient (one requiring zone 1 resuscitation), or the Rushton ED local protocol for presentations "*potentially suitable for deflection to primary care services*" - a document used by streaming nurses, listing 20 conditions and criteria for autonomous decision making and referral away from ED. Such explicit frameworks also included standardised approaches to prioritising the process of care; for example, in snapshot 6, Katy's journey from arrival in ED to dispatch to CT was predefined by guidelines dictating the roles and responsibilities of the trauma team. This comprehensive document organised the professionals that were deployed, the work that they subsequently undertook, the order of that work, individual professional priorities, and even the space that they occupied.

In most instances however, such prioritisation decisions were far more tacit, requiring the HCPs to adopt rational, intuitional and political perspectives (deMattos *et al.*, 2012). The patient depicted in snapshot 5 is a prime example of this. At first glance this individual appeared to be in need of immediate attention having sustained a fall. The attending HCPs however were able to formulate a rapid decision based upon rational judgement (basic physiological assessment) and intuition (prior experience of similar behaviours). The decision was therefore made to 'demote' this patient down the priority gradient.

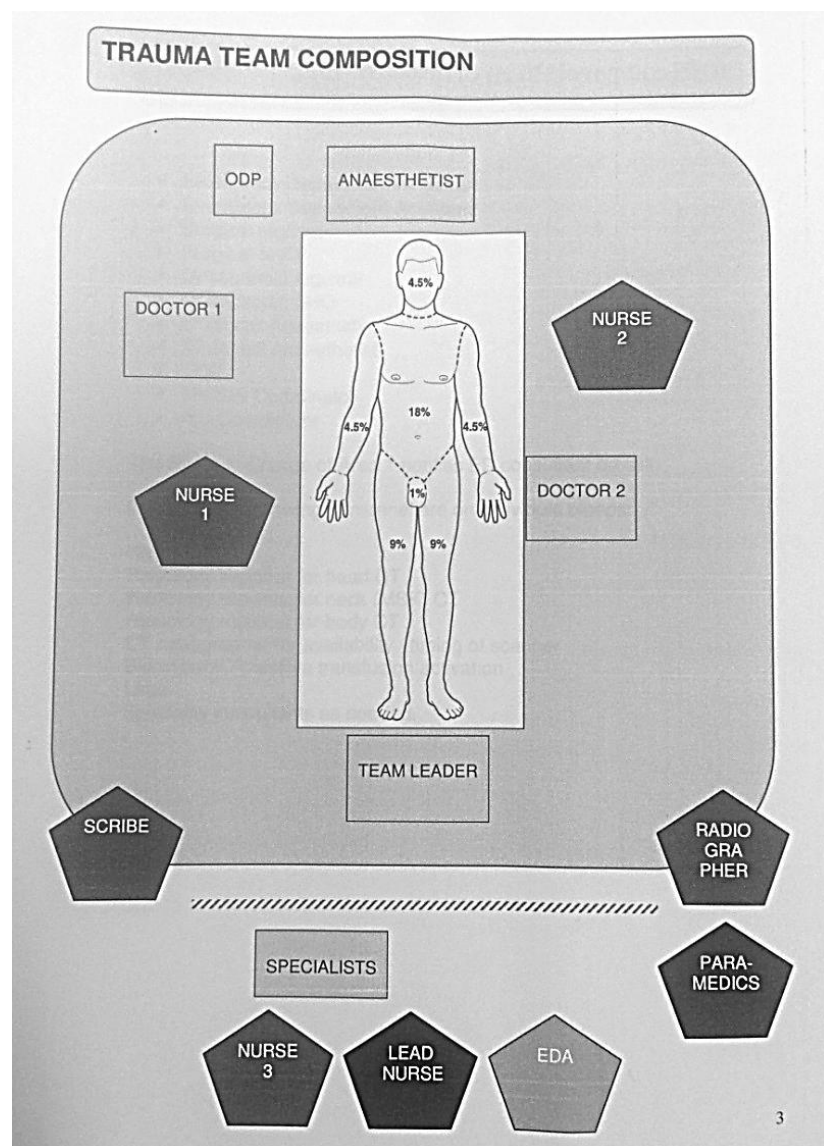
The regular attender project (snapshot 6) illustrates an interesting aspect of prioritisation. Historically, frequent attenders, typically those with substance-abuse problems, were viewed with derision by ED HCPs, stereotyped as individuals guilty of diverting care from more 'worthy' or professionally satisfying patients (Jeffery, 1979). Increasingly however, there has been growing interest in this patient group, and the opportunities for ED staff to manage them more appropriately (Newton *et al.*, 2011). The repeat attender project aimed to manage the complexity of these patients and their presentations, re-prioritising them to ensure more productive management by ED personnel, and more productive use of ED services by the patient.

Prioritisation decisions were not always easy for ED staff, particularly those who were less experienced. There was an awareness of the ramifications of error, both clinically and organisationally. Describing prioritising his caseload in terms of patients requiring hospital admission versus those who could be discharged home, an ANP stated:

*"It's a major decision... if I get that decision wrong and admit them unnecessarily then I'm being unproductive because I am wasting a bed... Or if I get it wrong totally and send them home when they should come in, then goodness knows what could happen" (ANP1).*

In some situations, ED HCPs were unable to adequately prioritise because of inordinate demands on the service in terms of both volume and case complexity. These situations resulted in frustration, dissatisfaction and a sense of inefficiency:

*"I've just been very frustrated by last night because I just never felt as though I got on top of it, and that was, I think, because of 3 complicated, sick patients all at the same time... If I'd had an hour dedicated to one that would have been fine I would have been done and dusted, but I was bitting and bobbing between each one which made me feel very inefficient. So I don't think I've seen a low number of patients, but those 3 particular patients made me feel inefficient" (SDoc1).*



**Figure 31 Trauma Team Composition and Positions within the Trauma Bay (From: Roles and Responsibilities of the Trauma Team, Rushton NHS Trust)**

## 4.6 Summary

For the HCPs of Rushton ED, productivity was embodied by maintaining a sense of forward motion, ensuring that patients flowed through the department (and into the hospital if necessary) thereby creating capacity with which to manage future attendees. Waiting time was considered wasteful by Rushton ED HCPs, consistent with the view that *“time is the prevailing currency of emergency clinicians”* (Nugus, 2007:131). Many staff took pride in this sense of dynamism and believed that it defined emergency medicine as an inherently productive speciality. Some HCPs even referred to the ED process of care as ‘production line’:

*“If you look at ED we are a production line... essentially that is what we do, we are a production line... We see, treat, discharge or admit. That’s our job! It’s not like some of these wards where you have the same patient for days, it’s not!”* (SN1).

However, in this specific context HCPs did not appear to use the production line analogy in a derogatory sense, rather one that suggested a way of work that was *“swift and slick”* (SSN2), inspiring confidence and promoting professional credibility and competence. The centrality of flow (time and motion) in the collective work of ED HCPs has previously been described by Nugus (2007) in his study of Australian EDs. Nugus conceptualises a notional carousel that symbolises the mutually dependent trajectories of individual patients as well as that of the whole department. Individual patients are only able to temporarily ride the carousel by virtue of the prior forward motion that enables a place for them.

The use of space to generate flow was very visible during observation, and a strategy that most staff alluded to when discussing productive healthcare.

Space utilisation had been a major focus of the 2009-2010 change programme which may explain why it remained highly perceptible in both practice and discussion. Not all the uses of space were attributable to the design of the change programme however. HCPs had modified the department re-design to incorporate unofficial 'clinical' spaces designed to meet demand and promote patient flow. This demonstrates the inherent contingency of 'technologies' such as the change programme, and the role of social construction or social shaping in defining a technology's ultimate outcome once implemented (Brown and Webster, 2004). In this case the re-designed space of the ED was further adapted (informally) by HCPs in order to serve their notions of productive healthcare.

The place of professional roles and prioritisation in generating flow hinged heavily on the process of decision making, with many of these processes codified using guidelines and protocols. Berg *et al.* (2000:766) describe the guideline as *"the ultimate bureaucratic instrument: it explicates what to do when, in what way and with what means. It categorises patients, each with their own specific stories, into distinctive, homogenous categories to ensure uniform treatment."* At first glance, this may seem at odds with traditional professional values, however, such guidelines could be utilised or subverted to achieve different ends. For example, in the case of nursing staff, the use of guidelines allowed them to act in the revered capacity of 'decision maker', a clear professionalisation strategy. ED HCPs elected to move away from these guidelines on occasions, and in doing so cited use of their own 'clinical discretion'. Indeed, it was emphasised that a productive HCP viewed *"pathways as guidelines and not absolutely rigid recipes"* (ANP1). In these

situations HCPs often relied on intra and inter-professional collaboration to problem solve and rationalise their decisions to deviate.

This chapter has endeavoured to illustrate how ED HCPs at Rushton organise their work to deliver 'productive care'. It is intended to provide a foundation for subsequent chapters that aim to further explore this notion of productivity and productive healthcare from both professional and organisational perspectives. This exposition commences in the following chapter with a study of the external influences (national and local) that call for productive practice.

## Chapter 5: Constructing notions of healthcare productivity: The call for a new professionalism?

*“Human identities are constructed from a range of subject positions...  
each of us is subject to diverse and sometimes competing discourses  
which constitute our identity in multiple and fractured ways” (Halford  
and Leonard, 1999:117)*

### 5.1 Introduction

In the previous chapter, the nature of productive professional work within the study setting was introduced. In this chapter<sup>21</sup>, the endeavour is to situate that professional behaviour in the context of external influences, in particular the productive healthcare policy produced at either a national or organisational level. The relevance of a multi-level perspective is to elicit the ‘big picture’ and also the way in which these issues were represented within the study setting. Consequently the chapter aims to unpick certain assumptions underlying healthcare productivity (and the drive to improve it) in order to explore its utility and influence upon professional identity and work.

Using discourse analysis of contemporary documents to unpick the representations of productive healthcare, or healthcare productivity, this chapter questions the implications for contemporary professionalism. This approach is relevant as, following the recommendations of Noordegraaf (2011), in order to understand the complexity of professional work, one must explore the *“linkages between societal, organisational and professional fields”*

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<sup>21</sup> A significant part of this chapter has been published as a paper (Moffatt *et al.*, 2013)

(Noordegraaf, 2011:1350). Furthermore, in their study of governmentality and managed healthcare networks, Ferlie *et al.* (2012) advocate detailed examination of credible truths, with particular attention to underpinning authorship, construction, values, domains of knowledge and analytical moves.

The data presented within this chapter is also intended to contribute to the debate on professional autonomy, and whether this is in fact in decline. However, contrary to the deprofessionalisation thesis (Haug, 1988), the following sections will argue that an ethos of a 'new (productive) professionalism' is now visible in NHS discourse at both a macro and meso level. Consequently, this chapter aims to explore the emerging notion of a new professionalism, specifically via the construction of productivity in the discourses of both contemporary macro-level NHS policy/reports and meso-level Rushton organisational literature. In particular, the chapter asks how do these discourses construct the rights and duties of the professions in the context of responsible productivity in healthcare, and what consequences does this have for professional autonomy?

The following sections will consider analysis of national and local policy in turn.

## **5.2 Analysis of National Policy**

### **5.2.1 Productivity as a problem**

A key discursive construction of productivity in the selected texts is a pejorative one, whereby recent healthcare productivity is presented as being generically problematic. This is the process of problematisation identified as



a starting point within the governmentality conceptual framework. The documents refer to *“ten years of almost continuous decline”* in hospital productivity (HoCCPA, 2011:7), and *“a tragic missed opportunity”* to secure value for money (HoCCPA, 2011:Ev1). In the minutes of the HoCCPA, the state of hospital productivity is repeatedly referred to as *“depressing”* (HoCCPA, 2011:Ev2), with the chair querying *“why has it gone so bad?”* (HoCCPA, 2011:Ev6). It is suggested that the imperative to address the situation is viewed as a necessary *“discipline”* (DH, 2010b:43).

How healthcare productivity becomes an object of possible knowledge is more complex. Professional productivity is made quantifiable in a number of arenas, being depicted in terms of statistics, charts and graphs and discussed in the terminology of economists and accountants. In this way, healthcare becomes permeable to other bodies of expertise (Miller, 1998). Information is accumulated, compared and league-tabled. And yet, within the data lie repeated references to the difficulty of measuring healthcare productivity (National Audit Office, 2010; NHS Confederation, 2006). There is a belief that the Department of Health and the Office for National Statistics are embroiled in a *“quarrel”* over the definition of productivity (HoCCPA, 2011:Ev2), and the productivity dilemma is framed as one imbued with considerable uncertainty (HoCCPA, 2011).

This position is supported by the King’s Fund (Wanless *et al.*, 2007) who claim that depending upon the assumptions made, change in productivity may have ranged from minus 7.5% to plus 8.5% between 1999 and 2004. Consequently they propose that because of the on-going debate regarding measurement, it is probably *“not sensible to draw definitive conclusions about*

*changes in productivity*" (Wanless *et al.*, 2007:26). In governmentality terms, one could argue that productivity measurement constitutes a calculative technology of government, but is problematic in its own right and therefore potentially contestable. However, despite the acknowledged ambiguity regarding productivity measurement, the key message from the documents is that the financial deficit will not be resolved without a marked increase in hospital productivity, and that failure to secure this could jeopardise the long-term future of the NHS (Wanless *et al.*, 2007).

Having problematised healthcare productivity, the scene is set for ascribing responsibility to some aspect of conduct, and developing the rationalities and technologies necessary for government.

### **5.2.2 Healthcare Professionals: Part of the Productivity Problem**

Within the national productivity discourse are numerous examples of HCPs implicated as a contributory cause of this productivity 'problem'. A notable theme is the perceived requirement for a fundamental cultural change within the NHS both in terms of the ways in which professionals work, and the ways in which they are managed. It is recognised that a significant proportion of hospital costs can be attributed to the remuneration of the workforce (Hurst and Williams, 2012):

*"Where does the NHS spend its money? It spends it predominantly on people... If the NHS is going to become more productive, it has to employ its people more productively and in different ways"* (HoCHC, 2010:Ev2).

Since 2005, a series of pay reforms have increased these costs further, and yet it is claimed that staff have not been managed in a way that performance

manages productivity (NAO, 2010; HoCHC, 2010). The NAO states that there is no evidence of the widespread cultural change that was essential if these reforms were to be used to optimise productivity. As a consequence, the changes made *“employees richer and the NHS poorer”* (HoCHC, 2010:Ev33).

This criticism is also applied to HCPs more generally as it is claimed that professional/clinical performance standardisation across the NHS would liberate substantial savings, exceeding those deemed achievable by reducing management costs, back office support functions and procurement (£1.8 billion per annum) or transforming management of chronic conditions (£2.7 billion per annum) (Department of Health, 2009). As such, productivity is presented not just in terms of failing, but also in terms of what could be achievable. This reflects the notion of government as both representation and intervention (Miller and Rose, 2008). NHS staff are reminded that poorer quality care during periods of financial challenge is *“indefensible when the scope for improving quality and productivity is still so great”* (Department of Health, 2009:11). This constitutes a pre-emptive strike intended to counter arguments that driving productivity will inevitably be detrimental to quality and safety. The evidence is presented as being indicative of a missed opportunity, particularly given the period of growth in the NHS following considerable financial investment:

*“When I look at the headcount numbers from around the country, it doesn’t reflect the sort of reductions we would expect from developing new ways of working, from moving forward in the way we had planned to be more productive and more efficient”* (HoCCPA, 2011:Ev2).

A second theme concerns more surreptitious aspects of professional motivation as within this discourse is also the suggestion that there may be professional obstruction that requires conquering (HOCCPA, 2011). These discourses become more overt in terms of blame attribution. For example, in evidence provided by a Professor of Economics to HoCHC (2010:Ev32), it is proposed that methods to reduce variation in practice (and therefore improve productivity) have been advocated for at least thirty years and that *"[i]t is time to challenge the dinosaurs that resist contract enforcement, challenges to clinical practice variations and innovative and potentially cost effective changes in skill mix"* (HoCHC, 2010:Ev38). The issue of skill mix is also highlighted elsewhere (Appleby *et al.*, 2010), with claims that inflexible role demarcations between professional groups have obstructed patient-focused care and perpetuated inefficient practice. In this context professionalism is depicted as self-serving, and relatively resistant to strategies based on command and control. As such, professionals are depicted as 'knaves', rather than professional 'knights', who have resisted policy alignment in favour of their own interests (Le Grand, 2010). It is noteworthy that whilst some of the critique is directed specifically at doctors (in particular consultants), in general the professions are referred to collectively within the productivity discourse. This may represent a rhetorical tactic intended to diminish the perceived power of the medical profession. Alternatively it may simply reflect the increasing impetus for nurses and allied health professionals to assume a more equitable stake in healthcare work, rather than adopting the role of doctors' handmaidens.

Within this debate, productivity improvement is described as a tool with which to repair, demolish or re-build NHS services. When asked why

strategies associated with productivity improvement cannot be enforced, an NHS Institute representative responds that he cannot *“imagine a world in which external regulation will be able to become more significant than the professionalism of services”* (HoCHC, 2010:Ev4). It is at this nexus that HCPs become identified not only as contributors to the problem, but also the potential solution. Specifically, the notion of professionalism is conceptualised as a rationality of government.

### **5.2.3 Healthcare Professionals: A Solution to the Productivity Problem**

The emergence of new discourses regarding productivity can be seen in the national discourse where HCPs are identified not only as part of the productivity problem, but also as the potential solution. For example, HCPs, as the frontline teams or *“clinical microsystems”* are identified as having the *‘greatest potential to unlock productivity’* (Appleby *et al.*, 2010:26).

These discourses are framed by three interwoven themes namely duty, individualisation and engagement. Improving productivity is presented to HCPs as both essential to the cause (Department of Health, 2010b), and an obligation:

*“As clinicians we make the decisions that, every day, have an impact on how the NHS budget is spent. Our duty is to do this in a way that makes the best use of NHS resources and taxpayers’ money”* (Department of Health, 2010a:7, *emphasis added*).

There is the implicit threat that if HCPs fail to *“respond to this challenge there is a real risk that the need to cut costs will overtake all our best intentions to improve care for our patients”* (DH, 2010a:19). Linking productivity and efficiency to

the notion of 'care' is a persuasive rhetorical tactic for advocating individual and organisational change. This legitimising discourse builds on the notion of holism and public partnership, a common theme within contemporary work on the sociology of the professions and notions of new professionalism (Gabe and Calnan, 2009; Gabe and Monaghan, 2013). The discourse is also specifically directed at individuals:

*"You may think that money is someone else's business but we believe that addressing financial inefficiencies is a key personal, professional and moral responsibility" (DH, 2010a:5, emphasis added).*

The ideal-type professional is depicted as possessing the personal capacities with which to achieve the socially desirable goal of increased productivity and therefore, by inference, greater prosperity and salvation of the NHS. There is an emphasis upon the alignment of personal and organisational priorities with a perceived need to incorporate cost reduction and value for money into individuals' objectives in order to drive the desired behavioural changes (Appleby *et al.*, 2010; HoCCPA, 2011). Furthermore, productivity is portrayed as being compatible with notions of social justice and good citizenship. This moralistic construction is characteristic of political rationalities as they endeavour to claim 'truths' regarding who subjects are and what they should aspire to (McKee, 2009).

The challenge for driving productivity improvement is presented as ensuring rapid dissemination of information and innovation, and active engagement of professionals in programmes of direct change (HoCCPA, 2011):

*“It is **they** who decide the length of stay, treatment and care options, **they** spend 80 to 90 per cent of our costs. So we need **them** on board, hearts and minds” (Hurst and Williams, 2012:36, emphasis added).*

This approach was exemplified by The Productive Series, an NHS Institute programme intended to improve healthcare productivity and increase clinician-patient contact time; where professionals are supplied with a series of tools to re-design care in a locally relevant manner (HoCHC, 2010). The Chief Executive Officer of the NHS Institute describes the power of implementing productivity improvement in this fashion:

*“It has two names, this piece of work. It is known as The Productive Ward, Releasing Time to Care. The nursing profession told us that they find that their members find the word “productivity” has negative connotations, that a focus on releasing time to care created far greater ambition to be involved...” (HoCHC, 2010: Ev9).*

This quote clearly demonstrates the perceived importance of staff engagement and ownership, and the implementation of more subtle strategies for aligning staff with discourses legitimising organisational policy (such as strategically re-naming the project to avoid potentially unpalatable connotations with Taylorism).

#### **5.2.4 The Call for a ‘New Professionalism’?**

What do these discourses set out to achieve? Clearly, the technologies of government involve the construction of productivity and fiscal responsibilisation as an individualised professional duty. A number of perceived experts are also used within this discursive arena such as the NHS Institute for Innovation and Improvement, The King’s Fund and The Nuffield Trust. Miller and Rose (2008:43) state that these agencies are

*“powerful translation devices between authorities and individuals, shaping conduct not through compulsion but through the power of truth, the potency of rationality and the alluring promises of effectivity”*. In *High Quality Care for All*, Lord Darzi (a surgeon and parliamentary minister who undertook an NHS review on behalf of the Department of Health) acknowledges the desire of clinicians to place quality at the heart of the NHS (Department of Health, 2008), and the selected data recommend that the economic challenge does not alter this focus. Darzi advocates a cultural shift away from top-down command and control, towards a *“new professionalism”* (Department of Health, 2008:60) where, as well as being a ‘practitioner’ and ‘leader’, each modern HCP must also act as a ‘partner’ in care delivery with *“individual and collective accountability for the performance of the health service and for the appropriate use of resources”* (Department of Health, 2008:60). This move to reconstruct professional obligations (requiring individuals to assume responsibility and accountability for the efficient use of resources) relies upon adoption of a new strategy based on professional self-governance. This is a clear step away from previous, more traditional, forms of governance such as regulation, disciplinary measures, or creation of professional mediators via formal management structures (Flynn, 2002; Llewellyn, 2001).

The sociology of the professions literature has considered ‘new medical professionalism’ being constructed around new forms of clinical governance, quality, regulation, accountability, trust and public partnership (Kuhlmann, 2006) particularly following well-publicised medical scandals (Elston, 2009). What is proposed here is that the notion of healthcare productivity is emerging as a rhetorical device in policy discourse constructing a novel flavour of ‘new professionalism’ that encourages the acceptance of



productivity as a duty for all professionals. It may be argued that this is a natural evolution given that new professionalism has previously been associated with greater acceptance of managerialism and leadership (Elston, 2009). Trust and partnership are still important elements of the productivity discourse – after all, improving accountability is about economic as well as clinical practice – but here professionals are referred to as “*custodians of value*”, trusted with taxpayers’ and treasury money (Patel and Spilsbury, 2010:23-4). To establish to what extent the terms ‘productivity’, ‘efficiency’ and ‘minimising waste’ are new buzz words within the professional literature, one can return to medical professional documents at the turn of century as an example. In 2001 the UK’s General Medical Council’s Good Medical Practice document simply makes a brief allusion to “*efficient use of resources*” (General Medical Council, 2001:3), but by 2004 further challenges are acknowledged e.g. changing government expectations of doctors and “*growing expectations of accountability for productivity and performance*” (Rosen and Dewar, 2004:16). By 2012, there is evidence of clear expectation that all doctors (without exception) should demonstrate leadership in effective resource management including minimising waste, improving services and promoting effective use of resources (General Medical Council, 2012). In a King’s Fund commissioned report a clinician states that:

*“Doctors need to be the advocates for [productivity] change... The people who are spending NHS resources are then being held accountable”*  
(Lemer et al., 2012:8).

In a similar vein, a report commissioned by the Nursing and Midwifery Council aiming to identify the relevant drivers of change to UK healthcare

delivery up to 2015, mandates improving productivity as a key policy issue, and consequently the 'future nurse' is depicted as one that:

*"...will have the opportunity to direct and lead care... and will be encouraged to take a more entrepreneurial stance" (Longley et al., 2007:4)*

One could perhaps also argue that the idea of professional responsabilisation continues in the recent shift to GP-led commissioning, with GPs as *"accountable custodians of NHS resources"* (The Nuffield Trust, 2010:2). Whilst there have been earlier examples of such strategies, this current level of responsibility is identified as unique (Barratt, 2011).

To what extent the productivity message and the notion of 'new professionalism' are being embraced and internalised by HCPs is not particularly evident from the national productivity discourse data studied. Comments allude to the successful dissemination of the Productive Ward using professional channels, although it is acknowledged that this is not yet nationwide (HoCHC, 2010). Equally, there is an indication that some professionals acknowledge the notion of productivity as relevant to their practice and one that they have a responsibility to consider (HoCHC, 2010). Whilst there is clearly an emergent policy discourse, this does not necessarily translate into practice in the field. The empirical work presented in Chapters six and seven aim to explore the implications of productivity discourse and productivity improvement strategies for contemporary HCPs.

### **5.3 Analysis of Rushton Organisational Literature**

The previous sections have elucidated the external influences at play in terms of productivity and professionalism at a macro-level. Subsequent analysis of

discourse contained within Rushton organisational literature permitted an exploration of these same issues at a meso-level. This approach follows the Miller and Rose suggestion (1990) that Foucauldian analysis should proceed on a multi-level basis – the use of political rhetoric and interventional strategies, *and* locally applied technologies of governance (Ferlie *et al.*, 2012).

### **5.3.1 Problematisation of Productivity**

In a similar vein to the national literature, productivity is presented as problematic, with productivity improvement touted as the solution to many ills: poor quality; patient dissatisfaction and escalating costs. In a concordat agreement to delivering on QIPP signed by local chief executives within the county's health community (of which Rushton NHS Trust is a local partner) allusion is made to the national literature:

*"In recent years the NHS track record in respect of improved and demonstrated productivity leaves something to be desired... for example, private sector productivity growth averages around 2% per year"*

[Rushton Area Productive County Health Community, dated 2009]

In Rushton's Service Productivity and Efficiency Plan [Rushton document, dated 2008], it is claimed that financial balance for that year can only be achieved by delivering savings of £29.96 million, but that the focus on meeting this target has changed emphasis from one exclusively of cost reduction (where many cost-improvements are non-recurrent) to one that includes service productivity and efficiency. This approach is further rationalised by the suggestion that recurrent savings are likely to be required year on year given the economic climate. The work-streams essential to this

plan are all encompassing including: bed productivity; ward productivity; theatre productivity; outpatient productivity; elective productivity; diagnostic productivity; staff productivity; clinical quality/patient safety; financial productivity; estates productivity; and reducing waste and other economies. Within this document, the projected savings anticipated from each work-stream are also presented.

### **5.3.2 Making Productivity ‘Knowable’**

Productivity is rendered knowable in a number of ways within Rushton. Trust performance is recounted at Board level, producing a monthly report laden with graphs, tables, dashboards and action plans. Like the national policy and discourse, quantification of clinical performance is therefore made highly visible, with clinical issues re-framed in the language of the market. Specifically within the Emergency Department, the key performance indicator is the 4 hour target. Indeed it was the failure to perform adequately against this target that resulted in the decision to launch the ‘Committed to Care’ project within that speciality. External experts were invited into the Trust to diagnose the problems and suggest remedial therapies, including the clinical lead for the national Emergency Care Intensive Support Team. The assistance of this team (which collaborates with NHS trusts to improve emergency care) was engaged following the delivery of a performance improvement notice by local Primary Care Trust chief executives during Winter 2009/2010. These transgressions have also been widely reported by local media [Rushton Evening News], with associated sensationalist headlines: *“Rushton misses targets on A&E patients”*; *“10,831 A&E patients waited more than four hours”*; *“Casualty patients at Rushton deserve better”*; *“45-minute hospital wait for over 200 ambulance patients”*; *“A&E bosses told: You must*

*improve*". As such, the 4 hour emergency target (and associated breaches) became a key productivity measure for Rushton to the extent that it is expressed as a permanent agenda item at monthly directorate performance management meetings.

In literature produced for service users and HCPs, productivity is defined in an overwhelmingly qualitative fashion:

*"Productivity... Doing the right thing for patients is often the most efficient thing for us. Solving issues before they happen... takes less time than resolving them afterwards. And avoiding harm and getting things right first time are clearly both better for patients and more effective for us"* [Rushton document, dated 2010].

The Rushton organisational literature was particularly abundant and so selection was guided by those documents and initiatives commonly discussed by participants during the ethnographic fieldwork, predominantly the 'Committed to Care' and 'Committed to You' programmes. The following section describes these programmes (first introduced in Chapter four) in further detail.

### **5.3.3 Making Change, Improving Productivity: Rushton's Committed to Care and Committed to You Programmes**

In the latter half of the first decade of the new millennium, Rushton NHS Trust faced a number of challenges: a recent merger; a financial deficit of £60M; underperformance on key access and infection control targets; a radical cost improvement plan involving the loss of 1200 posts; and a concomitant decline in staff morale. The Trust however had high aspirations for its future and recognised the necessity for a strategic and cultural shift in

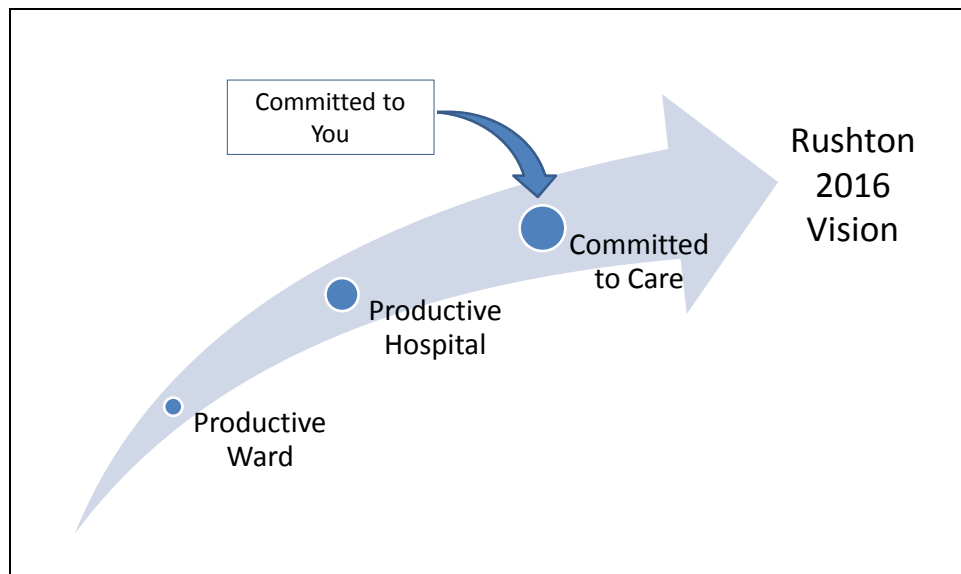
order to “do better with fewer resources” [Rushton document, dated 2012]. The Trust’s Chief Executive, in a news statement for the DH’s Modernisation of Health and Care website, declares:

*“Like other NHS organisations, we face our toughest financial challenge at the same time as the NHS goes through a period of unprecedented change. Our response is that the challenge we face is unprecedented, and so must be our response. The Rushton response is Committed to Care”*  
[Rushton Chief Executive, dated 2011].

‘Committed to Care’ (Figure 32) constitutes a hospital-wide transformational change programme that developed and embedded a culture of continuous improvement, reaching as many HCPs as possible by engagement and empowerment. The overarching philosophy is that “high quality and safer services which reduce variation and eliminate waste will deliver financial savings... safety, quality and value for money are of equal importance” [Rushton document, dated 2012]. Committed to Care is intended to be a “signal to staff that this was a new way of doing things, distinct from anything that had preceded it” [Rushton document, dated 2012]. In developing the Committed to Care (and related ‘Committed to You’) programme, Trust documentation describes Rushton’s reflection on its experience with the earlier ‘Productive Ward’ initiative, and the subsequent realisation that it would not be possible to achieve and capitalise fully upon potential benefits unless the hospital as a whole participated. Consequently its aspiration is to move from:

*“... a collection of productive wards to... a productive hospital... [via a] framework which outlined what needed to be in place, from initiatives at a Trust-wide level to the required responsibilities and actions of every*

*individual member of staff*” [Rushton document, dated 2012, emphasis added].



**Figure 32: Development of the Committed to Care Approach**

This productive framework acknowledges four organisational levels: Trust; Speciality/Departmental; Team and Individual, with descriptors of the mechanisms, initiatives, culture and behaviour necessary to transform the Trust into a *productive*, continuous improvement organisation. This framework is an inherent element of the ‘Committed to Care’ approach. Running parallel to Committed to Care was a secondary programme, ‘Committed to You’, which involves the devolution and dissemination of new values and standards for employees. These complementary programmes are intended to represent both the ‘what’ (the transactional aspects of care) and the ‘how’ (the relationship aspects of care). Both these programmes are significant in Rushton’s construction of the individual productive HCP. The following section will consider this ‘individual’ level in further detail.

### 5.3.4 Whither New Professionalism at Rushton?

Previous sections within this chapter have highlighted the way in which the national productivity discourse portrays HCPs as a solution to the problem of productivity and constructs this via a call for ‘new professionalism’. At Rushton improving productivity is constructed around the same cardinal themes of duty, individualisation and engagement, and is made visible via the ‘Committed to Care’ and ‘Committed to You’ programmes. This is well demonstrated in *“Committed to You – Behavioural Standards for Everyone at Rushton”* [Rushton document, dated 2010]. This document incorporates feedback from patients and staff that is organised by Trust management into 12 behavioural standards. The intent of ‘Committed to You’ is employee behaviour modification to ensure compliance with the desired organisational culture, including engagement with the principles of ‘Committed to Care’. Underpinning the behavioural standards are six values *that “encompass a desire in all of us to provide the highest quality of care to patients and each other, and to continue to improve the service we provide”* [Rushton document, dated 2010]. Whilst these values and behaviours encompass a range of domains, a duty to improve productivity is clearly identified (see Figure 33 – shaded cell, and Figure 34 – standard 11). The document proposes that *“key to these behavioural standards is that **improving is everyone’s job**”* (*ibid.*, emphasis in text). Charts are available that exemplify the ‘right’ and ‘wrong’ beliefs (Figure 35).



<p><i>Caring &amp; Helpful</i></p> <p>Polite, respectful individuals, thoughtful, welcoming</p> <p>Helpful, kind, supportive, don't wait to be asked</p> <p>Listening, informing, communicating</p>	<p><i>Accountable &amp; Reliable</i></p> <p>Reliable &amp; happy to be measured</p> <p>Appreciative of the contributions of others</p> <p>Effective &amp; supportive team-working</p>
<p><i>Safe &amp; Vigilant</i></p> <p>Clean hands and hospital so patients feel safe</p> <p>Professional so patients feel safe</p> <p>Honest, will speak up if needed, to keep patients safe</p>	<p><i>Best Use of Our Time &amp; Resources</i></p> <p>Simplify processes to find more time to care</p> <p>Eliminate waste, investing for patients</p> <p>Making best use of every pound we spend</p>
<p><i>Clinically Excellent</i></p> <p>Best outcomes through evidence-led clinical care</p> <p>Compassionate, gentle, see whole person</p>	<p><i>Innovation for Patients</i></p> <p>Empowered to act on patient feedback</p> <p>Improvement led by research &amp; evidence</p>

**Figure 33: Rushton Values**

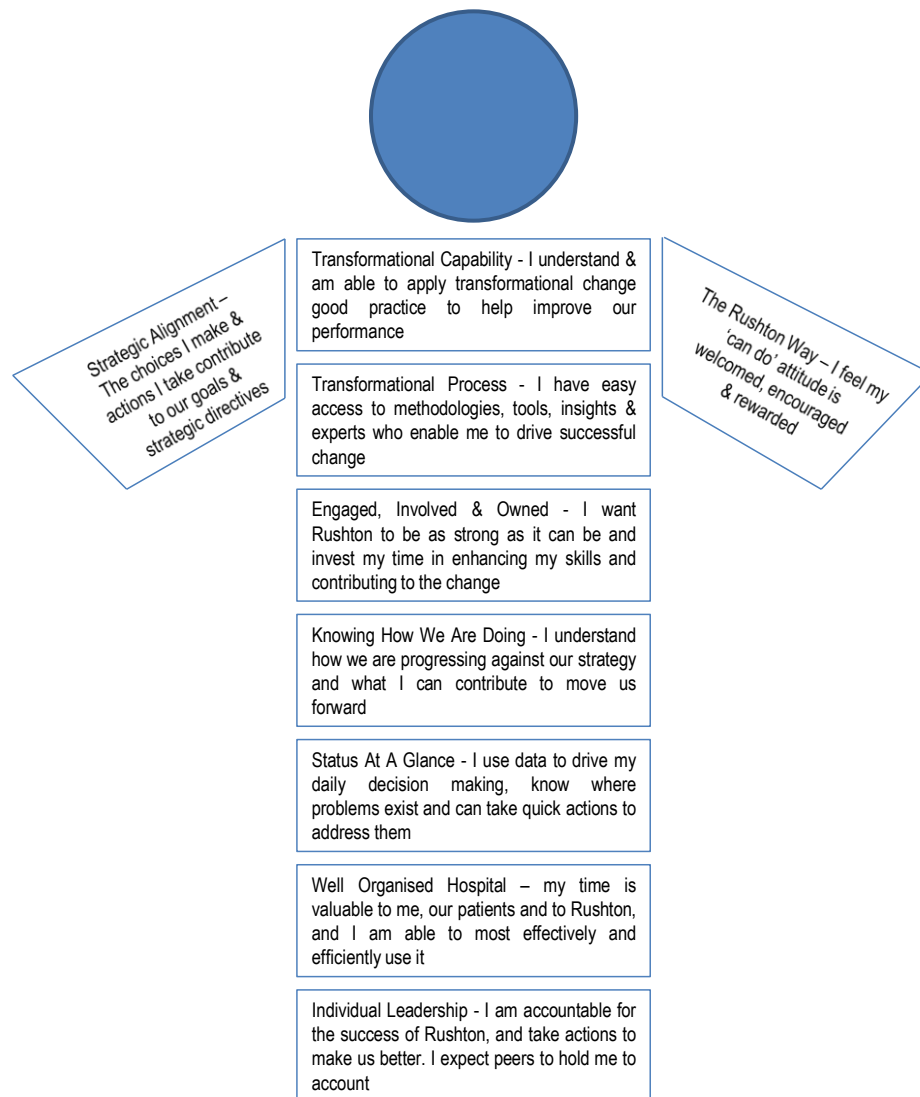
<ol style="list-style-type: none"> <li>1. Polite &amp; respectful</li> <li>2. Communicate &amp; listen</li> <li>3. Helpful &amp; kind</li> <li>4. Vigilant</li> <li>5. On stage</li> <li>6. Speak up</li> <li>7. Informative</li> <li>8. Timely</li> <li>9. Compassionate</li> <li>10. Accountable</li> <li>11. Best use of time &amp; resources</li> <li>12. Improve: our best gets better</li> </ol>
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**Figure 34: Rushton Twelve Behavioural Standards**

Do...	Don't...
11. Make best use of time & resources	
<ul style="list-style-type: none"> <li>• Look for ways when the caring thing is also more efficient e.g. right first time, regular nurse ward rounds</li> <li>• Simplify processes, cut out waste</li> </ul>	<ul style="list-style-type: none"> <li>• Think that providing a better experience for patients needs to take up more time</li> </ul>
<i>"It'll be quicker to do it right now"</i>	<i>"I don't have time to think about how to do things differently"</i>

**Figure 35: Examples of Behavioural Standard 11**

These behavioural standards are clear to stipulate that making change is the responsibility of each and every member of the healthcare team, “*not an added extra to their core responsibilities, but part of their core everyday work*” [Rushton document, dated 2010]. As such, these values and behaviours are critical in supporting the individual level proposed by Rushton’s Productive Hospital aspirations. Indeed in a document summarising the Committed to Care and Committed to You programmes, the attributes of a ‘productive individual’ are explicitly defined - literally embodied within a visual representation of the ideal-type (Figure 36). ‘Normalising’ behaviour in this fashion is a recognised strategic technology of government (Brockling *et al.*, 2011).



**Figure 36: Rushton's 'Productive Individual' from the Productive Hospital Framework**  
**[Rushton document, dated 2012]**

Who are the spokespersons for this organisational ideology or “*esprit de corps*” (Mintzberg, 1989:224), and what authority do they claim? Kunda (2006) describes three voices of authority: the direct voice of managerial authority; the voice of expert authority and the voice of objective authority. The direct voice at Rushton is encapsulated in a pervasive network of documents, reports, videos and training materials distributed in paper and electronic formats. The sources include the chief executive, the director of

nursing, the medical director, the programme director for Committed to Care, and other management executives. Their authority is based upon references to *“tried and tested methods”* and *“powerful evidence”* to support the programmes [Rushton Chief Executive, dated 2011]. The expert voice is attributed to the views of patients, other stakeholders, and over one thousand staff members collated via ‘consultation’ events. This reference to public and patient involvement is consistent with the notion of partnership that is a critical component of the extant literature regarding new professionalism; seen as essential to monitoring professional accountability (Light, 2003). Kunda (2006:68) claims that the purpose of the expert voice is to *“complement and moderate the direct voice of managerial authority”* thereby inferring greater impartiality and credibility. It also serves to make the more abstract notions of the direct voice more tangible. This was evident within Rushton via the display of ‘Just Do It<sup>22</sup>’ posters featuring a named professional, their experience of a specific productivity improvement project and often an alleged verbatim quote. These symbolic representations of the Committed to Care and Committed to You programmes were universally evident throughout the Trust in ward areas, corridors, entrances and lifts. By demonstrating a legitimating ‘professional’ or ‘insider’ perspective, these posters might be viewed as a powerful translation device. Rushton has also recognised the imperative to create and configure its own ‘expert voice’. During the infancy of the Committed to Care programme the Trust recognised that it lacked the required expertise to deliver the project on a wholesale basis. Consequently, a technology of government was the establishment of the Rushton Faculty for Improvement, a training resource

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<sup>22</sup> A 'Just Do It' is an idea or innovation that improves the experience for staff, patients or visitors. The underlying principle is to encourage Rushton employees to ‘test out’ their ideas.

that was intended to promote *“local teams and individuals... taking the initiative to lead their own local improvement work, thus requiring less central support”* [Rushton document, dated 2012].

The objective voice is one that emanates from outside the organisation, for example, journalistic and academic opinion. Whilst less obvious than the direct or expert voices, there was evidence of complimentary articles within local newspapers, video case-studies by the NHS National Leadership Council (circulated via YouTube), and a number of evaluations completed by private companies. The combined strength of these three voices projected ‘Committed to Care/You’ as a ubiquitous force, besieging HCPs with the preferred organisational culture.

What themes emerge from this organisational ideology concerning productive healthcare? Firstly, there is a clear move towards inter and intra-professional alliance and the allusion of de-bureaucratisation. The role of management is de-emphasised; the ‘voices’ maintain that local changes have been devised and driven by the influence of *“the hearts, the minds, the energies, experiences, frustrations”* [Rushton video, dated 2010] of HCPs and patients, and not imposed by managerial diktat. In one interview, the Chief Executive goes one step further stating that:

*“In many respects now **the role of the board is to help serve front-line staff**, and to help make sure that the Trust’s systems, processes and sometimes sclerotic decision making is overhauled” (Ibid., 2010, emphasis added).*

Furthermore, by not referring to specific professions or grades, the discourse suggests that membership is undifferentiated, and so the concept of unity is emphasised. This is reinforced by the use of the first person plural:

*“Most of us already put patients first much of the time. The role of the ‘Committed to You’ behavioural standards... is to help us do so consistently – all of us, in all we do, all of the time” [Rushton document, dated 2010].*

This intimation of a shared purpose may be viewed as an attempt at translation or alignment of organisational objectives with the personal aspirations of subjects (Flynn, 2002).

A second theme relates to the scope for improvement and the potential benefits to be reaped:

*“Not on one single occasion over the last two years have we found a service that cannot be improved through the insight of patients and staff. The question is not if the opportunities exist but if we choose to take them” [Rushton Chief Executive, dated 2011].*

It is suggested that the investment in establishing a cultural change has the potential to reap significant rewards, a glittering prize. Conversely, *“the risks are high if we choose not to”* [Rushton document, dated 2013]. The benefits of aligning corporate strategic ambitions with individual employee practice are widely reported. Despite being lauded as the solution to delivering the Trust’s financial and productivity challenges, Committed to You/Care are also repeatedly associated with improving ‘the experience’ for both patients and staff. This suggests a strategy to disengage the programme from economic connotations, and appeal to more traditional professional values. Following the national discourse, Rushton documentation promises releasing

time to both lead and care. Anecdotes are relayed including the often cited example of the busiest day in Trust history with 617 ED attendances in a 24 hour period. The rhetoric is that, as a direct result of applying Committed to Care changes, only one of these attendees breached the 4-hour target. The symbolic and material benefits for HCPs are also presented, for example, *“regain[ing] control of their ward and the care they provide”* [Rushton document, dated 2009], or being *“encouraged and recognised by their managers and peers”* [Rushton document, dated 2013]. An equally powerful technology of government is the allusion to personal advancement (Brockling *et al.*, 2011). Professionals are reminded that the behavioural standards are constructed directly around four of the six core competencies within the Knowledge and Skills Framework (KSF). Therefore, by inference, in order to advance through the KSF gateways<sup>23</sup>, professionals must be able to demonstrate these behaviours. Furthermore, managers are encouraged to use the behaviours that are most appropriate to the job role to *“recruit the **attitude** alongside technical competence”* [Rushton document, dated 2013, emphasis added]. This ‘right attitude’ is referred to as *“the Rushton way”* [Rushton document, dated 2012] and is formally explicated to new employees in both central and local induction processes. Mintzberg (1989) describes these strategies as selected identification and evoked identification (via indoctrination). Use of such strategies is perceived to reinforce the ideology in such a way that individuals are more likely to associate themselves with it.

Despite overt subjectification, the ‘Committed to You’ values and behaviours programme retain an element of top-down command and control,

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<sup>23</sup> KSF is a tool which provides a framework on which to base review and development for all staff, and contributes to decisions about pay progression.



particularly around performativity. Values and behaviours training sessions are mandatory with a target of 100% attendance set for July 2012. Those professionals who had failed to attend a session were specifically targeted by the Human Resources department, via their line managers. Documentation detailing the 'next steps' for Committed to Care/You also refers to embedding an approach for dealing with those HCPs whose behaviours are deemed to be 'unproductive'.

## **5.4 Discussion and Summary**

Adopting a Foucauldian governmentality perspective has revealed the way in which the rights and responsibilities of professionals have been constructed and represented via contemporary productivity discourse at both national and local levels. These two discourses share many common elements. Firstly, both discourses clearly aim to problematise healthcare productivity and promote its improvement as essential to the cause. Like the national drive for productivity (including QIPP and The Productives series), Committed to Care/You is presented as Rushton's response to the challenges facing the NHS. Rushton's aspirations also extend beyond financial security as improving productivity is one of the criteria for achieving its 2016 'vision' of becoming the best teaching hospital in the country.

Most fundamentally however, both macro and meso level discourses use professionalism as a rationality of government in the endeavour to improve healthcare productivity. Whilst the national discourse conceptualises the notion of 'new professionalism', the local discourse endeavours to operationalise this, reconfiguring the professional self via inculcating values and behaviours that are intended to shape responsibilities and conduct.

Within both sets of discourse, HCPs and professionalism are identified as the main solution to the productivity challenge. In the local discourse however the focus is on an organisational cultural change as the suggested vehicle for improvement (albeit via engagement and alignment of HCPs). Strong organisational cultures that inculcate values, shape norms and create emotional responses have previously been described in the academic managerial literature (Kunda, 2006). In such cultures, the suggestion is that:

*"... ideal employees are those who have internalised the organisation's goals and values – its culture – into their cognitive and affective make-up, and therefore no longer require strict and rigid external control. Instead, productive work is the result of a combination of self-direction, initiative, and emotional attachment, and ultimately combines the organisational interest in productivity with the employees' personal interest in growth and maturity" (Kunda, 2006:10).*

This approach is perhaps best exemplified by Rushton's portrayal of the ideal-typical 'productive individual'. The rhetoric of culture serves to emphasise the shift away from traditional top down command and control towards a more normative form of government. Under such government, employees align themselves to, and perform against, organisational goals, not because of the risk of punitive action, or to secure economic reward, but rather a result of internal commitment and intrinsic satisfaction. As Kunda (2006:11, emphasis in text) states:

*"... under normative control, it is the employee's **self** – that ineffable source of subjective experience – that is claimed in the interest of the corporate interest".*

What do these discourses mean for power and control? Both allude to empowering HCPs via promotion of self-governance, but what of the domain of the self that is now exposed to organisational scrutiny? Do these discourses really serve to liberate HCPs, or are they an act of domination? One might also question whether the tenets of bureaucracy have really been jettisoned, or whether this is in fact an 'overlay' (Mintzberg, 1989) that complements traditional methods of control. As Kunda has previously claimed in his ethnographic study of culture management in a 'high tech' organisation:

*"the essence of bureaucratic control - the formalisation, codification and enforcement of rules and regulations - does not change in principle under a system of normative control; it merely shifts focus, at management's discretion, from the organisational structure to the organisational culture, from the members' behaviour to their experience"* (Kunda, 2006:220)

The remaining chapters are concerned with the effects of this form of government. Based on empirical, ethnographic work, the aim is to explore to what extent this particular form of professional government has been successful within the Rushton ED. The premise is that discourses of 'new professionalism', articulated at macro and meso levels, influence individuals' subjectivities thereby constituting the sense of what it is to be a productive HCP (Doolin, 2002).

## **Chapter 6: What I talk about when I talk about productivity: ED professionals and their notions of productivity**

*“Productive work is the process by which man’s consciousness controls his existence, a constant process of acquiring knowledge and shaping matter to fit one’s purpose, of translating an idea into physical form, of remaking the earth in the image of one’s values”*

*(Rand, 2007:1020)*

### **6.1 Introduction**

The premise offered in the preceding chapter was that macro and meso level organisational discourses construct healthcare productivity as a contemporary professional duty, and thereby attempt to reconstitute professional identities. As such, this study sought to explore how UK HCPs constructed personal notions of productivity and productive healthcare work. This serves the dual purpose of filling the lacuna in the literature identified in Chapter two, as well as providing important empirical foundations for understanding the influence of healthcare productivity as a form of governmentality on professional identity and therefore contemporary professionalism. This chapter demonstrates that HCPs do indeed accept productivity improvement as a contemporary professional duty. It also endeavours to ‘deconstruct’ the notion of productive professional work into its constituent elements, allowing a more insightful exploration of the logics of professionalism therein. The first part of the chapter considers an overview of HCPs’ notions of productive healthcare. By exploring how HCPs experienced and made sense of productivity improvement and productive healthcare, the data reveals what is valued as productive (or

alternatively, discredited as non-productive) within professional work. This part also includes HCPs' discursive reflections of their 'LT experience'<sup>24</sup> and suggests how these have been influential in shaping professionals' views of productivity. The aim of the final part in this chapter is to trace the logics of organisational and occupational professionalism that permeate the discourses in order to create a contemporary vision of professional productivity as expressed by ED practitioners.

## **6.2 What is Productive Professional Work?**

Healthcare productivity is a slippery concept. Notoriously contentious in terms of measurement, it is also problematic semantically. A number of authors have acknowledged that a range of terms, although semantically distinct, are often used interchangeably within the academic literature: productivity; efficiency; cost-cutting; reducing waste; performance (Arakelian *et al.*, 2011; Evans *et al.*, 2001; Mullen, 2003). A similar picture is also seen within NHS policy and organisational literature. This issue of terminology can contribute to confusion and hesitancy for HCPs. Within this study, some professionals initially found it difficult to articulate their thoughts or felt over-whelmed by the nature of the subject. For example, when one member of staff was asked about healthcare productivity they responded:

*"Wow! That's an out there conversation isn't it!" (ANP2)*

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<sup>24</sup> The Committed to Care ED change programme, hereafter referred to as 'the change programme'

Most HCPs believed that productive healthcare was a concept that had become increasingly prevalent over the last five years, but for most (other than the newly qualified nurses) was something that their professional education had not particularly equipped them well for. Indeed, the change programme was identified by a significant number as an opportunity to learn the theory of productivity improvement which previously had been “*pie in the sky*” (Sister/CN3). The senior doctors believed that productivity had become increasingly relevant to them personally with the advent of revalidation (General Medical Council, 2013), and senior HCPs in general were starting to experience the introduction of productivity related issues within their annual performance reviews. Some participants had a wider experience of productivity that they were able to reflect upon, either within private medicine or a previous, non-healthcare, occupation. Most found the concept of healthcare productivity comfortable and relevant, although a minority felt it had discomfiting connotations of industry or business. During the ethnographic field work it became very obvious that the ED change programme had been marketed quite deliberately. Amongst professionals’ recollections of that time, and my subsequent observations of the ‘resurrected’ programme, terms such as ‘lean’ and ‘productivity’ were infrequently used. As one participant explained, the terminology of productivity improvement was all “*grey suits and BBC2 lectures*” (SSN3). This observation was confirmed by a senior member of the change team:

*“I think potentially the word productivity is fairly meaningless to a lot of people [Rushton ED Clinicians]. I don’t think the change programme has necessarily used that terminology even though clearly that’s its driver, to be more efficient more productive”*  
(Sister/CN1).

The ethnographic field work aimed to explore the multiple ways in which HCPs constructed their notions of productive work. Like previous studies in the international (non-UK) arena, this work demonstrated that HCPs express multiple constructions of productivity in the workplace. The data revealed five domains which were not mutually exclusive and to some extent shared blurred boundaries: The patient, the professional, the ED team/culture, the process and economics. These are depicted in Figure 37 to Figure 41, and key elements are discussed in detail below.

### **6.2.1 The Patient Domain**

HCPs constructed many of their discourses concerning productivity around the notion of the patient. This is perhaps not unsurprising given the contemporary drive for a patient-centric focus and the importance afforded to patient experience (Department of Health, 2012b; NICE, 2012). Many professionals framed their ideas of productive practice around orchestrating an outcome that was deemed satisfactory to the service users (patients, carers and parents). For most, these outcomes necessitated the provision of humanistic care. Participants discussed productive work as compassionate, welcoming, eradicating pain and suffering, reassuring, dispelling fear and providing 'basic' care such as toileting, feeding, chatting. Other ED professionals discussed productive practice in terms of framing the patient journey, for example, identifying the importance of the ED experience as the primary impression of the hospital. In particular, the completion of the ED journey by safe delivery to the destination ward was viewed by many EDAs as a critical criterion of productive work:

*“... at the end of the day I like to take the patients to the ward and put them in a better bed, especially the elderly patients. I like to think that they’re going to be safe, and that I’ve done it all right. I like to know that I’ve made them comfortable, given them the buzzer, asked them if they want some water. And that makes me feel productive in that way” (EDA3).*

Patients’ feelings, emotions and experiences were also paramount when HCPs talked about the notion of productive flow, previously discussed in Chapter four. Many acknowledged that whilst the ED system resembled a notional production line, this had the potential to be dehumanizing, compromising patients’ sensibilities. Consequently, a key factor for productive practice was to ensure that the patients did not feel ‘rushed’, ‘pushed through’, or a problem to be ‘got rid of’, or as one senior nurse described:

*“wham bam, there you go, that’s you done, let’s get onto the next one” (SSN4).*

The elements of productive work described within this patient domain are closely aligned to those attributed to a compassionate mentality (Crawford *et al.*, 2011) and those promulgated particularly following the Mid-Staffordshire NHS Foundation Trust scandal<sup>25</sup> and the Francis inquiry (Department of Health, 2012a; Firth-Cozens and Cornwell, 2009; van der Cingel, 2011). Data collection occurred during an epoch in which compassion within healthcare (or the lack of it) received significant professional and media attention and as such may have served to influence professionals’ views accordingly. There is also long-

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<sup>25</sup> A scandal revealing unusually high mortality rates within a UK hospital, triggering a 26 month inquiry, culminating in recommendations for increased transparency and candour.



standing empirical evidence that directed compassionate care in the ED may be more productive than 'normal' care, particularly in terms of reducing attendance rates for certain groups of frequent service users (Redelmeier *et al.*, 1995). Many of the elements of productive work described were humane tasks, for example, offering attention and presence. These are described by (Smith, 2008:368-9) as the *"little things that would otherwise go unnoticed... gestures of caring"*.

What begins to emerge within these discourses is that HCPs view a difference between their perceptions of productivity and that of the organisation or wider NHS institution. Nurses talked about discussing productivity amongst themselves in terms of *"what's best for the patient... based on patient feedback, and looking at whether we've done a good job, and then we get the very much organisational push for productivity to meet the targets and there is quite a difference"* (Sister/CN3).

There was also acknowledgment that the professional perspective may be at odds with that of the patients and many HCPs believed that exploring this patient perspective would be beneficial:

*"I think if we went back to basics then it would be our patients telling us about healthcare productivity, because if we were meeting our patient needs then you would assume we were being productive in healthcare. And with that would be the knock on effect that you would meet everything that the local ED, the organisation, that everyone wanted"* (Sister/CN3).

Consequently, within this discourse emerged repeated assertions that ascertaining patient feedback was essential in establishing whether or not work was productive, although it was generally recognised that this could be problematic for a number of reasons:

*“...if patients feedback well there and then you think, well that was a very productive interaction... Now unfortunately that sometimes means you have spent a bit more time with them, and I think from healthcare it’s that part of productivity that you cannot measure, and is ironically the part of productivity that is most important to the patients. And trying to capture that part of it is very hard because happy patients will tend not to write in and thank you for seeing their sprained ankle... More serious things patients will tend to write in, the MIs<sup>26</sup>, the bereavements, but the minor injuries, the bread and butter of what A&E can often be, it’s just too much effort to write in so it often goes unformally [sic] recorded that anyone has left satisfied” (ANP1).*

The importance of patient feedback was recognised by many, and a number referred to the fact that it was one of the Department of Health’s eight quality indicators (College of Emergency Medicine, 2011). However, the process of collecting such feedback within Rushton ED was reported inconsistently, some believing that it was undertaken on a rolling basis, with others articulating that it had not been done for several years. Observations revealed that a formal system had indeed been introduced – the dissemination of postcards featuring a photographic image of members of the Rushton ED multidisciplinary team and the slogan ‘we need your help to become the best’ on one side and 5 quality assurance questions on the reverse<sup>27</sup>. Whilst some staff

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<sup>26</sup> Myocardial infarctions, or heart attack in lay terminology

<sup>27</sup> 1. While you were in the ED, how much information about your condition or treatment was given to you? 2. Were you given enough privacy when discussing your condition or treatment? 3. If you needed attention, were you able to get a member of staff to help you? 4. Overall, how would you rate the care you received in the Emergency Department? 5. What one thing can we improve on?

made it a personal duty to disseminate these, clearly others were unaware of their existence. Elsewhere in the department were posters detailing results from previous patient satisfaction surveys. These posters were some years old and were not placed in an area that received significant patient footfall despite the fact that the results were generally positive. On occasions, letters from satisfied or grateful families would be shared within the morning roll call meeting or the coffee room. However, HCPs stated that these were too generalist, and instead sought more personalised, relevant feedback.

HCPs were acutely aware of the need to demonstrate their productivity to patients and families. This may have been partly attributable to the directive within Committed to You reminding professionals that they were effectively 'on stage'. Professionals often voiced concern that some of the interventions designed to improve productivity, especially EDIS, could give the impression that the staff were less engaged with patients. Indeed, as an observer, I was very conscious of the amount of time each nurse and doctor spent at the computer terminals, checking results and updating clinical fields. Several nurses expressed concern that this did not accurately reflect society's expectations of the nursing role. One participant described how a relative (an ex-ED nurse) had occasion to visit the department as a patient and had expressed shock that the nurse's role appeared to have been relegated to being behind a desk. This was believed to be extremely unsettling from the perspective of the patient, relative or carer. The desire by nursing staff to be "*on show out there... show[ing] our patients and our relatives what we're actually doing*" (ANP2) reflects the national drive for transparency (Henke *et al.*, 2011). Other changes however were believed to have greatly improved the patients' perceptions of productive professional work for example, the

processual modifications that ensured work proceeded around the patient rather than vice versa. For this reason, IAU was almost unanimously described as a successful element of the change programme. Not only did it feel more streamlined for those working within the area, it was also believed to deliver a 'slick' experience for patients:

*"...if you've got one cubicle full of all the equipment that you need to examine that patient... you can assess the patient in 10 to 15 minutes and you never leave that cubicle, and they can see that you are focused on them for the whole amount of that time... that specific amount of time is dedicated to them... [and] I think it looks as though you have competence" (SSN2).*

### **6.2.2 The Professional Domain**

For HCPs, productive work was that which gave the individual a sense of professional satisfaction, the notion of a job well done. When asked to explicate this further, all HCPs without exception described a productive professional service as one that offered high quality and safety. Whilst none of the participants mentioned QIPP by name, there was a universal acceptance that productivity, safety and quality could and should be *"intimately related"* (Sister/CN1), provided both patient *and* professionals were placed centre-stage. This section considers the ways in which productive practice was conceptualised within the professional domain.

The most explicit representation of this professional focus was the expression of specific clinical skills as perceived markers or components of productive healthcare. Nurses and EDAs invariably discussed

practical, 'hands-on' skills, particularly those that extended their scope of practice:

*"... practical skills like plastering, suturing, taking bloods, stuff that 20 years ago we didn't do. That makes a massive difference, a massive difference [to productivity]" (SN5).*

Ownership of these skills awarded individual professionals greater opportunity for designated roles within the ED. For example, nurses who were able to suture could be assigned the 'theatre nurse' role<sup>28</sup>, whilst paediatric staff with the APLS qualification (Advanced Paediatric Life Support) could act in the capacity of the 'front door' nurse. These roles had the potential to be viewed more prestigiously as they conferred greater professional autonomy. Doctors openly acknowledged the value of these extended role skills, and viewed them as beneficial to their own productivity:

*"I think without doubt, the level of skill in the nursing staff. If you've got a good skill base on offer that increases your productivity massively... experienced nursing staff that are almost ENPs, that go 'x-ray that, x-ray that and then you can see [the doctor]'. When we're super busy and you're on your own, that's invaluable" (JDoc1).*

This belief is consonant with empirical research that suggests a significant amount of junior trainees' work time involves uncomplicated and repetitive tasks that could be undertaken by a trained individual thereby releasing the doctor for other duties (Mitchell *et al.*, 2004). All professional groups discussed the place of expertise, knowledge and experience in delivering productive work, particularly in cases of perceived complexity. For more senior staff, this

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<sup>28</sup> Nurse able to undertake minor suturing activities

tacit professional knowledge was particularly relevant and could include both clinical and managerial elements:

*“...being able to assess somebody better or with greater experience than a lot of colleagues...when the patient is obviously very poorly or complicated... making the department run smoother, knowing how to bypass certain managerial issues, how to get people in or out of the hospital quicker, managing an area that is obviously getting busy and moving staff resources around accordingly”*  
(Cons2)

*“...within any of the roles I do, whether that be nurse in charge or working in IAU, as long as I’ve put in my knowledge in a practical sense, assessed the patient, got them on a treatment pathway, sent them to the right area to see the doctor, then I feel like I’ve done a productive job”* (SSN3).

Junior staff also referred to the productive value of experience and expertise, and aspired to attain these qualities as quickly as possible. New starters within the ED frequently spoke of their desire to complete their ‘packages’<sup>29</sup> in order that they could assume responsibility for more advanced elements of clinical management. Consequently, education and training was viewed as essential for productive practice by all professional groups:

*“as soon as you start taking away from education and training, and it’s the first thing that gets taken away from, I kind of think you’ve lost the productivity of your staff”* (ANP2).

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<sup>29</sup> Extended scope packages – a process of education and supervised practice that must be completed in order to adopt extended roles

Participants who were responsible for delivering education and training stated that this approach added value to professional roles, added value to the patient experience and, by virtue, improved productivity. I observed this process in practice, as EDAs received training on the execution and interpretation of physical observations such as temperature, respiratory rate, peripheral oxygen saturations, blood pressure, heart rate, urine output and airway patency. The educator rationalised this strategy:

*“I can give them enough of a skill that they are providing more to the patient and more to the department and being better value for the department and the patient than they were previously”*  
(SSN4).

ED staff also shared stories of occasions when productivity improvement strategies had been implemented without foundational education and training, to the potential detriment of patient safety. One such account concerned the decision to transfer ‘well’ patients to a medical admission unit using a lone EDA and no registered nurse chaperone:

*“... and we had an incident where a patient went off [deteriorated] and luckily the EDA who was dealing with it was very experienced, dealt with it and the patient was fine, but there had been no training process.”* (EDA2).

Whilst education and training were invariably discussed in terms of clinically related skills, many participants also highlighted knowledge gaps regarding productivity improvement. Many of those individuals who had been involved in the initial change programme and who had received training from external ‘LT’ consultants and the in-house team spoke keenly about the need to bridge that gap in order to effect

engagement and promote sustainable change. Some referred to it as an essential professional skill, as one 'change champion' explained:

*"...you're sitting in roll call one day and 'right then, we're going to be doing this new change project, blah blah blah'. Everyone's like productivity? What's going on here? Change? What's that about? If it was already instilled, and it was already part you know, as we learn to cannulate, we learn to do our ABCDE<sup>30</sup>, why not learn about productivity as well?" (SSN3).*

There was a general acceptance amongst both doctors and nurses that productivity hinged on early decision making, and significant importance was afforded to those in the role of autonomous 'decision makers'. In the main, these decision makers included the medical staff, the ENPs and ANPs, the streaming nurse and the nurse in charge. When asked to reflect on what she valued as productive, a doctor replied:

*"... I think clinical decisions, so my clinical judgement, how accurate it was, time I wouldn't want them to measure particularly [laughter] it would be in there you know, but it would be how accurate my clinical judgement was... did I back track and cover ground that I've already covered?" (JDoc2).*

The developing professional role of nursing staff within the ED was associated with a beneficial change in productivity. Staff viewed nurse empowerment as a vehicle for this change:

*"... going back to the bad old days, we used to have 8 and 12 hour waits, and those were times where there was a lot of non-productive use of staff... nurses weren't able to do anything to*

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<sup>30</sup> Airway, breathing, circulation, disability, exposure – clinical assessment tool



*impact those waiting times. And as a result we saw a dramatic rise in aggression and violence within the department. Those waiting times have reduced through better use of nursing staff being able to make clinical decisions... Why does a splinter require a doctor? Empowering nurses to make decisions has been a big, big boost to doing that and actually meeting productivity demands.” (ANP1).*

A key theme within this domain of the productivity discourse was the perception of productivity improvement as a potential opportunity for HCPs, particularly those historically marginalised by the hegemony of medicine. The change programme allowed both nurses and EDAs to participate in theory training, strategic change planning, teaching, project implementation and data collection. This was acknowledged as significantly adding to individuals’ skills sets and experiences:

*“I wasn’t used to sitting around the table, being a champion of change with 3 consultants and a couple of band 7s who I’m writing a timetable for and asking them to meet targets. That’s not what, as a band 5, I was taught to expect, but it’s something that was put on my plate and I really enjoyed it you know!” (SSN3).*

Many of the HCPs who had been employees at the time of the change programme, but who had not been directly involved, believed that it had offered them the opportunity to voice their interests. A minority however, discredited this and maintained that the listening exercise had been tokenistic and failed to take account of expertise and experience. These individuals asserted that some of the proposed changes had been previously attempted, and believed that the change team failed to acknowledge the professional opinions of many ‘shop-floor’ staff. This perceived lack of recognition, or failure to value individuals’

contributions caused significant discontent and disengagement with the change programme. Equally, failure of the organisation to recognise or acknowledge achievements was viewed as antithetical to productivity improvement:

*"I started here at 7 o'clock; my first break was at a quarter to two. The first time I got a drink was quarter to two. And that's fine, I knew next door was busy and I was the only one round here, so I don't whinge. But it would just be nice to have this general perception that you're valued, which is absent. So productivity, good thing, absolutely necessary, but if we're contributing we need to feel valued and that doesn't exist" (JDoc1).*

Both nurses and EDAs described how the change programme and the drive to improve productivity had provided some opportunities for professional role advancement. The ongoing development of the ANP training programme was a case in point. One of the main workforce issues for the department had been the dip in performance associated with the start of the junior doctor rotation. Consequently the ANPs came to be identified as the 'constant' in the department, and were expected to mitigate some of these effects and maintain service standards. I asked if this was an acknowledged formal arrangement, for example, did the ANPs offer the new doctors training and mentorship? The response was that it was essentially an unspoken expectation. Professional opportunities were also accessible to EDAs, a group that had previously had little scope for professional development:

*"We've invented a new role down here because of the change programme. This clinical support worker role... which the Trust are backing big style... The consultants loved it! Everybody loved it... It's made a phenomenal difference [it] was something for them*

*[EDAs] to aim for because if they wanted to progress they had to leave, there was nothing here in the department for them at all, unless they wanted to go away and do their nurse training and come back as a band 5" (EDA2).*

All occupational groups described productive healthcare/productivity improvement as a professional responsibility. A service improvement lead deployed to the ED commented how she had recently been struck by the number of HCPs who articulated the belief that they had a “*duty to the taxpayer*” (SIL-obs). The following excerpt is taken from the focus group transcript:

*Interviewer: Do you feel a personal or professional responsibility for productivity?*

*ANP2: Yes, every second of the day*

*Sister/CN3: Definitely*

*ANP2: I think professionally I feel a responsibility. I've changed my role and I feel very responsible for what we deliver as advanced practitioners and the effect we have on productivity... If you think professionally of EDAs, I think they feel the responsibility for productivity*

*Sister/CN3: I don't think you can work here and not be affected by it, it's everything. In my heavily scrutinised role not a minute goes by without feeling a very big responsibility to productivity.*

Professionals described notions of personal, professional and moral responsibility, but maintained that this responsibility should be shared at all levels of the organisation – from grass roots up. A number of participants maintained that this shared responsibility must be meaningful; “*people being given the tools they need to do their jobs, being*

*allowed to do them, there being real dialogue so that honest answers can be given to 'how are we doing?' and 'what can we do better?' and that things are listened to and acted upon"* (SN6). Many described feeling that staff had become lost within the productivity debate:

*"I think all have to share in delivering value for money because if we were in the private sector we would have to do that, we would want to know that the money you're paying is, you're getting the right treatment, good treatment, so yeah, there's no excuse, everyone else is doing it, we have to do it, but with that comes responsibilities for the upper echelons to recognise that there is no feeling of investment in staff, and I think we are all trying to work towards productivity and best outcomes for the Trust"* (JDoc1).

Wilkinson *et al.* (2011) describe similar attitudes in response to quality improvement in general, claiming that HCPs need to perceive that they (as well as patients) will benefit in order to compensate for the effort involved in effecting a change.

### **6.2.3 The ED Team/Culture Domain**

A common discursive construction of productivity related to the idea of having shared values and standards or 'the way we do things around here'. HCPs believed that their ability to maintain flow through the department was dependent upon their colleagues working to the same principles and standards whether that involved the way in which a cupboard was stocked, equipment maintained and returned to its home, procedures undertaken or communication delivered. There was often talk of indoctrinating new doctors into the way of the Rushton emergency department:

*"Some of the doctors are really good and some aren't you see. Again it depends, if they've come as [junior trainees] in the department and this is how they've been told this is what you do, they're ok, but if they haven't..." (AP1).*

Socialisation of new staff, particularly the junior medical trainees, was discussed by many staff as essential to the smooth and productive running of the department. One nurse talked of new doctors 'still learning the game'. When I asked what he meant by this, he explained that there needed to be an understanding that ED nurses were not the doctors' handmaidens, and that they needed to consider if they themselves could do certain jobs (for example, removing intravenous cannulae or completing a set of observations) in order to keep the process flowing. Senior medical staff echoed similar sentiments claiming that rotational staff, whilst aware of the *"magical figure of 4 hours"* (SDoc-obs) did not yet have the appreciation of how to play the system in order to deliver on time.

When asked to reflect upon their experiences of the initial change programme, HCPs who had been actively involved eulogised about a time where the culture was greater acceptance and advocacy of continuous improvement, open participation across the professions and grades (*"people who work the problems know the best solutions"* [ANP2]), and the delivery of visible results:

*"They had the hub for quite a while and they had all sorts of different ways of putting forward ideas, looking for quick wins. They had teams dedicated to setting up these quick wins... they had big boards so you could put your post-it note on saying I think we should do this, and there were hundreds, the board was full of post it notes. And I haven't even gone through half of the stuff that*

*has changed since the 'committed to care' programme came in... There's hundreds of little things that have made it so much easier... All these sort of things have come out of what people have said" (SSN1).*

Documentation from this time stated that the department's objective for quick wins and continuous improvement was *"to have a formal system to capture staff ideas for improvement, cost-benefit analysis/prioritise, empower individual staff to then drive the change through to implementation"* (Hub Poster, Field Notes). Whilst this sort of culture was considered to breed productivity, it was clear, that by the time this ethnography commenced, the impetus for change had significantly subsided. The strategic support team had moved on to other projects within the Trust and the local change champions were often involved in other projects. ED staff generally felt that things had 'gone off the boil' and enthusiasm had waned. This was compounded by the scarcity of non-clinical time (classified as non-effective time on the electronic rostering system) in which staff could pursue projects and the perception of competing pressures:

*"I think it's drifted away to be honest with you... staffing got very tight and there were a lot of pressures so people didn't have the time to implement things, to strive to improve things... [ENP] numbers went down and it got tight, and all they wanted me to do was see patients, patients, patients. So you can't do anything, and it's hard when the department isn't investing anything to actually have the energy and enthusiasm when there's nothing there to pull on to actually enthuse anyone. And I know for me personally I was quite disheartened that when they withdrew a lot of the things that*

*we were doing and there was no more. It just seemed to stop”*  
(ANP1).

No-one was able to describe to me the ‘formal system’ for capturing process improvement ideas. My observation was that the Hub – the heart of the change programme – was increasingly being used as a generic training or meeting area rather than a resource for staff to pursue improvement ideas. The ‘ideas’ wall was conspicuous by the total absence of any notes or comments. This seemed in stark contrast to the staff nurse’s description given above. In my field diary I noted that Lean (with its philosophy of continuous improvement/striving for perfection) was “*something that was **done to** the department rather than something it **is**”*. Whilst there were still pockets of innovation evident within the department (particularly around IAU), the consensus was that the ‘low hanging fruit’ (Radnor, 2010) had been picked, and instigating change was now a far more difficult and laborious process.

#### **6.2.4 The Process Domain**

In Chapter 4, the perceived importance of patient flow and ‘wait as waste’ was introduced. All staff discussed these factors when giving accounts of productive practice. Most referred to processual changes that had been instrumental in improving ED flow and mitigating waste: changing shifts to improve skill mix during busy periods; standardisation of treatment rooms, applying 5S<sup>31</sup> to storage areas; electronic orders; standard operating procedures for EDIS; standardised

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<sup>31</sup> 5S is a workplace strategy associated with LT. The 5Ss represent the following: Sort (identifying necessary items, eliminating waste or non-essentials), Set in order (ensuring all items have a clearly identified location), Shine (keeping the environment clean and tidy, equipment well-maintained) Standardise (ensuring a system is in place with defined responsibilities) Sustain (maintaining accomplishments)

assessment processes; the use of CISCO phones for team communication; ability to refer to direct access clinics *etcetera*. Most of these changes had been implemented during the initial change programme utilizing a LT approach. Many HCPs expressed initial scepticism for LT, fearing an inappropriately industrial approach that would fail to take into consideration the complexities and nuances of the healthcare setting, and constitute a step away from individualised care:

*"I thought the basic principles would work but their ideas of having times for certain [activities]... I remember them timing me to do a plaster and I thought you've only timed me on one plaster and it totally depends on the patient, do they walk, are they confused, have they got a helper, do they move around a lot?"*  
(SSN1).

During the first 8 weeks of the initial change programme, over 400 process improvement ideas were identified by ED staff. Many HCPs came to see Lean as a positive opportunity to bring about change, addressing *"avoidable mistakes, avoidable waste, avoidable repetition, making sure the tools to do the job are in working order when and where they're needed and minimizing unnecessary use of resources, time and energy by not having to work around problems"* (Cons2). Most however pragmatically recognised that there were individuals who were less enthusiastic and who might present obstacles. One lean advocate suspected that the change programme had been viewed by some as a Trojan horse, and consequently cynicism underpinned the logic of the dissenters:

*"... clearly you know there is potentially with all change programmes a money saving element and I think more so now people are becoming cynical as to the key messages of committed to*



*care and potentially they are focusing on that... that committed to care is there to save money and not to pride quality and safety... I have certainly heard that and it worries me" (Sister/CN1).*

Other staff became less convinced as the change programme evolved, and re-designed processes were trialled:

*"I think a lot of them were unrealistic because they were based around extra staffing. Like red team for instance, when red team was trialled there were doctors and nurses coming out of your ears. And I came in one Sunday shift and said to the person running the trial, how's it going? And they said, not very good I've got people ringing in sick, and I said, there you go that's real life and what you'll face" (EDA2).*

Despite addressing some of the processual challenges within the ED via the change programme, HCPs believed that their attempts to maintain flow were frequently confounded by factors outside their control. One of the principal culprits was identified as bed waits for patients requiring admission. A poster within the hub, designed by ED staff, claimed that given a recent ten-fold increase in the number of breaches of the 4-hour target, 20% of these could be attributed to bed waits. The concomitant sequelae were listed as below:

- Massively increased workload – patients requiring additional care, further observations, pressure area care, toileting, nutritional needs, analgesia, additional communication
- Additional moves in and out of cubicles
- Impact on team leaders' ability to fulfil their role, continually having to chase beds, escalate, contact Duty Nurse Managers

- Additional medical reviews needed, especially in the face of the deteriorating patient
- Definite inevitable knock on effect delaying 'time to be seen' and creating 'decision delays'

*(Hub Poster, Field Notes)*

These external limits on ED staff productivity were viewed with derision and frustration:

*"It's really annoying when you've got people bless 'em spending 12 hours in an A&E department because there's no capacity to have them anywhere else. So you kind of think to yourself, you start thinking 'well, I know this patient's going to be here for 6 hours so why should I be productive?' and 'why should we work so hard to put these things into place?' when it doesn't seem as a whole [Trust] culture keyed into that... trying to motivate staff or trying to be motivated to move patients around the department just to have them sit in the middle for 10 hours isn't a great motivator to be productive" (SSN3).*

A strategy was subsequently developed by Trust management to address this. Plans were made for the opening of a clinical decision unit, and ED extended its 'empire', acquiring space from an adjacent department. Some staff remained sceptical about this plan, viewing it as a method with which to essentially 'game' the 4 hour target (Bevan and Hood, 2006), or a 'feinting manoeuvre' to conceal the reality of ED waits (Burstrom *et al.*, 2013).

### 6.2.5 Economic Domain

The notion of economic factors (numbers of patients seen, the speed with which certain targets were hit, potential for financial savings *etcetera*) was discussed as productive work by some members of staff. However, this domain of the discourse was less evident and where it materialised, it was invariably qualified with a caveat regarding preservation of quality. HCPs believed that the economic domains were more likely to be the focus of clinical managers or Trust management who had specific financial responsibilities. Again, there was a clear indication that ED staff saw a dual perspective to productivity, and that the management perspective might not resonate with their own priorities:

*"So we will be spoken to about productivity by [management] about patient flow and expediting treatment which is obviously good for the patient experience but cynically perhaps will meet the end target. Whereas productivity for a lot of people who work on the shop-floor, the doctors and nurses and EDAs alike would be that the patients are not left in the middle for hours waiting for a bed or not waiting hours and hours for a treatment because there is only the one area that will do suturing, that sort of thing"*  
(Sister/CN3).

This gave the sense that productivity was essentially two sides of the same coin, but predicated upon different convictions and rationale. One participant described her views in a most memorable interview. She believed that the 'financial bottom line' and quality could not be divorced and recounted a recent conversation between herself and another staff member from the same Trust:

*“... she was saying about a 50 stone patient who needed a scan of [their] head. They couldn’t fit in our scanner so they’d had to take them to a zoo. That’s £2000 the zoo charges... And she was saying, when one of our scanners needs replacing, it would make more sense to go for the bariatric version, because although it’s more money initially, we can then save the £2000, and charge other hospitals £1000 to bring their patients here which is more dignified... clearly it’s better to come to a hospital rather than to go to a zoo – but also you’re saving money. So I don’t think you can ever say, well your money’s over there and your patient care’s over there, because that isn’t how it works anymore” (SSN4).*

In contrast to Radnor’s (2010) proposition of cultures of efficiency versus cultures of caring, this suggests that a hybrid position may be acceptable to HCPs.

Halford and Leonard (2006) have previously discussed the relevance of place and time on the formation and transformation of individual subjectivities. The nature of the global economic crisis had clearly shaped professionals’ constructions of productivity, not just in terms of their professional identities, but also their personal ones. A number of HCPs spoke of the imperative to consider productivity in all aspects of life, not just their professional roles. In this way, participants used their experiences outside of work to make sense of the changing vista of healthcare. Under these conditions, economic domains were likely to be articulated:

*“I think everyone needs to think about [productivity] in their lives, their life. Productivity is around you every day – the way you do your food shopping, the way you manage your house is productivity. You know everyone has budgets, everyone has to*

*make their money stretch further, so carrying that into your line of work I kind of think is you know part of everyday life and is a natural thing" (SSN2).*

This is in keeping with du Gay (1996:181) who claims that a pervasive enterprise culture has come to dominate the totality of individuals' lives assuming an "*ontological priority*".

Domain	Descriptors
Patient	<p>Eliciting patient/carers satisfaction (receiving feedback, avoiding complaints)</p> <p>Making a difference to the patient outcome</p> <p>Providing care - eradicating pain, fear, discomfort</p> <p>Avoiding admission (where appropriate)</p> <p>Admitting and transferring patient to destination ward (where appropriate)</p> <p>Investing time in holistic care provision</p> <p>Releasing time to care</p> <p>Deflecting inappropriate referrals</p>

**Figure 37: Healthcare Professionals' Notions of Productivity - The Patient Domain**

Domain	Descriptors
Professional	<p>Achieving clinical accuracy</p> <p>Providing a high quality, safe service</p> <p>Managing clinical risks and preventing errors</p> <p>Working to one's capabilities (not above or below)</p> <p>Clinical prioritisation (autonomously deduced)</p> <p>Using and developing practical/clinical skills (especially extended role skills)</p> <p>Experiencing personal professional satisfaction (notion of 'job well done', recognition from peers/management and avoiding 'bad press')</p> <p>Prompt clinical decision making</p> <p>Practical application of tacit knowledge</p> <p>Dealing with clinical complexity</p> <p>Using clinical/contextual expertise</p> <p>Providing others with professionally relevant skills (training and education)</p>

**Figure 38: Healthcare Professionals' Notions of Productivity - The Professional Domain**

Domain	Descriptors
ED Team/Culture	<p>Working cohesively (recognition of communication, skill mix, delegation, inter and intra-professional collaboration)</p> <p>Importance of ED socialisation 'how we work round here'</p> <p>Preserving morale and well-being</p> <p>Sharing values</p> <p>Engaging staff in engendering and sustaining a culture of continuous improvement, and maintaining the pace of change</p>

**Figure 39: Healthcare Professionals' Notions of Productivity - The ED Team/Culture Domain**

Domain	Descriptors
Process	<p>Maintaining flow (avoiding waste and bottlenecks) – no ‘downtime’</p> <p>Avoiding duplication/repetition</p> <p>Avoiding unnecessary paperwork/documentation</p> <p>Co-ordinating care with other stakeholders e.g. ambulance services, medical specialities, primary care services</p> <p>Standardising treatment spaces</p> <p>Having usable equipment to hand and usable space available</p> <p>Designing/utilising/re-evaluating processes (PDSA – Plan, Do, Study, Act - cycle)</p> <p>Adding extra value to the process</p> <p>Avoiding chaos</p> <p>Allocating resources to meet demands (staff, skill mix, space)</p> <p>Managing distractions/interruptions</p> <p>Utilising supportive technology, having the right support staff</p> <p>Streaming - Right patient, right place, right time</p> <p>Maintaining a manageable workload – not hitting the tipping point</p>

**Figure 40: Healthcare Professionals’ Notions of Productivity - The Process Domain**

Domain	Descriptors
Economic	Number of jobs completed How many patients, how fast? Not breaching the 4 hour target Meeting other time relevant targets Saving money Not squandering money Sensible procurement Not incurring financial penalties Generating income

**Figure 41: Healthcare Professionals' Notions of Productivity - The Economic Domain**

### **6.3 Tracing Professional and Organisational Logics Through Productivity Discourses**

HCPs clearly talk about many different things when they talk about healthcare productivity. This multiple perspective has previously been demonstrated by other authors in different clinical and geographical contexts (Cattaneo *et al.*, 2012; Arakelian *et al.*, 2011 Arakelian *et al.*, 2008, Nayeri *et al.*, 2005/6, McNeese-Smith, 2001). In concordance with the work of Arakelian *et al.* (2011), this data suggests that HCPs who are organised within a robust team culture are more likely to express productivity with a patient/quality focus, rather than an individualised or quantitative emphasis. The descriptors within the 5 domains share many similarities with the work by McNeese-Smith (2001) interviewing US nurses. However, whilst few participants discussed the relevance of teamwork or systems change within that study, this was clearly not the case in this empirical work. Contextual differences may go some way to explaining this disparity. For example, whilst McNeese-Smith studied a

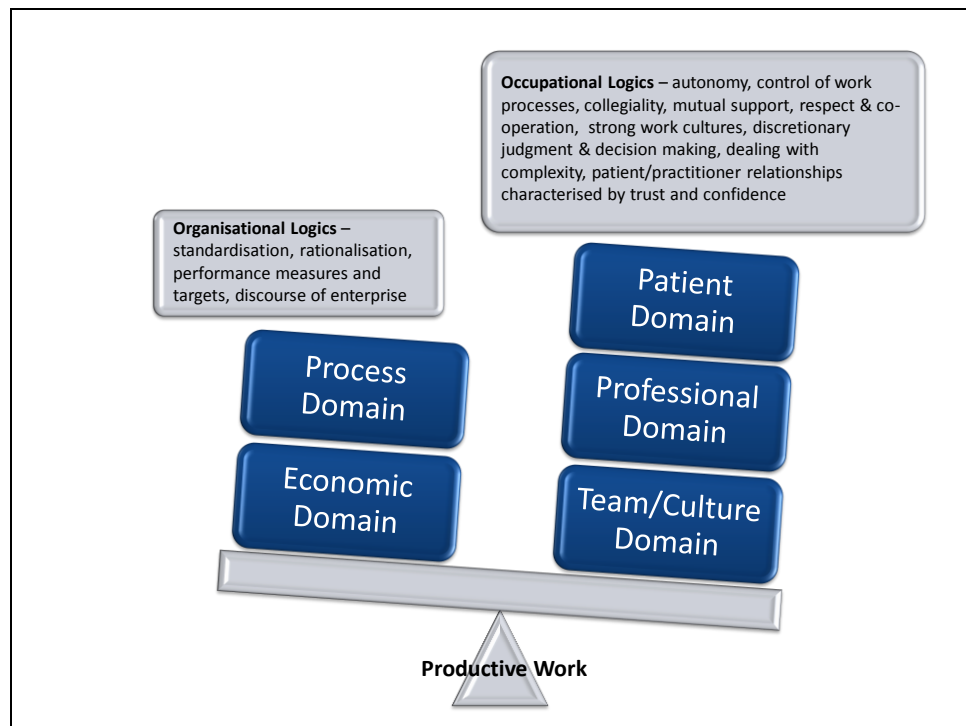


broad cross-section of nurses from a number of departments within a hospital, this study specifically examined one team. Furthermore, the Rushton team had recent experience of a process improvement technology, and as such were more likely to consider it when discussing productive work. As per the conclusions of Nayeri *et al.* (2005, 2006), this work demonstrated that for HCPs quality assumes primacy in productive healthcare. Both this work and that of Nayeri *et al.* demonstrated that management / organisational recognition is essential in promoting and sustaining productive practice. Nayeri's work however emphasised the importance of managerial leadership, which was not apparent within the discourses studied here. This may in part reflect cultural differences (Nayeri *et al.*'s work was conducted in Iran), or alternatively may be a reflection of UK HCPs' internalisation of productivity as a governmentality, and therefore an issue for self-governance rather than managerial direction.

The philosophical position for this study supports an interpretivist epistemology. Consequently it is accepted that social actors construct their own reality and that meaning is context dependent. As such, tracing the influences of organisational and occupational/professional logics may go some way to aiding the conceptualisation of these multiple perspectives. One participant who entered the study field (an ex-nurse who had assumed a Service Improvement Lead role for the Trust) eloquently encapsulated this with her perspective:

*"Productivity is in the eye of the beholder" (SIL-obs).*

From the professionals' own productivity discourses one can identify clear logics that can be attributed to both the occupational and organisational fields previously described by Evetts (2011) (See Figure 42).



**Figure 42: Occupational and Organisational Logics Associated with the Conceptualisations of Productive Professional Work in the ED**

All HCP groups discussed the domains of productivity in a relatively consistent manner with minimal variation between professional/occupational groups. Most frequently represented were the domains aligned to occupational logics, in particular the patient and professional domains. This was apparent in both registered and non-registered HCP groups, even though some of the EDAs acknowledged that they did not have a registration to ‘put on the line’ if they disagreed with or failed to meet productivity challenges. Senior HCPs with managerial responsibility within the ED were more likely to consider the economic domain as an essential element of productive work, albeit one tempered by the other domains. All HCPs who considered the economic domain within productive work described this as a relatively new consideration.

An interesting viewpoint was offered by a Trust Service Improvement Lead who had facilitated the original ED change programme before moving on to other projects within the Trust. Reflecting upon her Trust-wide experiences, she claimed that those in the higher echelons of the medical hierarchy were less likely to engage with productivity improvement. This was presented as being unique to medicine, and the SIL speculated that this was based on assumptions of professional security – these ‘medical elites’ did not fear becoming the next cost improvement saving. This attitude however was not experienced during this study where many of the senior doctors had engaged willingly and enthusiastically with the change programme. Their willingness to engage with productivity improvement may potentially be explained by the fact that, as a specialism, emergency medicine is still very new and therefore not as entrenched as other disciplines (Green *et al.*, 2011). In addition, many staff described how the nature of emergency medicine made it highly visible and susceptible to public scrutiny to a far greater extent than other (less visible) clinical divisions:

*“We’re the most complained about department along with medical admissions... because we’re the front door of the hospital and the public face, you know no-one knows anything about the 18 week cancer referral to treatment time, but everyone knows that if they go to ED it’s a 6 hour wait and all the staff are rude” (Cons2).*

Whilst the first 3 domains (patient, professional, culture/team) related strongly to occupational logics, the last 2 domains (process and economic) related more to discourses of organisational logic – bureaucracy, performance management, rationalisation, standardisation *etcetera*. And yet, all domains were considered essential to productive work by ED HCPs. Following a more traditional

perspective, one might have expected HCPs to shun organisational logics rather than embrace them as components of productive work. However, this was not the case at Rushton. The processual element in particular was something that many professionals saw as valuable. This was perhaps a direct consequence of the LT experience (a process improvement technology) within the ED. Although not all elements of this experience had been universally popular, one of the 'success stories', in the opinion of the HCPs, had been the numerous 'quick wins' - rationalisation, simplification or improvement of a process via a professionally initiated 'common sense' innovation that conferred instant gratification. These quick wins, whilst extremely beneficial to the department, were invariably less disruptive than the major programmatic changes and therefore had few negative implications for traditional professional values or occupational professionalism (Evetts, 2006). In this manner, this particular element of LT conceptualised productive professional work in a way that was commensurate with that of HCPs. The ideology behind Lean was also aligned to occupational professionalism as it purportedly allowed HCPs to autonomously define the problems and control access to the solutions. Consequently, the positive experiences derived from the change programme may well have convinced HCPs of the importance of process within productive health work.

The economic domain was the domain that was least palatable for professionals (and the least discussed), and yet it was still perceived as an important component of productive work. This was particularly influenced by the prevailing context of economic recession and the concomitant interplay of personal as well as professional subjectivities. In addition, the ED environment ensured that HCPs were bombarded

with data that related to the economic domain. A glance at EDIS would instantly remind HCPs of the status of patients with respect to meeting time based targets, pop-up messages would inform staff of bed pressures and emphasise the importance of discharge planning to accelerate turnaround time, and blood results were returned with accompanying details of costs incurred. A number of HCPs referred to this constant background awareness of resource constraints, and as such, this may have influenced their subsequent construction of productive work.

It could be argued that HCPs' construction of productive healthcare around both occupational and organisational logics demonstrated the potential for self-governance. After all, the premise of self-governance is essentially the reconciliation of the organisational with the occupational, or even the transformation of the organisational to the occupational. The notion of this hybrid position, the embodiment of new professionalism, was explicitly acknowledged by a number of the study participants:

*"... at that time when the change project was being introduced ... I could kind of see it from both sides, from kind of a managerial hat that says oh this is brilliant because our patient's going to be done within two hours... and there's the other, kind of a hands on junior nurse which went brilliant I can get to my patient I can do a thorough assessment I can do everything that needs to be done, I can introduce aspects of care which can make their stay a lot more positive..." (ANP2).*

## 6.4 Discussion and Summary

Productivity concerns the means by which an individual achieves their aims, but the evaluation of the value of those ends is a matter of personal, professional and philosophical judgement. Hsieh (2010) argues that to be productive in an objectivist sense requires that the outcomes of production serve human life and happiness. As such a person can be productive in the sense of economic productivity, without being productive in the objectivist sense. For HCPs the objectivist approach to productivity was clearly aligned to logics of occupational professionalism. However, organisational logics were also apparent and ED staff talked of situations where the two could co-exist in a calculated balance. It has been suggested that HCPs are reluctant to work to productivity values (Young and McClean, 2009), but this work demonstrates that this is not necessarily true, it depends upon which productivity values and how they are represented. Given this, and the acceptance of productivity as a professional responsibility, the pre-conditions for self-governance (or new professionalism) appeared to be evident.

The rationale behind exploring professional conceptions of productivity within healthcare was in part to ascertain an understanding of how professionals had experienced and made sense of national and local discourses around productivity. To what extent these discourses had directly influenced HCPs' constructions is impossible to accurately extract. The Productive Series and the Committed to Care/You programmes were discussed by many during observational sessions and interviews, and the fact that productivity improvement was identified as a contemporary professional duty is certainly consistent

with the local and national discourses of responsabilisation and self-governance. What this data has demonstrated is the way in which HCPs identified their professional selves and constructed professional expectations and norms with respect to productive work.

This chapter has been concerned primarily with what might be termed 'professional productivity'. The next chapter changes its focus to consider how this sense of professional productivity is maintained or exercised within an organisational setting. In particular it questions whether, in this context, new professionalism is visible.

## Chapter 7: Seeking new professionalism: Political ideal or lived reality?

*“We’re busy going nowhere, isn’t it just a crime?*

*We’d like to be unhappy, but we never do have the time”*

*(Van Heusen and Burke, 1949)*

### 7.1 Introduction

The previous chapter demonstrated how HCPs have experienced and made sense of healthcare productivity and its improvement, potentially influenced by extant discourses at macro and meso levels. The aim was to demonstrate what these HCPs valued as productive, and this has been termed ‘professional productivity’. However, within the HCPs’ constructions were suggestions that the organisational view of productivity placed a different emphasis on the value of the five domains. The aim of this chapter is to explore in greater detail how this notion of ‘organisational productivity’ played out in practice, and how HCPs then mediated their positions accordingly. The intent was to reflect on what this meant for the premise of self-governance and new professionalism. Following Noordegraaf (2011), the aim was to avoid assuming and reifying an inflexible dualism of professional versus organisational features, but rather a more nuanced approach that considered the interplay between the two. This approach was also in keeping with the governmentality framework that considers contours of power as mutable and ubiquitous (McKinlay *et al.*, 2012).

This chapter is structured as follows: the first section shows the problematics for professional notions of productivity. These include the issue of quantification and the predominance of time-relevant targets, the perception



of external scrutiny and surveillance, and the threats these hold for the 'essence of care' or professional *raison d'être* as understood by HCPs. It is proposed that time is a dominant theme, with HCPs articulating a conflict between the time constraints applied organisationally, and the notion of time that accounts for professional aspirations and visions. The second section explores how HCPs respond to these problems, namely exercising professional veto, and having recourse to logics of professional expertise and finite resources to justify their actions.

## **7.2 What are the problematics for professional notions of productivity, and how do they arise?**

In Chapter six, data was presented which demonstrated that, for almost all the HCPs, healthcare productivity was seen as a contemporary professional duty or responsibility. It was suggested that the pre-conditions necessary for self-governance were established within the ED, and yet the majority of HCPs had failed to sustain engagement with the long term philosophy of a productivity improvement programme, and there were repeated references to a different (problematic) organisational view of productivity. Using ethnographic observational and interview data, four key problematics for the notion of self-governance were identified, each interwoven with the thread of temporality. Colley *et al.* (2012:373) have previously described how neo-liberal reforms have disrupted the boundaries of human service work, including time as a "*critical social and symbolic practice*". They allude to the competing time orders of work, adopting Davies' (1994) typology of clock-time versus process time. This conceptual framework underpins the analysis of the four problematics presented below.

### 7.2.1 It's all about the numbers: the economic domain

Within the five domains of productivity identified by ED HCPs, the economic domain was the one that professionals were least likely to align themselves to. Indeed, it was the notion of targets, numbers and time that proved a significant problematic for the notion of self-governance. This was in no small part due to the dominance of the four hour target. Since 2004, ED HCPs have lived and worked under the shadow of a four hour wait target (Guly and Higginson, 2011). With the advent of the 2010 coalition government this was 'de-emphasised' at a Department of Health level, however it has in fact remained a key strategic target for UK NHS Trusts, and a critical outcome for commissioners of services. Failure to meet this target has implications for Trusts' financial position, as breaches incur significant penalties. The organisational significance of this target meant that HCPs viewed 'organisational productivity' as driven by the four hour target rather than the patient:

*"... from a management perspective obviously they've got to have a focus and the main focus, and their priority, will be the one that creates the biggest connotations and complications and that's still the four hour target" (Sister/CN2).*

As such, organisational productivity was viewed as one potentially at odds with their own professional notion of productivity.

*"... I actually think that's where, as shop-floor workers, we've lost what productivity means because targets have been drummed into us so much" (ANP2).*

Many qualified this position however, acknowledging that different organisational roles incurred different pressures and expectations:

*“I think there’s reality and rhetoric. I think the rhetoric is, yes they do [share professionals’ views of productivity] and that is demonstrated in Committed to Care and Committed to You, and certainly all of the trust management whenever they are speaking at any of the time out days are supportive of productivity involving high quality care as well as numbers of patients. But as with any organisation, and particularly the health service, we are driven by what’s put onto us, like the 4 hour target... is put onto me, [the chief executive] gets targets put down onto him, and he has to achieve those, and he’s measured by those targets. He’s not measured by the fact that Mrs Bloggs who I spent half an hour chatting to, to explain, to help her out...” (ANP1).*

Consequently, time and numbers colonised the HCPs’ productivity discourses. Organisational productivity was described multifariously as number of 4-hour target breaches, number of patients seen per shift, ambulance turn-around times, and time from an in-patient bed being declared to the time the patient arrived on the ward. Furthermore, HCPs discussed the expected patient trajectory in terms of discrete units of time; for example, 15 minutes for patients to be streamed, 20 minutes to initial assessment within IAU, 40 minutes per case for medical trainees. These were the criteria and metrics believed to be valued by the organisation, whereas professionals prized other productivity criteria that *“wouldn’t be recorded anywhere... or valued anywhere in the emergency department” (SSN1).*

This focus on numbers and time was viewed as ‘de-personalising’ and some HCPs questioned the applicability of such an approach:

*"[What] frustrates me is stupid non-relevant targets. Key performance indicators, call them what you will... I actually think [the 4-hour target] is the worst thing ever invented because there is nothing clinical attached to it. There is nothing clinical to say that you have to do something within 4 hours, it is purely a function of time and waiting right?... For me it is just the notion of irrelevant KPIs<sup>32</sup>" (Cons1).*

Many HCPs referred to the frenetic nature of a department driven by the 4-hour target, stating how it was easy to get 'sucked in' under these conditions with the risk that *"the patient gets forgotten and we all become a little bit too keen to stop the clock..."* (SSN2). Here HCPs once again used the industrial metaphor of a production line but, unlike Chapter four (where its use was a pragmatic representation of ED flow) here it was clearly derogatory, describing a situation that the HCPs often felt ill at ease with. A number of HCPs referred to this conceptualization of the ED as a 'sausage factory'.

This does not mean that HCPs were entirely dismissive of the 4-hour target. Most considered the state of play prior to the target being implemented as unsatisfactory or, as some described, *"criminal"* (SN5). Longer serving employees recollected finishing a shift and returning the next day, only to find some of the same patients still in the ED. This was clearly perceived as unacceptable, and was linked to the high levels of aggression and violence widely reported within EDs nationally (James *et al.*, 2006). Many HCPs referred to productive practice as care delivered in a timely fashion, but this was time as constructed and dictated by the HCP themselves, in one participant's account depicted as a notional journey rather than a destination:

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<sup>32</sup> Key performance indicators

*"[T]he 4 hour target in the emergency department is a sound principle but it's got in the way of the fact that it's about the 4 hour journey for an individual that comes through that door needing care, and they seem to have got lost, it's all about the target and not about giving this person the care they need within 4 hours, it's about getting rid of them in 4 hours" (SN6).*

This participant's perspective resonates with Letham and Gray's (2012:72) viewpoint that *"[r]ather than striving to provide good care within the target time, good care appears to have been redefined as achieving the target"*.

This conflict between process time and clock time has previously been problematised by Davies (1994), in an effort to understand the potential tensions in care delivery. Davies states that the legacy of industrialisation and capitalism is work that has become inextricably linked to the notion of linear or clock time, where it is the clock that closely regulates both the work undertaken and the workers themselves. Although care work is very different to production of goods, Davies notes that it is a *"clock-time consciousness"* (Davies, 1994:279) that predominates in institutional settings, closely linked to neo-liberal ideas of efficiency and rationalisation. However, she also describes the existence of process time, where the needs of the recipient of care assumes primacy, or in Davies words, the technical-limited rationality is overshadowed by the rationality of caring. Davies refers to process time as one that allows *"the task at hand, or perceived needs of the receivers of care, rather than the clock, determine the temporal relation... not letting the mentality time is money primarily guide the actions... provides and creates space for the use of the carer's own judgement and action"* (Davies, 1994:281). In this study, the quantification of work (by virtue of primarily time-oriented

targets) clearly generated tensions between process time and clock-time for ED HCPs.

### **7.2.2 The eye in the sky**

Despite accepting the responsibility for providing productive care, ED HCPs were overwhelmingly aware of the burden of external scrutiny. This scrutiny emanated predominantly from the bureaucratic hierarchies within the Trust, and related to performance on time relevant targets:

*“... we’ve got people up in various offices in places within the trust watching and having flags come up, that patient’s been here for that amount of time, there’s nothing been written for so long...” (ANP1)*

Two excerpts from the study field diary illustrate this pervasive panoptic influence, in particular the internalisation of discipline and self-surveillance:

#### **THE PANOPTICON AND UNEQUAL GAZE (1)**

*Today I attend the daily bed meeting with Helen, the nurse in charge. Prior to leaving the department, Helen collates all the information she needs, for example, numbers of patients in the department, number of breaches, staffing issues. She also does a last check of all the patients on EDIS ‘amber’ because she says ‘they [duty nurse managers] are bound to ask, and you look stupid if you don’t know’. The bed meeting is at the other side of the hospital in a room marked ‘Operations Room’. As we enter I am struck by the numerous screens adorning the walls. A new system for monitoring hospital in-patients is being trialled. The screens are extensive and replete with patient information. One manager quips ‘we know everything other than the name of their dog’. To monitor ED, there are two dedicated display screens. One runs the same version of EDIS available within the department; the other is*

*EDView, a simplified version that only shows patient numbers, gender, age and time in the department. Like EDIS it is colour coded to red, amber and green and is clearly intended to function as an 'at a glance' system.*

*Whilst we wait for the bed meeting to commence, a manager reflects on the events of the previous evening. The EDIS history screen is a sea of red indicating a vast number of patients who had breached the 4-hour target. The problem is discussed, and the conclusion is that it was a result of both patient volume and ED staffing issues. However, we are warned that a senior member of the Trust has 'steam coming out of [their] ears' and is likely to visit the department at some point that morning. When the meeting finally commences, individual directorates share their bed status. ED is asked to contribute first and is then immediately dismissed with the acknowledgement, 'you need to get back'.*

*When we return to the department, the atmosphere is tangibly different to anything I have experienced before. Gone is the friendly banter and chat. Everyone is aware that there may be an impromptu visit from Trust management given the large volume of patients that breached overnight, and this obviously causes considerable anxiety. I chat to one of the doctors who had been on duty the previous early evening. It had clearly been a relentless night, and yet there were distinct overtones of responsibility, blame and culpability. The doctor accesses the EDIS history screen and checks the details to ensure that none of the patients who breached were legacies of her care. When the system exonerates her, she cheers out loud and is visibly relieved.*

## **THE PANOPTICON AND UNEQUAL GAZE (2)**

*I am observing in paediatric ED and see Ash, one of the junior doctors, updating EDIS. He has been attending to a patient who appears quite well, and has now been waiting some considerable time for their blood results to be returned. Ash repeatedly*

*checks the system and even rings the lab directly to chase these results. Each and every attempt is documented within the clinical notes via EDIS. I ask Ash if he feels duty bound to do this. He replies, 'Yes, otherwise the duty nurse manager will be calling and then the nurse in charge from next door [adult ED] will be coming round.' He points out that if he did not make all these entries and the patient subsequently breached, he would be seen as culpable. Andy, one of the senior trainees, chips in at this point: 'And because of this, we write all sorts of unnecessary stuff!' When the blood results are eventually returned, they are accompanied by a pop-up message that details how much the Trust has had to spend on this particular test in the last few months, and questioning whether it was really essential. Julie, another junior doctor, states that this definitely influences her practice, causing her to err on the side of economy and creating (at times) ethical tensions.*

ED HCPs clearly associated this surveillance with disciplinary power. Many discussed individuals who had “copped for it” (AP1) when they had been caring for a patient who subsequently breached the 4-hour target, even when it seemed clear that it was in the best interests of the patient to stay in the ED. A startling story emerged during a focus group discussion:

*“SSN5: Can I tell you about an incident I had and I got really **heavily** scrutinised for it, and it was about a girl who came in... I won't say what had happened to her, however the police didn't want her moving because of the chain of evidence... and the forensic medical examiner also didn't want to move her because of the chain of evidence and how serious this crime was. And my consultant said not to move her because of this reason and because she might also need other medical speciality input... But she was coming up to going over 12 hours of being in the*



*department and I got absolutely **roasted** for it because they were like, just move her, just get her out to the ward...*

*Sister/CN3: And I've had the same with an organ donor who they couldn't accommodate in theatre so they had to stay down here and ITU were completely backing us but the main problem for the hospital was that it was going to be a 12 hour breach and you know ITU were saying I'll argue with the Department of Health you know, but..."*

This autocratic approach provoked considerable stress for ED HCPs. Individuals spoke of feeling anger and demoralization at being challenged about their clinical judgements. Many professionals spoke of “*a fight inside*” (SN-obs) when challenged by time targets, and inevitably a sense of having to “*fight the system*” (EDA1). I commented to one participant that it seemed like a Catch 22 situation, damned if you do, damned if you don't. He replied, somewhat sardonically, “*Mainly damned if you don't*” (Sister/CN2). The notion of having an “*eye in the sky*” (JDoc1) was attributed to emotional fatigue within the ED. Many HCPs described the extent of this surveillance as counter-productive to their care efforts as a result of repeated interruptions and distractions:

*“... if patients are beginning to get towards the end of their time you can often actually find that you can't finish off what you are doing with the patient because you've got the person ringing you saying, what's happening?... And you're saying, yep, yep, well when I get off the phone that's what I'm doing. So... the interruptions can often hinder things because you can't complete what you are doing... And even if the time isn't there, that person that is being badgered for information is not getting their clear train of thought about what am I doing with each of*

*these patients, and they're constantly coming back round the circle to re-start where they've left off" (ANP1).*

HCPs believed that their high level scrutineers demonstrated a singular perspective that had the potential to elide the complexities of the ED:

*"my experience of the management coming down here, and by that I mean senior nursing staff, matrons and senior doctors, is that they are focused on the four hour wait and they don't care about the clinical.... That's all the conversations I've ever heard over that desk or overheard or when questions have been directly put to me it's always been... 'you've got 15 minutes to get them out of the department' never 'is that child ok? Can we help?' Or never 'how you doing round here? Why are you 3 hours down today?'" (JDoc1).*

Whilst many of the duty nurse managers I observed over the course of the ethnography did indeed offer help during their visits to the department, staff often felt that they weren't engaging in a *"meaningful conversation"* (SN6). The emphasis was believed to be on sorting out the present problem, micro-managing an immediate organisational risk, and not a more profound perspective of 'why the system is not working'. HCPs also worried about the inherent risk of being driven by individuals who did not necessarily appreciate the contextual subtleties of the ED environment:

*"... I just wonder if they always know the risk to the patient, and somebody sitting in an office, they don't always know or understand the risks that are associated with rushing things through or the volume of staff and patients in the department and how stressed everybody gets... I think it is the people who are driving the risks who are the ones who have*

*the power but they don't always understand what's happening at the bottom line" (ENP1).*

Colley *et al.* (2012) have previously described how the privileging of clock-time at an organisational or policy level can shift practice along a continuum whereby caring and meeting the clinical and emotional needs of the clients are consumed by surveillance and control. One Rushton ED team leader described how they endeavoured to mitigate such a situation by *"absorbing the time pressure"* (ANP1) in order that their staff could focus on the quality of care. Despite this, the tensions between two competing time orders – process and clock-time – and the disciplinary discourses and actions used organisationally, often resulted in HCPs perceiving the 4-hour target as an *"increasingly tightening belt"* (SSN-obs).

### **7.2.3 Protecting craftwork and the essence of care**

The notion of healthcare craftwork has previously been described (Sennett, 2009). Carmel (2013:742) describes such craftwork (in the context of critical care) as *"a practical, interpretative orientation to different kinds of knowledge... require[ing] embodied skills to be mastered"*. Sennett (2009) has considered the demise of such medical 'craft' at the hands of numerous neo-liberal reforms of the NHS. He claims that nursing and medical craftwork traverses a *"liminal zone between problem solving and problem finding"* utilizing a continuous interchange between tacit knowledge and explicit awareness (Sennett, 2009:48). Within this study the theme of craftwork and craftsmanship was predominant and constituted a significant stumbling block for organisational productivity. HCPs expressed concerns regarding the humanity of care delivered under the spectre of organisational

productivity with the potential for the patient to be considered a package needing to be moved on. This depersonalization was described as insulting to the patient and families, but also a slight upon the profession and the professional care being delivered. Many HCPs affirmed that they did not enter their chosen profession to “*chase figures*” (SN2) and were insulted by the implication.

Nursing staff in particular spoke of the risk to the essence of care or the ‘little things’ (Smith, 2008) aspired to by HCPs as productive practice; for example, the ability to engage with patients, talk to them for more than an account of their past medical or drug history:

*“...we have so many other things that we have to do that talking is a luxury... the risk for me is that **if you measure your productivity by things like turnaround times, breaches that sort of thing, then you miss to me what is nursing**, and if you don’t value that at the same levels as different productivities then things get missed that are important because they are not on a tick list... more of the nursing that the patients will actually value” (SSN1, emphasis added).*

The ‘craft’ of being able to talk and develop a rapport with patients and family is an example of Sennett’s bridge over the liminal zone between functionalistic problem identification and expert problem solving (Sennett, 2009). This was exemplified by a staff nurse caring for an elderly lady who had sustained a fall. The staff nurse spent a significant period of time establishing a wealth of information regarding the patient: expectations; anxieties; mobility; safety; nutrition and family/social support. This data was communicated to both the ED and reviewing orthopaedic teams. The staff

nurse was then able to present a case for supported discharge home, a productive alternative to hospital admission, both for the patient and the Trust.

ED staff also spoke regretfully about the potential for de-skilling given the focus on clock time rather than process time. One staff nurse described the suturing of facial wounds as an art form or labour of love that she could no longer indulge properly:

*"I can tell you cases, as could lots of my colleagues, where we were chucking them onto the wards before they'd had proper treatment. Often things like wound care... sometimes you would spend three hours stitching one wound, because it was so huge, but I could guarantee that those wounds were beautifully done and we used to suture faces in the past, the nurses, and they were beautifully done. You would argue it had been done by a Max-Fax<sup>33</sup> person the job was so good because we would sit and we would take our time. We went from that to being told at 220 minutes this patient needs suturing and... all that was in the back of your mind was this isn't going to be my best work... I'm not here to do crap work... I want to feel as though I'd be sewing up the queen"*  
(SSN4).

Similarly some senior doctors lamented the loss of opportunity to carry out repairs of extensor tendon injuries, a procedure that could no longer be undertaken because of the organisational time constraints.

Whilst HCPs constructed their personal notions of productive practice as a triad with productivity at one locus, and quality and safety at the others, they

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<sup>33</sup> Maxillo-Facial Surgery

expressed concern that organisational productivity risked disrupting this intimate relationship. Senior members of staff who had been involved in the change programme claimed that during the early days of the initial project, the message of productivity as quality and safety had become lost in translation. This clearly contravened personal professional values and the edicts of HCPs governing bodies:

*“Normally... we see them [patients] in around an hour. It’s always focused on the time and not the quality of the clinical care. And I get frustrated because the GMC send out regular emails to us juniors... little packs at least once a year with their guidance in etcetera, and emblazoned over all of this is - your first priority is the care of your patient” (JDoc1).*

Many HCPs gave highly personal accounts of episodes of care where they felt organisational productivity had jeopardised quality and/or safety. In describing these incidents they invariably used technical details to underscore their professional expertise, and as well as acknowledging the risk to patients, frequently recognised the affront to their own professional sensibilities:

*“I was asked to take a patient up to the medical admissions unit... everything was said to be sorted, they were put in the middle<sup>34</sup> because you have to keep getting patients in... she wasn’t in my team and she’d come right up, about four minutes to breaching and I got handed over the photocopied notes, an EDA with me, take this patient up to the ward. I was just leaving the department and I was reading the notes and she’d been diagnosed with a nasty chest infection, her blood pressure was on*

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<sup>34</sup> The unofficial waiting area (loose space) in the centre of zone 3

*the low side and she was a bit tachycardic<sup>35</sup>, and she had a bag of fluids prescribed that wasn't running... and [she] had no antibiotics and was on a wet bed. So I brought her back in because I thought I can't take her up like this, it's not safe and it's embarrassing" (SSN1).*

Another nurse described a situation where a patient reached 238 minutes whilst in X-ray. The EDA brought the patient back to ED and the nurse in charge *"went mad and said don't bring them back into the department because they're going to breach"* (SN7). The patient however had not received their last dose of antibiotics and so this was then administered in the corridor. The nurse relating this account was appalled at this: *"... because of the timeframes there are times when safe working practice is thrown out of the window and that's what I can't get my head round"* (SN7). EDAs also experienced this sense of shame, describing discomfort at transferring patients to wards when they had not even had chance to establish the patient's name:

*"You know... it's rude, I think, if I'm taking an elderly lady up to the ward and I don't know her name. I don't know whether she's a Miss a Mrs or anything about her. I don't think that's good enough" (EDA1).*

ED staff clearly wanted time to do 'good work' that engendered professional pride, rather than a *"quick fix"* (SN5) that resulted in the ED running *"like a sausage factory... churning out this end product that was, you know, like your cheapo pork sausages and not your Lincolnshire best, you know, on a link in a paper"* (SSN4).

This pressure to provide a *"pit-stop approach"* (SN-obs) caused considerable anxiety for many, especially less experienced ED HCPs who had assumed decision making responsibilities. Being unable to *"complete everything that*

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<sup>35</sup> Supra-normal resting heart rate

*you'd like to complete"* (JDoc1), led to the development of safety-netting behaviours. An example of this was demonstrated when a baby presented, unwell and with a high temperature. The differential diagnoses included a urinary tract infection, but the ED staff were unable to catch a urine specimen. The baby's observations improved and consequently the decision was made to discharge. However, the attending doctor claimed that in an ideal world she would have kept the baby until a specimen could be obtained and tested. As a compromise she 'safety-netted' the family by giving them a specimen bottle, asking them to "*catch some wee and take it to the GP to be tested*" (JDoc-obs). This behaviour, she confided, left her dissatisfied, worried and hoping that something important had not been missed. Having their 'craft' approach truncated subsequently meant that process time and reflection was necessarily extended into personal time. One staff nurse explained that when they finished work and went home, they did not speak to the partner for an hour whilst they re-lived the shift. On a number of occasions junior doctors also referred to this continued anxiety and reflection, one declaring "*it's those ones [patients] that make you sit bolt upright at 4am in the morning*" (JDoc-obs).

### **7.3 Mediating the ethical tensions**

The "*temporal ordering of modern life*" (MacBride-Stewart, 2012), in particular the domination of clock-time, presents challenges for professional identities. This has been demonstrated in a number of studies including community midwives experiencing the introduction of clinical supervision (Deery, 2008), generic youth support workers facing austerity measures (Colley *et al.*, 2012), General Practitioners following changes to contracts and regulatory mechanisms (MacBride-Stewart, 2012) and Finnish academics influenced by



changing managerial and financial structures (Ylijoki and Mäntylä, 2003). Tietze and Musson (2002) have previously argued that the practical responses individuals orchestrate in response to changing temporal frameworks within their work are critical to the construction and maintenance of professional identity. The following sections describe how the HCPs within Rushton ED responded to what they viewed as 'organisational productivity', in order to resolve ethical tensions and preserve/reconstruct a sense of productive professional self in the face of attempted normative control.

### **7.3.1 Power of professional veto**

Organisational productivity, in particular the 4-hour target, at times constituted an untenable threat to ED HCPs' values and notions of productive work. One notable response exercised by HCPs was the preservation of professional veto. HCPs were well aware of the organisational consequences of breaching: each breach had to be accounted for by a Band 7 nurse; daily breach reports were issued to the Director of Nursing, ED Matron and Trust management; incremental fines existed for increasingly serious breaches; and there were financial implications for not meeting quarterly targets. Staff also perceived personal ramifications and would describe situations where individuals had been "*investigated*" (SN-obs) and exhorted to personally account for that breach.

Despite the impetus to move patients through ED within organisationally and politically defined timeframes, HCPs sometimes elected to "*put their foot down*" (EDA1) and allow their patients to breach, regardless of the potential consequences for them personally and professionally. All participating ED

HCPs without exception stated that they would be prepared to take such action. All occupational groups – doctors, nurses and EDAs/other support staff described similar degrees of collective agency although it was acknowledged that junior members of staff would be more likely to find exercising power of veto disconcerting. One HCP believed that ‘breaching’ had lost its significance, and allowing patients to go over the 4 hour target was approached with greater complacency by staff members. This opinion however was an isolated one, and during my periods of observation I was never aware of such complacency.

I spoke to many staff about this decision to allow patients to breach. All HCPs were clear to point out that they believed most patients could and should receive their care within the 4-hour window. However breaches were advocated under conditions where it involved *“doing the right thing for that [patient]... I’m less inclined to push for time targets and more inclined to get the right outcome for the [patient], first time”* (JDoc1). These findings are in contrast to those of Deery (2008) who demonstrated that the words of midwives suggested a commitment to the organisation rather than to individual women. Clearly in this study, the HCPs placed the patient before the organisation:

*“... I would not transfer anyone like that [a patient on a wet sheet]... obviously every breach we save is important, but I will never do that, it will never happen, and there has been times when you have had to stand and argue and say I’m not doing it, just because it’s not appropriate”*  
(SN2).

HCPs rationalised their decisions to oppose organisational productivity by recourse to tacit knowledge and dealing with clinical complexity.

### 7.3.2 'We're just too busy, too busy'<sup>36</sup>

In discussions of productive healthcare, all HCPs alluded to increasing public demand. The number of patients presenting at Rushton ED had increased exponentially over recent years, and staff frequently referred to the numbers of patients presenting over a 24 hour period almost as a badge of honour:

*"I worked last Monday and we saw 573<sup>37</sup>, Tuesday we saw 551. It was crazy, stupidly crazy, ridiculously crazy, and everyone's saying, 'well, you've got extra staff now...' What? We've got extra staff now? It doesn't mean we can cope with 551 patients. You know we didn't go under 90 patients per hour for 7 hours. It was ram-jammed" (ANP2).*

This increase in demand was described as the one thing professionals had no control over. Ironically, this was in no small part attributed to the 4-hour target:

*"What's in the community just isn't working and so people just come here because at the end of the day we give a damn good service. People come here with aches and pains, they'll have a full MOT, they're discharged or admitted in 4 hours. And I think we're a victim of our own success" (SN1).*

Figures for earlier years were described as *"chicken feed"* (EDA2), leading a number of HCPs to conclude that, as staffing had not increased until very recently, the inherent productivity of the department must be good in order to have dealt with the upsurge.

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<sup>36</sup> Direct quote (ANP2)

<sup>37</sup> Ten years ago the 'norm' for Rushton ED was approximately 250 patients/day

HCPs also had a clear sense of the maximum number of patients that could be reasonably managed through the department without disrupting flow. This figure was in the region of 450 patients. Numbers above this constituted a tipping point where resource-demand mismatch occurred, staff became overwhelmed by the number of tasks to complete, and professional work became a function of *“keeping all the balls in the air”* (SN-obs). I repeatedly observed this in zones 2 and 3, and noted in my field diary *“there is almost a critical mass where patients flow well through the system, but then falter when this is exceeded”*.

Discussions of demand were invariably counterposed to HCPs’ perceived lack of resources – time, staff (of the correct skill-mix) and physical space. Many believed that there was little waste in terms of professional work and therefore the capacity to make it ‘leaner’ and release further time was minimal. Consequently, continuing to drive productive care without an increase in resources constituted a threat to safety and quality:

*“If we are with a fixed number of staff which effectively we are now... you are not going to be able to increase your number productivity without sacrificing your quality productivity” (SDoc1).*

Many HCPs also considered that the resource-demand mismatch confounded attempts at productivity improvement, and that it was essential to *“speculate to accumulate”* (Cons1) in order to reap the maximum dividends:

*“...if you don’t match your resource to your demand then you’ve missed the boat with healthcare productivity... If you need 15 people on the shift and a mixture of EDAs, CSWs, nurses whatever and you only have 8, as far as your chance of being productive, it’s greatly reduced ... So I think it is probably what we do wrong down here... it took us too long, despite*

*the shop-floor workers and... the band 7s banging on about 'there's not enough people on the shop-floor to be productive'... So I kind of think, lots of middle and higher management talk about productivity to us, but sometimes I don't think they actually want to listen to the real solutions that could make a difference because they're not cheap" (Sister/CN3).*

The adverse effect of inadequate resources on productive care was not purely a function of having insufficient clinicians to assess and treat patients. HCPs maintained that the system did not have adequate capacity to release staff for project work, team building or training (despite a pro-active education team and well-equipped resource room designed to facilitate professional development opportunities). The training issue was particularly contentious and frustrating for HCPs and was formally raised in a number of official fora (for example, rapid improvement events and education/research meetings) as well as during interviews and clinical observations. During the study a poster had been placed on the coffee room notice board asking staff to make recommendations regarding the resource room; for example, desirable learning resources, equipment, journals *etcetera*. The first (and only) comment documented was: "*Time to go in there*" (anon). Those who had received training regarding healthcare productivity and productivity improvement recognised that there had been limited opportunity to disseminate this expertise more widely among ED HCPs and this had contributed to misunderstandings and disengagement with the change programme. It also left them as isolated champions attempting to continue project work in relatively lonely silos. The aspirations of an ED staff who adopted a philosophy of continuous improvement and striving for perfection became less and less tenable because of this issue of resource-demand mismatch:

*"I kind of think it won't happen here, probably because targets are too important and the shop-floor's too important, and 551 patients a day means that there aren't any nurses free to go off and do a Joanna Briggs literature review on quality improvement in the emergency department" (ANP2).*

For some, the perceived inability to adequately resource the department produced a sense of futility regarding the work already undertaken during the initial change programme. HCPs recounted professionally sound processes and reconfigurations such as the IAU that struggled because of inadequate staffing levels. One junior doctor described how the lack of an 11:00pm doctor<sup>38</sup> meant that he himself became the consistent bottleneck in the department, something that caused him significant professional angst. Many contested that the ED could formulate the slickest processes conceivable, but without adequate resources, productivity would inevitably flounder:

*"I'm not sure how effective another change or the continual change we're undergoing on a trust wide basis is going to be. I think there's always going to be an element of you know, can't fit everyone in the box kind of thing... and everyone's just doing their best they can with the tools that they've got, and with the financial constraints put on there's only so much you can do isn't there?" (SSN2).*

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<sup>38</sup> During the change programme professionals shifts had been reconfigured in an effort to match demand with capacity

### 7.3.3 Tacit knowledge and dealing with clinical complexity

Davies (1994) notes that process time is at best very difficult to measure and schedule. She describes the boundaries as extremely fluid, with elements of waiting and weaving of tasks, and as such the application of quantitative measures becomes contentious. This sentiment was effectively expressed by the Rushton ED HCPs who, in rationalizing their decisions to exercise power of veto, frequently alluded to the complexity and intricacy of their work, as well as the importance of professional tacit knowledge. By implication, this 'professional expertise' could only be exercised by HCPs and 'trumped' organisational fiat. HCPs argued the importance of having a "*clinical exclusion category*" (SSN4) that they could use at their discretion. The 4-hour target does indeed include such exclusion criteria, based on clinically defined parameters. However what became clear within this study was that clinical exclusions, as defined by HCPs, extended far beyond the relatively narrow remit of the DH guidelines:

*"I just think that they need to give it a bit more flexibility... every single patient's case needs to be assessed individually and there are times when I'm sorry, just to make sure things are right, this patient is going to breach by 10 or 15 minutes and as long as we can justify the reasons why we've done it, whether it be patient dignity or patient comfort, safety from our point of view, I think that should be acceptable" (SN7).*

HCPs often referred to the target as too rigid, not recognizing the complexity of emergency medicine and their patient population. This was a stance often adopted by members of the nursing profession:

*"I think the targets are a good idea but they are very black and white aren't they? And in nursing there are a lot of grey areas" (SSN5).*

This position endorses the notion of a high indeterminacy/technicality ratio to professional work within the ED (Jamous and Peloille, 1970). By promoting the indeterminate elements of professional work, there is greater capacity for jurisdictional control and professional autonomy because of the effective inaccessibility to the non-cognoscenti (Allen, 2002).

The complexity of the patients was an often cited rationale for the inadequacy of time and quantity based targets. Clinicians discussed patients who needed greater assistance, were poor historians, possessed greater numbers of co-morbidities, were critically ill or injured *etcetera*, and therefore required a greater period of time for a diagnostic work-up and management:

*"[I]t's (number of patients seen per shift by nurse practitioners) very clunky, it doesn't allow for if someone has been particularly upset, it doesn't allow for the fact that you've had a difficult joint relocation or a cannulation that you've spent an hour trying to do, or anything along those lines. And it doesn't allow for complexities of the case to be considered" (ANP1).*

It was also believed that the surveillance systems in place did not adequately reflect this complexity and professional expertise:

*"EDIS changes colour as you move towards this 4 hour time. 'This child is now red', it takes no account of 'are you doing the right thing for that child' so it doesn't say 'red, but green you're doing the right thing because this child should be here for this long because they are sick'" (JDoc1).*

The uniqueness of the emergency medicine specialism was identified as problematic for the measurement of productivity. Doctors in particular were



aware that, unlike their colleagues in other specialities who had a set number of allocated beds, theatre places or clinic slots, ED doctors did not have a direct equivalent. This was further confounded by the heterogeneous nature of the clinical caseload:

*“I could see nobody this afternoon technically, but still be extremely valuable for the ones I’ve been involved with. Or I can see 10 patients with varying value you know, they could be all paediatric admissions or minors and I send them all home, and I really make not much difference to them because they are all sore throats and ankles and things like that, or they could be really sick, resus patients, and I could be involved and make a big difference to their care and you can’t just judge that on clinical notes unfortunately” (Cons2).*

During the study I asked many HCPs what would be professionally meaningful in terms of gauging productive healthcare. For one member of staff, the change programme was viewed as a missed opportunity to assert collective authority, stop targets driving professional work and behaviours, and *“make real what we want to be measured on”* (ANP2). All participants felt that metrics should have a clinical and professional focus that acknowledged complexity, rather than top down command and control.

*“There should be coherent clinical targets, now you say what is a coherent clinical target, well if we know that if for example, in a stroke the patient’s brain is going to die if we don’t get them thrombolysed within 4 hours, then I am going to move heaven and earth to get them thrombolysed if it’s appropriate. Okay? If we know that for every minute someone has myocardial infarction without reperfusion means x percent of life lost then I am going to move heaven and earth to get them*

*reperfused. Those are the targets that really mean something to me.*

*Purely numerical targets based on the fact that the patient has to come into the hospital within 4 hours because the government wants to get rid of the waiting time in A&E are an irrelevant target" (Cons1).*

The importance of setting targets locally rather than nationally was also discussed by HCPs. It was believed that what could be safely achieved in one ED would be different to another because of *"the business of the department... your attendances and your staffing levels"* (Cons2). By implication, these locally defined targets would be established at a professional level.

The national A&E quality indicators were discussed by the majority of HCPs, although few seemed to have an understanding of how (or if) they were utilised within Rushton ED. Many junior staff alluded to them erroneously as targets that were likely to be implemented in the near future, and may hold some hope of being something more meaningful than the 4-hour target alone. In fact, these A&E quality indicators were introduced by the Department of Health in 2011. Those who were more familiar with the indicators had high aspirations for them, particularly as the 'time for initial assessment' could be considered a professional opportunity as the *"first real nursing target"* (ANP2):

*"Because nurses can do a comprehensive initial assessment, they can meet and greet the patient, they can do a set of observations, take their history, give them pain relief, and get them on their way, do bloods and get investigations, and if that can be done in 15 minutes you can't tell me that's not quality! But it's nursing quality! Surely that's what we're all about, to meet and greet patients that come through the door (ANP2).*

## 7.4 Discussion and Summary

This chapter has aimed to illustrate how ED HCPs mediate their positions in order to reconcile productivity and professionalism within the context of a professional organisation (Mintzberg, 1989). In previous chapters it has been suggested that new discourses regarding productivity are visible, and that these discourses are directed at HCPs with the intention of engendering a notion of duty, individualisation and engagement. Specifically, this discourse (at both national and local levels) makes a move to reconstruct professional obligations via professional self-governance.

Whilst it became apparent within Chapter 6 that Rushton ED HCPs did indeed identify productivity as a contemporary professional duty, the data within this chapter has demonstrated three problematics for professional notions of productivity and the premise of self-governance - the organisational focus on quantification, the pervasive influence of external scrutiny and organisational surveillance, and the perceived threat these all hold for professional craftwork. These problematics have been analysed using a temporal framework based on clock time and process time.

Time is not uniform or immutable. It is a social construction (Bergmann, 1992) that develops amongst societal members and in response to socialisation processes. Like the work of Colley *et al.* (2012), this data illuminates the potentially competing time orders in contemporary human service work, in this instance in the context of an ED facing calls for productivity improvement. In particular, this data has demonstrated how both clock and process times compete for the attention of the ED HCPs. Whilst HCPs are cognisant of the relative value of both in modern day

healthcare, compassionate care and craftsmanship requires a process time approach, and it is therefore this temporality, being more compatible with professionals' own notions of productivity, that invariably takes precedence. This is despite the fact that clock time is perceived as the prevalent organisational yardstick (Colley, 2012), with the 4 hour target becoming symbolic of organisational productivity. Colley *et al.* (2012) argue that preservation of process time in human service work is a reaction to the Taylorist approach that implies that there is one best way to complete a task. In support of this, Rushton ED HCPs condemned a production line approach that elided professional tacit knowledge and expertise, and one that focused on *"being on time"* rather than *"spending time with"* (Deery, 2008:360). This has previously been discussed by Sanders *et al.* (2011) where erosion of process time and medical craftwork within emergency care renders ED a *"quick fix referral place... like the ten items or less check out of the hospital world"* (Sanders *et al.*, 2011:86). Professional allegiance to process time however meant that it was often difficult for staff to demonstrate what they had achieved as the elements and outcomes of work framed by this temporality were much more nebulous and intangible. Despite this fact, in this and other studies HCPs believed process time to be associated with productive relationships, satisfaction for both user and clinician, and good clinical outcomes (Deery, 2008).

It should be pointed out that in Chapter 4 the ED approach was also discussed as production line by HCPs, but in this instance the term was used in a favourable sense, advocated as one that embodied a sense of continuous flow and forward motion. This dual representation of ED as a production line acknowledges the fact that HCPs were required to straddle multiple

temporalities. Davies asserts (and demonstrated in her own study in Swedish Day Nurseries) that clock time and process time are not dichotomous, but co-exist and infiltrate care work. Within Rushton ED, HCPs were able to switch between or accommodate both temporalities dependent upon the context such as the departmental 4-hour target status, patient requirements and professional aspirations. Negotiating temporalities in this way allowed professionals to mediate the constraint of organisational productivity and protect their interests either by embracing elements of it in order to preserve/enhance their own professionalism and autonomy, or reject it when it threatened professionalism.

How did this straddling of temporalities influence professional behaviours? HCPs verbalised and demonstrated the processes they had re-designed to improve clock time, and they accepted the virtue of clock time under certain conditions (particularly when it offered the opportunity for enhancing professionalism, as in the case of the time to initial assessment target being potentially 'commandeered' by the ED nurses). Sometimes their behaviours were more reactive because of uneasiness with (but accommodation of) clock time, such as safety-netting behaviours and attempts to absorb external pressures and scrutiny regarding clock time. However, there were also frequently times when professionals elected to assert professional veto and explicitly resist clock time by making a clinical decision to allow a patient to breach. Such actions were rationalised by recourse to, and defence of, traditional professional values or occupational professionalism, principally allusion to expert knowledge and managing complexity (Evetts, 2011). HCPs believed that the solution for restoring craftsmanship was establishing a point of equilibrium:

*"We've got to get the balance right... You can't just say time, you can't just say quality because they've got to marry up somewhere" (SN1).*

This was emblematised by a diagram created for use on a poster in the hub (designed by clinicians within the change team) describing the challenges for the initial change programme depicting a set of balanced scales with safety, quality and experience on one side and demand, efficiency and targets on the other.

The multiple temporalities presented here were instrumental in creating the impression that there were two discourses on productivity, professional and organisational, that at times talked past each other. This was seen as an influential factor in the failure to engage a critical mass in the Lean ethos of continuous improvement aspired to by the ED change programme:

*"I think things have kind of got lost in translation along the way and people are hesitant because it is seen as a target kind of thing, it's only to achieve a target, it's not because it's delivering a good standard of care" (Sister/CN2).*

In terms of embracing and internalizing self-governance and new professionalism, the foundations initially appeared favourable. Whilst the ED HCPs perceived themselves to be inherently productive they also accepted that there was always capacity for improvement. Productivity was seen as a shared responsibility, but one that very clearly should have a clinical and professional focus. HCPs also utilised the language of productivity (for example, bottlenecks, flow, process, waste, and value) and could understand the relevance, identifying knowledge gaps and training requirements. What this chapter has demonstrated however, is that certain

problematics existed for professional notions of productivity and self-governance. In particular, the explicit surveillance, scrutiny and disciplinary control represented a potentially competing mode of governance that, in theory, could constitute an effective impasse for the notion of self-governance and 'new professionalism'.

## Chapter 8: Discussion and conclusion: Working the ED production line – A tale of time and motion

*“Any customer can have a car painted any colour that he wants so long  
as it is black”*

*(Ford, 2009:55)*

### 8.1 Introduction

The aim of the study was to explore the changing nature of professional work during times of austerity, using the Emergency Department of a large NHS Trust as an ethnographic case study. The over-arching question related to the ontological nature of the relationship between contemporary work and professional identity. Three specific research questions were identified:

1. What are the macro, meso and micro level influences that frame the call for increased productivity and productive roles for UK HCPs?
2. How do HCPs negotiate and rationalise productive healthcare, and what identities do they craft in response to this call for productivity?
3. What is the governance structure for productive healthcare within the case study setting and what implications does it have for professional identity?

The chapter commences with a summary of the individual chapter findings where these research questions are provisionally addressed. Section 8.2.1 accounts for scene setting, whilst subsequent sections (8.2.2 to 8.2.4) respond to questions 1-3 respectively. Following this, the central problematics are



discussed in greater detail. To conclude both the chapter and the thesis, a reflection upon the study limitations will be offered, as well as a consideration of the likely contributions of this work to the fields of clinical practice and policy, education and academic research.

## **8.2 Chapter Summaries – The vertical arguments**

### **8.2.1 Summarising Chapter 4 - Setting the Scene: Professionals, Productive Work and the ED**

The intention of Chapter 4 was to provide a thick description of the ethnographic case study site – a portrayal of both structure and agency in terms of organisational and geographical configuration, history, culture, demands and pressures, social actors, technologies, work processes and division of labour. The purpose of this chapter, in the tradition of thick description, was to lay down successive strata, developing the account from being simplistic, literal or journalistic, to one that was profound and scholarly. Yambo (2012) conceptualises this as adding pixels and mega-pixels to add clarity and quality to an image. For Gilbert Ryle, the originator of the term, thick description involved “*understanding and absorbing the context of the situation or behaviour... [as well as] ascribing present and future intentionality to the behaviour*” (Ponterotto, 2006:539). In having a rich understanding of the context in which data was gathered, the reader of this thesis is then better positioned to assess the credibility of the subsequent interpretations (Geertz, 1973). Providing thick description as a starting point also mirrored the process of ethnographic data collection and abductive analysis undertaken in this study. On entrance to the ethnographic field the research perspective adopted was broad, but as data emerged and themes became apparent, the focus became increasingly narrowed.

This chapter demonstrated how productivity within the ED is embodied by the notion of flow or forward motion, and is consistent with the findings of authors who have studied the ED process in other countries (Nugus and Braithwaite, 2010; Nugus *et al.*, 2010; Wiler *et al.*, 2010). It is within this section of the work that participants first discuss productive healthcare within the ED as a 'production line'. As a researcher, and HCP myself, I was surprised by this representation as I did not anticipate HCPs embracing, what I assumed to be, an essentially industrialist approach. Indeed, previous authors have described this 'industrialisation' of healthcare and advocated the exercise of caution, citing the potential for erosion of professional values and risk to patient safety (Morton and Cornwell, 2009; Rastegar, 2004). Calne (2007) provides a cutting satirical exposition:

*"Working in the NHS today, is similar to working on the production line of a very large impersonal factory... The (foundation level) doctor's role is like that of a shop floor factory worker. He or she must be able to look at the patient simply as a product on the conveyor belt of the NHS factory. All empathetic sentiments must be left with their coats when the workers clock in... Any emotional feelings about the product (patient) or extra time spent talking to it would only waste valuable factory time. The product must get through the system in the specified time and the factory worker (doctor) must commit all his or her energy to making sure that as many products get onto the conveyor belt as possible. The new factory worker... needs to be cold and unfeeling. He or she must also be reasonably efficient; although cutting corners is acceptable as long as the product has a label (diagnosis) on it. The supervisors (consultants and registrars) do not usually check that all the labels are correct as they are*

*so busy themselves, usually in another part of the factory. So even the correct label is not important, the only thing that matters is that the labels are slapped on as quickly as possible and that the products look as if they are finished. Unfortunately, the products often break again after leaving the factory but that doesn't matter as long as the managers can tick the boxes on their clip boards and count that the right number of products are delivered for the target count at the end of the day".*

As the ethnographic study unfolded, I came to realise that this representation of the production line was far from being industrialist or automated, and contrary to Marxian theories of capitalist production (Braverman, 1974), HCPs were not reduced to an undifferentiated mass. Instead, the production line analogy related to a notion of perpetual flow (which is accepted by HCPs as essential practice within ED) that remained under the autonomous and discretionary control of the HCPs themselves. In this concluding section I refer to this notion of flow as the 'desirable production line'.

Within this chapter also emerged the notion that ED HCPs actively intervened in order to improve flow within the department. Much of the work undertaken had been initiated under the auspices of a recent departmental change programme, predicated on productivity improvement and LT methodology. The drive for improved productivity had clearly influenced the way in which space and technology was utilised, professional roles configured and patients prioritised. Whilst many of these changes were based upon an approach that could be broadly described as standardisation (for example, standardised spaces/rooms, admission procedures, treatment protocols), HCPs adapted and, at times, subverted these in order to preserve

or even extend occupational jurisdiction. This finding was important in demonstrating that most ED HCPs were willing to engage with productivity improvement strategies (whatever their motivations), rather than being alienated by them (Wilkinson *et al.*, 2011).

### **8.2.2 Summarising Chapter 5 - Constructing Notions of Healthcare Productivity: The Rise of a New Professionalism?**

Whilst Chapter four served to illustrate and introduce productive healthcare at the micro-level, the intent of Chapter five was to consider the macro and meso-level influences using a perspective based upon the Foucauldian concept of governmentality. In this chapter I suggested that the current crisis of productivity is not necessarily new, but merely framed in an alternative manner. The contemporary representation is that the responsibility for both the problem of productivity and its potential solution is laid quite resolutely at the door of the professions. The implication in NHS policy literature is that 'old professionalism' is self-serving and effectively fails both the service and the service users. Furthermore, it is acknowledged that strategies based on top-down command and control have been evaded and have failed to influence the behemoth that is the professions. From the national and local data emerges a policy move to transform 'old professionalism' to a new incarnation that embraces new professional identities, responsibilities, accountabilities and ethos. Whilst it could be argued that this approach was apparent as early as the 1980s it is clear that the figure of a 'new professional' is now made visible, and extends its reach to include all professionals rather than a professional elite.

Contrary to the thesis of productivity improvement as an act of deprofessionalisation, this discourse is framed via professional self-governance whereby all clinicians are targeted via autonomising and responsabilising technologies of government. In this manner, it is implied that professionals should assume responsibility for productivity and resource management, not as a manager, but rather as a dutiful and professional clinician, or a 'partner' in healthcare provision. The national and local (macro and meso-level) discourses are linked via this use of professionalism as a rationality of government. This reflects Rose's ethic of freedom whereby "*autonomy, self-responsibility, and the obligation to maximise one's life as a kind of enterprise*" is a principal strategy of advanced liberal government (Rose *et al.*, 2006:91).

Adopting a conceptual framework based on the Foucauldian notion of governmentality rather than a functionalist, Marxist or neo-Weberian perspective has permitted a consideration of the "*microphysics of power*"; that is attention to the complexity and co-dependency that enables a programme of government (Miller and Rose, 2008:33). In terms of rationalities, healthcare productivity improvement has emerged as an imperative for the future well-being of the NHS and Rushton NHS Trust, but there are many differences in opinion regarding its accurate measurement. Numerous agents however, including authoritative 'experts', appear to agree that improving hospital productivity should be a goal nationally and locally. In acknowledging that direct approaches to improve productivity have been less than successful, attempts are made to govern the professions from a distance. Using specific rationalities and technologies, professionals' decisions regarding resource management are translated into a professional duty or responsibility. The

construction of productivity in discourse therefore establishes a connection between economic health (and viability of the NHS), and the professional choices of individuals or, stated another way, an alliance or harmonisation of value and values.

In this way, neo-liberal practices offer professionals the opportunity to autonomously resolve issues that were previously within the jurisdiction of governmental agencies. In assuming responsibility however, professionals are required to conduct themselves according to the 'approved' model of action (Burchell, 1993). As such, the rhetoric around 'new professionalism' may be conceived of as a strategic game to encourage professionals to identify with policy or organisational aims. Fournier (1999:280) has previously discussed such appeals to professionalism as *"a disciplinary logic which inscribes 'autonomous' professional practice within a network of accountability and governs professional conduct at a distance"*. In her work with non-traditional professions, she suggested that rather than being imposed on employees, professional conduct, competences and values were 'offered' as a way for individuals to achieve self-improvement. This form of control translates the objectives and values of one party (in this case the state or organisation) into terms acceptable by others (the professions). In this regard certain norms such as service and dedication may be supplanted by others such as competition and financial rationalisation, and these may subsequently *"become consonant with and provide norms for [professional] ambitions and actions"* (Miller and Rose, 2008:35). Consequently, the top-down control that was once deemed unwelcome by the professions and likely to promote disengagement and disenchantment (Teasdale, 2008; Wilkinson *et al.*, 2011) is now re-packaged as self-governance - a seductive logic that holds

the allure that the state may be less influential in the lives and decisions of HCPs. Le Grand (2010) states that the 'best' model for delivering public services, such as healthcare, is largely ideological, but depends primarily upon the motivational structure of professionals (knights or knaves) and the influence of context upon that structure. The 'mistrust model' that assumes inherent knavish tendencies of HCPs broadly equates to command and control. Superficially, new professionalism may appear to be imbued with a flavour of the 'trust model' and therefore more likely to engage the professional knights. However the governmentality framework allows this to be critically evaluated and instead presented as a variation of the 'mistrust' model, albeit one intended to appeal to more altruistic assumptions.

### **8.2.3 Summarising Chapter 6 - What I Talk About When I Talk About Productivity: ED Professionals and Their Notions of Productivity**

Whilst the governmentality perspective has been increasingly utilised to good effect within social research since the late 1990s, a criticism has been its *"disregard of empirical reality"* and the suggestion that there is a disconnect between what is attempted by mentalities of rule and what is actually achieved (McKee, 2009:473). McKee (2009:474) suggests that this is problematic *"for those researchers interested in the effects of power at the micro-level and the lived experience of subjection"* as it risks overlooking the potential of (multi-vocal) human agency in disputing, challenging and disrupting the governmental project. In this manner, Stenson (1998) advocates an approach in which the discursive analysis of governmentalities is complemented with empirical data from relevant social settings. Specifically, the use of an ethnographic approach is advocated:

*“...to show how policies are implemented, expose their material effects and reveal their unforeseen and unintended consequences, as well as their outward limits... In doing so it aims to reveal the messiness and complexity involved in the struggles around subjectivity, and offer a more nuanced and finely grained analysis of governing in situ” (McKee, 2009:479).*

Consequently, Chapters six and seven endeavoured to explore these effects of human agency in relation to this governmental project.

The remit of Chapter six was to identify the ways in which HCPs constructed their notions of productivity and productive professional work. The literature presented at the beginning of this thesis had demonstrated a marked lacuna in relation to this field, specifically within the UK setting. Therefore, the intent was to fill this void, as well as considering self-formation; the way in which HCPs constituted and defined their identity as ‘productive’. This study has demonstrated that ED HCPs construct multiple perspectives regarding productive healthcare. This reinforces the findings of a small number of non-UK studies (Arakelian *et al.*, 2011, 2008; Cattaneo *et al.*, 2012; McNeese-Smith, 2001; Nayeri *et al.*, 2006, 2005), and moves the boundaries forward further by developing a new conceptual model of ‘professional productivity’ that is characterised by five domains: the patient; the professional; the ED team/culture; the process and the economic. Of these five domains, the first three (patient, professional, and ED team/culture) were most frequently expressed by HCPs. The patient domain depicted productivity as patient centred and compassionate, whilst the professional domain represented productive care in terms of professional knowledge/skills and the critical role of clinical decision making. It became



clear that the drive for productivity had offered nursing staff and (to a lesser extent) EDAs an opportunity for professionalisation. The ED team/cultural domain was focused on a cohesive team socialised to the rituals of the department and Emergency Medicine. Data from this domain also revealed that for many HCPs the LT inspired change programme had been seen as productive, but the failure to secure a longer term cultural change had effectively rendered it obsolete. In the fourth domain of productive healthcare, HCPs described productive care in terms of the processual changes they had experienced, especially those that had been sustained once the enthusiasm for the change programme had waned. The final (economic) domain was the least discussed by HCPs, but was still seen as a critical consideration for contemporary productive healthcare.

This work stands apart from previous studies in identifying that HCPs accept responsibility for productivity as a contemporary professional duty, one that is critical to practice and practice development. The multiple perspectives reflect the 'slippery' and contested nature of healthcare productivity previously alluded to by other authors (Berwick, 2005; Black, 2012; Black *et al.*, 2006).

The relevance of this data is the demonstration that productivity is identified by HCPs as a contemporary professional duty, and that normative beliefs about productive professional work encompass organisational as well as occupational logics (Evetts, 2011). This seems to suggest that the pre-conditions for the notion of self-governance (as suggested within the discourses on productivity and Darzi's notion of new professionalism) (Horton, 2008) were, at least in part, established.

#### 8.2.4 Summarising Chapter 7 – Seeking new professionalism: Political ideal or lived reality?

The purpose of Chapter seven was to examine the ways in which organisational influences affected productive professional work in the ED. The data revealed that two modes of governance co-existed: self-governance as promulgated at national and local political levels, but also a pervasive and persistent top-down mode of governance that related to panopticism and disciplinary control. The tension between these modes of governance was expressed and enacted by participants as problematics of quantification; external scrutiny and surveillance; and the perceived threat to the craft of emergency medicine and nursing care. A key finding was the way in which competing temporalities underpinned these problematics, and the typologies of clock-time versus process-time were used to provide a theoretical foundation (Davies, 1994).

The four-hour target was the most widely articulated representation of clock-time during the study. This was perceived by HCPs to be the metric valued organisationally as being most representative of productivity, despite the introduction of quality indicators in 2011 (College of Emergency Medicine, 2011). Cooke (2012:435) supports this position arguing that *“the reason for establishing the clinical quality indicators was to provide a broader picture and encourage a more sophisticated debate”*. HCPs believed that the dominance of clock-time not only failed to capture excellence and quality within healthcare work, but could also potentially drive clinical behaviours that were contrary to professional principles of the essence of care. The view that time-focused targets fail to promote quality care has previously been reported by Beattie *et al.* (2012), whose cross-sectional survey of 81 ED patients concluded that the

length of wait time was not associated with patients' perceptions of care quality. Within this study of Rushton ED, the HCPs' notions of productive practice as an intimate relationship between productivity, quality and safety were often threatened by the dominance of clock-time. This position was further reinforced by the burden of external scrutiny and surveillance that extended far beyond the geographical confines of the department. This scrutiny was associated with disciplinary power, and was apparently internalised by all occupational groups at all grades. This co-existing authoritarian mode of governance – one that HCPs believed to be the embodiment of 'organisational productivity' - appeared to be at odds with the suggested premise of self-governance and 'professional productivity'.

This chapter shows that ED HCPs did indeed attempt to straddle the multiple temporalities. Where possible, HCPs endeavoured to work to the 4-hour target and believed that it had brought some beneficial changes. Indeed, some of the HCPs had been able to extend their own occupational jurisdiction as a direct result of the organisational desire to meet the target. However, there were occasions when the dominance of clock time influenced professional sensibilities to such an extent that HCPs described their work as industrialised, and the ED production line as undesirable. Under these conditions, the authoritarian mode of governance was usually actively contested, and HCPs would invariably exercise power of veto, justifying this position by recourse to arguments of complexity, tacit knowledge and resource-demand imbalance.

In this final chapter, the objective is to unpick the 'horizontal' themes that traverse the 'vertical' arguments presented within the body of the thesis

(Figure 43). Allowing these horizontal themes to coalesce will draw to a conclusion the narrative thread that has permeated this work. The amalgamation of the horizontal themes will draw upon the literature presented within Chapter two, as well as the study's research objectives.

Chapter 4	Chapter 5	Chapter 6	Chapter 7
Flow is the embodiment of productivity in the ED	Productivity discourse does not represent act of deprofessionalisation	HCPs accept responsibility for productivity and construct multiple perspectives of productive healthcare	In the organisational context, problematics exist for notion of self-governance and new professionalism
Premise of new professionalism: redefining duty/accountability			
'Productivity' influences the way in which space/technology is used, professional roles configured and patients prioritised	Discourse constructs notion of new professionalism, whereby individual HCPs are responsibilised (via process of self-governance) for productive healthcare	These perspectives are characterised by 5 domains	Problematics relate to authoritarian governance and perceived industrialisation of craftwork
Multi-dimensional nature of productivity in the way that it is contested and shapes the social			
HCPs actively intervene to improve flow within the department	National and local discourses linked via the use of professionalism as a rationality of government	Domains can be traced to both logics of the profession and the organisation	HCPs mediate responses to resist authoritarian governance when professional subjectivities challenged
The empirical interplay between modes of governance			
Productivity is an inherent part of everyday work in ED		Pre-conditions for self-governance established	
'Producing' professional identity			

Figure 43: Vertical arguments and horizontal themes

### 8.3 Productivity and professionalism – The horizontal arguments

#### 8.3.1 The premise of new professionalism – redefining duty and accountability

The premise of 'new professionalism' is a well-rehearsed argument in healthcare (Christmas and Millward, 2011; Evetts, 2011; Spyridonidis and Calnan, 2011). This work demonstrates that the drive for productivity represents a novel flavour of new professionalism whereby all HCPs are

identified as responsible and accountable for delivering and/or improving productive healthcare. This has been demonstrated theoretically via discourses at national/local level (the call for a new 'productive' professionalism) and also at the level of praxis. For, in constructing their notions of productivity, Rushton's ED HCPs identified productive healthcare as a contemporary professional duty at an individual level. This was demonstrated in a number of ways; for example, identifying a duty to the taxpayer, and (for many) engaging with productivity improvement technologies: *self-evaluating* productive performance, designing and constructing *professional* strategies for improvement, and participating in *reflexive* re-evaluation and re-design as necessary.

It is perhaps interesting to consider why HCPs might have elected to adopt this position. Whose interests ultimately prevailed when professionalism was constructed in this way? Acceptance of the responsibility for productive healthcare offered the professions a route to self-governance and therefore a potential opportunity to strengthen professional jurisdiction. It has been suggested that redefining professionalism in a way that encompasses organisational as well as occupational logics is highly relevant in ambiguous domains with escalating demands and limited capacity (Noordegraaf, 2007). New 'productive' professionalism may therefore have offered opportunities to maintain or preserve professionalism in an age or context where this concept has become undermined. Furthermore, the notion of 'partnership' advocated by new professionalism could have provided a more secure organisational foundation for enhancing professional authority (Freidson, 1984). It is also worthwhile moving beyond the level of the individual and considering the social effects of embracing new 'productive' professionalism

within Rushton ED. Emergency medicine is a relatively new speciality compared to other well-established disciplines (Fatovich, 2002). The kudos afforded by participation in the change programme served to bolster the stature of Rushton ED at local, national and international levels, depicting emergency medicine as fiscally responsible, responsive, creative and innovative.

However, all these gains incur a notional price tag. The discourses make little reference to which of the productivity measures professionals would be held accountable, nor what the consequences of perceived failure would be. Although policy makers professed to support professional autonomy as a method of securing economic stability (rather than an obstacle to be managed) this may be viewed as the state/organisation divesting itself of the obligation for healthcare productivity, yet controlling it more surreptitiously from a distance via technologies of government that include audits, standards and targets (Rose *et al.*, 2006).

Doolin (2002) states that such discourses of professionalism have a performative function defining and delimiting certain subjectivities and futures. What cannot be accurately elucidated from this data is, which elements of the discourses had been most influential in this acceptance of productivity as a contemporary professional duty? Few HCPs made reference to the national discourse without prompting, however the majority discussed the influence of local discourses related to the Committed to Care/You programmes. It could also be argued that other, more general discourses around austerity and accountability had been influential; for example, enterprise or market-related discourse (Doolin, 2002) or those that

promoted ethical consumerism and fiscally responsible citizenship (Malpass *et al.*, 2007). Certainly a number of participants discussed the importance of productivity relative to their personal lives; for example, managing a personal budget, housekeeping and fulfilling external roles such as a school governor.

It would be epistemologically and methodologically flawed to claim that the data proved or disproved any particular causal relationship. Perhaps a more apposite aim is to discover not why ED HCPs adopted certain notions of productivity, but rather to interrogate the notions themselves. This approach opens up a space to examine the effects such notions have socially for HCPs and their work, with the aim of presenting an alternative perspective on the black-box of healthcare productivity. This perspective will be considered next.

### **8.3.2 The multi-dimensional nature of productivity in the way that it is contested and shapes the social**

HCPs constructed their notions of productivity in healthcare around a model that was characterised by 5 co-existing domains. These domains were infused with both occupational and organisational logics. Whilst those domains characterised by their allegiance to occupational logics were most widely discussed by HCPs, there was a clear sense that the organisational – the process and economic domains - could not be marginalised.

A body of literature exists that theoretically and empirically supports a paradigmatic shift towards the form of professionalism described above whereby traditional professional values and objectives are increasingly re-

fashioned and re-defined through the apparatus of the organisation (Bezes *et al.*, 2012; Evetts, 2012, 2011). In their work with globalising law firms, Faulconbridge and Muzio (2008:20) acknowledge this mode of professionalism, yet suggest that *“these organisational tactics and mechanisms are ultimately defined and influenced by professional interests”*. This renegotiation of boundaries between professional and organisational interests has been described by others, who demonstrated that primary socialisation remains oriented towards professional and clinical sensibilities (Cohen and Musson, 2000; Doolin, 2002). For some ED HCPs – those who assumed the role of change champions - this process of renegotiation was particularly profound. These individuals assumed a 2-way window role (Llewellyn, 2001) and were important ‘legitimaters’ or role models (Ibarra, 1999) for other HCPs. Indeed there was evidence that when these individuals stepped down from the change champion’s role, other HCPs’ subjectivities changed and engagement with the change programme waned.

This study demonstrates that consideration of the terms ‘productivity’ and ‘productive work’ as multi-dimensional constituted a form of identity work, permitting HCPs to mediate their new professional position. In particular, contemporary notions of new professionalism (Christmas and Millward, 2011; Evetts, 2011; Spyridonidis and Calnan, 2011), specifically the new ‘productive’ professionalism proposed within this study, could be accommodated whilst still preserving (and privileging) traditional occupational values. Constructing productivity in this manner could be perceived as a positive internal assessment of congruence (Ibarra, 1999) or an act of ‘reconciliation’ or ‘mediation’ between the culture of caring and the culture of efficiency (Radnor, 2010). Similar effects have been noted with



other 'elastic' policy devices and political discourses such as clinical governance. Flynn (2002:158) suggests that the discursive flexibility of that term may *"be a factor which eventually contributes to its widespread acceptance"*. This study demonstrates that productivity, as a multi-dimensional construct, is not necessarily a notion that is antithetical to that of professionalism.

The multi-dimensional construction of productivity thereby created particular agential opportunities for HCPs; for example, permitting certain organisational issues or changes to be contested or discredited as non-productive. By ensuring that the qualitative domains of productivity were appropriately weighted, HCPs were able to legitimately challenge productivity improvement strategies that were perceived to be purely associated with reducing costs or increasing the rate of throughput; for example, the decision to use un-chaperoned EDAs to transfer patients to the wards. Indeed, it became apparent at an early stage of the study that HCPs believed the organisational view of productivity to be different to that of their own. Whilst I have referred to these states as 'organisational productivity' and 'professional productivity' respectively, they are in fact two sides of the same coin with differing subject positions affording differing primacy to the various domains of productivity. Conversely, HCPs utilised the multiple domains of productivity to sanction certain personal projects such as a proposed trial of patient cooling systems during cardiac arrest or the regular attenders' project.

It might be argued that the multiple perspectives of productivity do not represent a professional strategy, but instead could be attributed to the confusion and uncertainty regarding the semantics of the term. The literature

has indeed reflected the relative enigma related to capturing healthcare productivity (Berwick, 2005; Black *et al.*, 2006; Smith, 2010). In their work considering managerial perceptions of productivity in the Finnish public sector, Linna *et al.* (2010) noted that the term was not well understood by many respondents, and definitions covered a wide spectrum. These authors offered speculative thoughts regarding this apparent uncertainty; for example, the relative novelty of productivity in professional parlance, or the complexity or sensitivity of the concept. However, in this study, whilst there were undoubtedly some ED HCPs who had less well formulated ideas of productivity, all had been exposed to national and organisational discourses and as such had opportunities to form opinions and subject positions. The sensitivity of healthcare productivity was a relatively unanticipated phenomenon, and additional preparatory work had to be undertaken in order to reassure participants that study data would not be traceable to individuals. Consequently, once the study participants understood the remit of the study, the majority were most forthcoming in offering their views of productive healthcare. This situation was undoubtedly ameliorated by the methodological approach: as an ethnographic researcher I was able to earn participants' trust over a period of time and become privy to a number of encounters that might otherwise have remained concealed. In addition, awareness of the relative morass regarding the definition of healthcare productivity prior to entering the field allowed me to carefully consider my data collection techniques. This knowledge reinforced my commitment to multi-modal data collection strategies and underpinned the deliberate construction of the opening questions during the semi-structured interviews.

Given the enormous semantic footprint generated by the notion of productivity, how useful is the data generated by this study illustrating how HCPs understand and perceive productive healthcare? Linna *et al.* (2010:311) suggest that:

*“There is a jungle of definitions [for public service productivity]... in practical contexts, definitions are not that relevant in themselves... the crucial issue is how people grasp the aims of the operations in their own field... and how these aims may be achieved”.*

To some extent I support this claim. As the data from this study clearly illustrates there is a potential minefield to be navigated attempting to ‘nail down’ a concrete definition of productivity that reflects all the interests of a diverse range of HCPs. The essential consideration is, however, that productivity and its attendant discourse is not monolithic, but instead a relative bricolage, one that can be appropriated by HCPs in a number of ways. Consequently, HCPs’ multifarious constructions of the notion of productivity become extremely relevant as they underpin various subject positions and therefore the subsequent agential shaping or re-fashioning of the social field. In terms of productivity improvement in the healthcare milieu, this may be the difference between success and failure in the implementation of particular productivity improvement strategies.

### **8.3.3 The empirical interplay between modes of governance**

A key consideration of this work has been the technologies of power and of the self by which HCPs come to know themselves as ‘productive’ HCPs. Whilst Chapters five and six introduced and developed the idea of new (productive) professionalism as a governmentality, Chapter seven evoked a number of potential problematics for this concept; specifically the co-

existence of an alternative mode of governance, one defined by an authoritarian, panoptic approach and disciplinary control. Whilst they produced different forms of subjectivity, it would arguably be overly deterministic to assume that these two modes of governance were inherently conflicting or competitive. Instead, it is worth reflecting upon the relationship between the two, and the implications that pluralised governance conferred upon productive professional work. This approach has been advocated by other authors (Fischer and Ferlie, 2013; Kurunmäki, 2004). Karreman and Alvesson (2004), using a neo-Weberian perspective, describe an organisational ethnographic case study characterised by superimposed layers of technocratic and socio-ideological control. They depicted an image of “*cages in tandem*” whereby the relative ‘softening’ of the iron cage of bureaucracy was countered by a tightening of the mental cage of subjectivity, with the combined effects exerting greater influence over organisational members’ actions and thoughts (Karreman and Alvesson 2004:149). The two modes of governance were not necessarily considered divergent or incompatible; indeed the authors conclude that the two had a complex and potentially reinforcing relationship. Similarly, in the study of governance of quality and safety in three NHS Trusts, Martin *et al.* (2013) proposed the notion of interdependence, whereby the more subtle governmental influence facilitated a more positive reception of disciplinary power.

Other authors have put these two Foucauldian theories of governance in tension. Knights (2002:580) assumes an historical perspective and describes how “*each power regime can be seen to coexist in a complex melée of conflicting and contradictory discourses, both in the present and in the distant past*”. More generally, Stenson (1998) and McKinlay *et al.* (2012) assert that periodising

Foucault's work into distinct time frames risks eliding many of the foundational continuities. Instead they propose that scholars should consider periods as overlapping layers that create a complex picture and which do not neglect or under-represent multifarious regimes of power. Indeed Stenson (1998) makes specific reference to consideration of the inherent tension between 'centripetal' and 'centrifugal' forces. Hamann (2009) supports this position, citing Foucault himself in a 1978 lecture:

*"...we should not see things as the replacement of a society of sovereignty by a society of discipline, and then of a society of discipline by a society, say, of government. In fact we have a triangle: sovereignty, discipline, and governmental management..." (Foucault, 1978, cited by Hamann, 2009:48)*

In considering the empirical interplay between these two modes of governance, a starting point was to consider a heuristic framework detailing three possible outcomes: dominance of self-governance and professional productivity, dominance of authoritarian control and organisational productivity or a negotiated balance between the two (Figure 44). This framework is adapted from Fischer and Ferlie's (2013) work demonstrating potential modes of governance in the field of risk management. These authors derived distinctions from Foucault's final lectures and the body of literature regarding hybrid forms of regulation.

In Figure 44, column one (professional productivity) portrays a productive subjectivity primarily predicated on traditional occupational principles whereby the productive self is achieved via personal self-governance. Conversely, in column two, organisational productivity is associated with surveillance, adherence to rules and subjugation in the face of external

authority. Column three represents a 'potential' interaction between these modes of governance and resultant subjectivities.

	<b>1. Professional productivity</b>	<b>2. Organisational productivity</b>	<b>3. Negotiated balance</b>
<b>Mode of governance</b>	Self-governance (ethics-oriented)	Authoritarian (rules-based)	Stable and enduring fusion of ethics-oriented and rules-based governance
<b>Professional ethos</b>	Broadly occupational	Broadly organisational	Hybrid
<b>Temporality</b>	Predominantly process time oriented (outcomes)	Predominantly clock time oriented (outputs)	Straddling temporalities
<b>Truth discourses</b>	The truth about productive healthcare is created through subjective experience and co-produced with others. Productivity is achieved via personal self-governance and promotion of the same ethical forms of government in others.	The truth about productive healthcare is calculable and codified. Productivity is achieved via adherence to rules and guaranteeing compliance in others.	The truth about productivity combines codified knowledge with subjective truths. Productivity is achieved via the internalization of codified rules which are assimilated as a form of self-governance.
<b>Practices</b>	Productive practice is self-developed in an iterative manner, with tolerance of deviance. Emphasis is on shared learning.	Productive practice is viewed as an expert technology that warrants surveillance, recording and upward reporting. Self-development requires conformation to externally defined ideals.	Productive practices are internalized, blending expert technologies with indigenous practices.
<b>Reflexivity</b>	Reflexive awareness is directed horizontally, with a focus on self and shared development.	Reflexive awareness is directed vertically, with a focus on second order scrutiny, internalized rules and defensiveness.	Reflexive awareness horizontally is mediated by a self-consciousness towards the authorities' perspectives.
<b>Inter-subjective relations</b>	Productivity is a mutual responsibility within the social field.	Individuals are personally accountable for productivity. Transparency to authority is assured, thereby potentiating blame attribution and discipline.	Responsibility for productivity becomes a shared venture – a balance between intersubjective and authority relations.

**Figure 44: Heuristic framework of possible outcomes in relation to governance and the governed (Adapted from Fischer and Ferlie, 2013:33)**

### **8.3.3.1 Conflict of interests or a negotiated balance...?**

The two modes of governance spoke to HCPs' subjectivities in different ways: the governmentality regime called for productive behaviour/entrepreneurialism as a responsabilised professional; the authoritarian regime demanded productive behaviour as an obedient organisational employee. And yet, for much of the time, the two modes of governance appeared to co-exist. Many HCPs had engaged with the ED change programme, working collaboratively to re-design pathways and processes in ways in which they believed that productivity would be ameliorated (according to the domains of professional productivity). At the same time, they completed their clinical work by abiding to the directive of the 4-hour target and complied with panoptic technologies designed to monitor productive performance. Both modes of governance created potential opportunities for HCPs in terms of professionalism. Under the auspices of self-governance, HCPs had designed professionally desirable productivity improvement strategies, incorporating the development of specific roles which promoted autonomy such as the clinical support worker, the change champion, the paediatric 'front-door' nurse, and the streaming nurse. Equally, the authoritarian/panoptic mode of governance had opened up a potential space for professional enhancement. Here, the professional 'gain' extended its reach to include not just individuals, but HCPs as a collective. Specifically, the use of data generated by EDIS was often utilised on an almost daily basis to demonstrate professional accountability and trustworthiness. For example, data relating to the compliance with the 4 hour target could be presented to the duty nurse managers during bed meetings, to Trust executives during board meetings and disseminated more widely in both organisational and public domains. This is indicative of the changing



professional landscape whereby the culture of performativity shares legitimacy with expert subjective judgement and knowledge (Dent and Whitehead, 2001).

It could also be argued that the two modes of governance conferred advantages for one another, a situation of complementarity (Fischer and Ferlie, 2013; Gendron, 2002). Complementarity refers to (in this case) two modes of governance coming together *“in ways that mutually complete and add value to each other”* (Fischer and Ferlie, 2013). I have proposed that the deployment of new ‘productive’ professionalism as a governmentality had influenced HCPs subjectivities, their thoughts and their actions, ‘diluting’ traditional occupational values and norms with organisational influences. As a result, the NHS as a whole and the organisation in particular, became reconstituted as a business, with patients remodelled as customers or clients. For many HCPs therefore, this went some way towards sanctioning or legitimising the necessity to quantify and measure or balance the accounts:

*“After all, the NHS is a business – it needs to be run like a business” –*  
(SSN2).

It could therefore be suggested that, in this way, HCPs became more compliant with authoritarian/panoptic regimes of productivity governance such as EDIS.

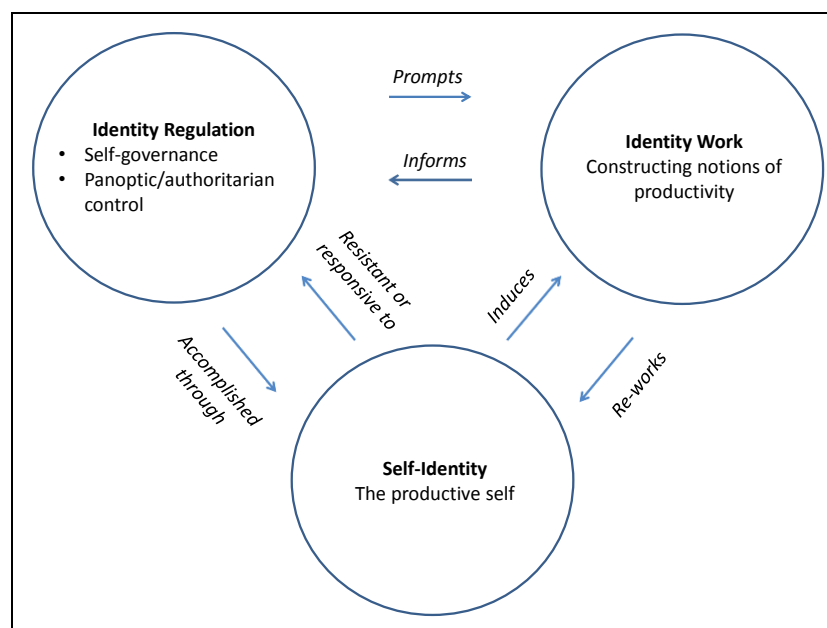
Given the interplay and synergism between the two modes of governance, one might consider that the criteria for position 3, the negotiated balance, were achieved. However, this conclusion would be immanently flawed, as it did not represent a *“stable and enduring”* position (Fischer and Ferlie, 2013:34). Indeed there were numerous times when this notional balance was

disrupted. These were situations whereby the professional ethos of productivity and the craft of emergency medicine (the one that is defined by a temporality based on process time) were deemed to be threatened by the authoritarian mode of governance. Some of the explanations for this disruptive force have been offered in Chapter seven, for example, clinical complexity and resource-demand mismatch. It is at this point that HCPs often asserted their power of veto, thereby resisting authoritarian governance and making the decision to allow the patient to breach. It should be made clear however that the exercise of power could equally move in the other direction: HCPs recounted experiences whereby care was considered sub-optimal because a member of staff had succumbed to authoritarian governance and the organisational pressure of meeting the 4-hour target. Whilst HCPs often ascribed such capitulation to professional inexperience, the data was insufficient to either substantiate or refute this.

To revisit the three possible outcomes, governance of productivity within Rushton ED was evidently not solely based on self-governance or “*governing without government*” (Flynn 2002:169) as suggested by the premise of new ‘productive’ professionalism. Nor was it dominated by an authoritarian/panoptic mode of governance, although the organisation did maintain a significant and pervasive presence. Instead, what emerged was a much more mutable relationship. In this way, rather than representing a novel paradigm of power based solely on governmentality, the governance of productive professional healthcare practice is perhaps best represented by a bipartite arrangement of power: authoritarian and self-governance.

### 8.3.4 'Producing' professional identity

What implications did this complex power dynamic have for ED HCPs? The ebbing and flowing tide of discursive governmental and disciplinary/authoritarian practices (identity regulation), combined with HCPs' own identity work, mediated a near continuous constitution and reconstitution of HCPs' subjectivities. This reinforces the dynamic and interactive nature inherent within Alvesson and Wilmott's (2002) model of self-formation (Figure 45).



**Figure 45: 'Productive' identity regulation, identity work and the productive self (Adapted from Alvesson and Wilmott, 2002)**

Multiple and dynamic subjectivities have previously been described in other studies (Doolin, 2002; Cohen and Musson, 2000). These identities were central to understanding the basis of ED clinicians' responses in terms of practice and behaviour. Depending upon the dominant mode of governance, and their own agential behaviours, ED HCPs responded to the drive for productivity by enacting professionalism in various ways. In their study of

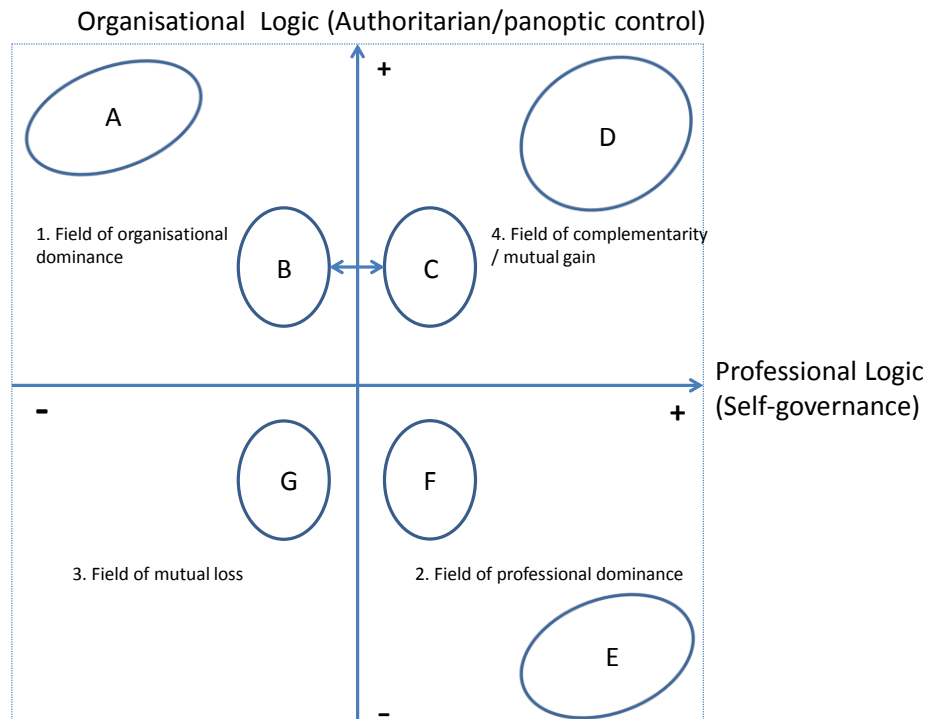
professional responses to healthcare commodification in Holland, Tonkens *et al.* (2013:368) revealed that “*differential levels of autonomy, dominance and discretion spawn different ways of weaving together the market, bureaucratic and professional logics*”. The work of Tonkens *et al.* described five professional responses, three of which were clearly demonstrated within this study: entrepreneurialism (embracing productivity as an integral constituent of professionalism, and potentially an opportunity to expand it), activism (resisting the encroachment of ‘organisational productivity’ on professionalism), and bureaucratisation (conforming to ‘organisational productivity’ to the detriment of ‘professional productivity’). Tonkens *et al.* (2013) also demonstrated pretending (faking compliance to protect professional autonomy) and performing (a smoke and mirrors construction in order to uphold the appearance of the profession in the eyes of the patients/public). During the study of Rushton ED, there was no evidence of the former. This may be explained by the fact that some years previously, Rushton ED had been subject to a full-scale, and high-profile, investigation regarding alleged allegations of ‘gaming’ the 4-hour target by misreporting on EDIS. Whilst the department had been exonerated of blame (the misreporting being attributed to error and misunderstanding rather than malicious intent), the issue remained contentious and delicate for many HCPs. Whilst there were no overt indications of performing in the way that Tonkens’ team demonstrated, performance per se was clearly a consideration for Rushton HCPs as evidenced by the expressions of concern regarding patients’ perceptions of changes instigated via the ED change programme.

Consequently, at Rushton, the two co-existing modes of governance contributed to the production of a range of productive professional identities

that HCPs moved between. This is in keeping with Hall's (1996:4) position on identities which he claims "*are never unified... never singular but multiply constructed across different, often intersecting and antagonistic discourses, practices and positions*", and where identity (and the process of identification) is not essentialist but contingent and positional. Baumann uses the notion of recycling to analogue this postmodern approach to identity:

*"... one might say that if the media... of modernity was the photographic paper (think of the relentlessly swelling family albums, tracing page by yellowing page the slow accretion of irreversible and non-erasable identity-yielding events), the ultimately postmodern medium is the videotape (eminently erasable and re-usable, calculated not to hold anything forever, admitting today's events solely on condition of effacing yesterday's ones, oozing the message of universal 'until-further-noticeness'..." (Bauman, 1996:18).*

Hall constructs identity as a meeting point or suture line between the discourses and practices that endeavour to produce certain subjectivities. He believes that the resultant identity constitutes a "*temporary attachment to [that] subject position*" (Hall, 1996:6). The key point here, and relevant to the ethnographic findings, is the notion of temporary attachment. What is seen amongst Rushton ED HCPs is an intermittent *detachment* from a new 'productive' professionalism subject position and *reattachment* to other subject positions, influenced in the main by the differing, but co-existent, discourses of governance.



**Figure 46: Subject positions created by the interplay of co-existing modes of governance**

Figure 46 depicts how these identities or subject positions may be mapped over four quadrants, created by the interplay of the two modes of governance: Organisational logic and authoritarian/panoptic control on an ascending vertical axis, and professional logic and self-governance on an ascending horizontal axis. The quadrants will be described in turn.

#### **8.3.4.1 Quadrant 1: The field of organisational dominance**

This quadrant represents the field of organisational dominance where the professional subjectivity is characterised as professional-passive. HCPs occupied this domain (position A, Figure 46) during the periods where they were disciplined against the 4 hour target or clinical decisions were challenged or over-ruled by the organisation. Such actions were usually justified by the epistemic claims of organisational management, and were associated with shame and stress for HCPs, often predisposing them to

undertake safety-netting behaviours. To a lesser extent, HCPs also occupied this quadrant during particular stages of the patient's journey (position B, Figure 46). For example, the inevitability of starting the clock on patient admission; responding to organisational targets such as 'time to initial assessment' and 'time to decision maker'; or towards the end of the patient journey as the clock ticked towards the magical figure of 4 hours. Whilst in this domain, HCPs were seen to adapt clinical space and technology to meet organisational demands, prioritise their patients against organisationally defined codes/criteria, and demonstrate compliance with EDIS. This domain was associated with some level of professional compromise, and is best represented by an observation from a senior doctor who claimed that the organisation's perception of 'good emergency medicine' was not necessarily what he considered to be 'good medicine'.

#### **8.3.4.2 Quadrant 2: The field of professional dominance**

Conversely, the second quadrant represents the field of professional dominance and a subjectivity that may be described as professional-ethical. Here professionals were resistant to organisational demands (position E, Figure 46) and instead elected to permit breaches of the 4 hour target, or failed to engage with or sustain productivity improvement strategies. These subjectivities were justified by professional epistemic claims to tacit knowledge, ethical and compassionate care, and in the case of attempted process improvement, the claims to knowledge of 'what works around here'. Again, there was a less extreme position within this domain that was predominantly driven by spatiotemporal issues (position F, Figure 46). For example, for those staff working within the resuscitation department of the ED, there was an unspoken acceptance that the only temporal issues to apply

were those that related to the physiology of the patient, and not the meeting of organisational targets. The patients in the resuscitation department were treated as 'clinical exclusions', therefore allowing the professional ethos to dominate.

#### **8.3.4.3 Quadrant 3: The field of mutual loss**

In the third quadrant, both organisational and professional logics are constrained; for example when bed blocked patients became 'parked' in loose spaces within the ED because of resource issues external to the ED or the organisation as a whole. This resulted in a disempowered professional subjectivity, which left HCPs frustrated and loathe to pursue further attempts to improve ED flow.

#### **8.3.4.4 Quadrant 4: The field of complementarity**

In the final quadrant – the field of complementarity or mutual gain - the subjectivities are portrayed as professional-entrepreneurial. Position D (Figure 46) was exemplified by those HCPs who had engaged wholeheartedly with strategies intended to improve compliance with organisational targets, whilst simultaneously extending their own occupational jurisdiction under the guise of productivity improvement. Equally, this position was also represented by the duty nurse manager moving patients out of ED (against the 4 hour target) to create capacity and free resources, thereby allowing HCPs to focus on the management of sicker patients in the resuscitation department or area 3. Once again, there was a less extreme position within this domain (position C, Figure 46), represented by transition to the 'middle phase' of the patients journey, where professional expertise became more dominant during clinical assessment.



Positions B and C were closely linked – HCPs often moved backwards and forwards between the two. This quadrant essentially represents the productive professionalism conceptualised within Chapter five, and would constitute a true hybrid approach if it were stable and sustained. My observation was that some HCPs were far more willing to move to this domain than others, and an interesting question is raised as to why this was so.

This depiction of shifting subjectivities across a number of domains has previously been acknowledged in the literature. Halford and Leonard (1999:115), for example, noted the “*instability of identity*” over space and time. They have built on the work of Bauman (1996) who rejects the gradual, chronological formation of identity and instead proposes that “[t]ime is no longer a river, but a collection of pools and ponds”. Halford and Leonard (1999:115) develop this notion further by problematisation of direction, scale and space, asking:

“... could it be that individuals move **backwards and sideways**, as well as **forward**, between identities? And could it be that these shifts take place within **days or even hours**, rather than across years or lifetimes? In addition...an individual’s sense of self may shift between... **spaces within organisations**” (my emphasis).

This ethnographic study of Rushton ED has demonstrated that this hypothesis is indeed plausible. In particular it has illustrated empirically the shifting subjectivities and the non-linear nature of such transitions. An interesting feature is the influence of space and time, with some geographical areas (e.g. resuscitation, the Hub) and stages of the patient journey more likely to be dominated by professional modes of governance and others by

authoritarian governance (e.g. zones 2 and 3). Temporal differentiation was also seen in terms of role switching; for example, in the case of the senior nurses, being the nurse in charge one day, and a 'hands-on' clinician the next. Such spatio-temporal differentiation has previously been noted by Gotsi *et al.* (2010) in their study of creative workers employed within new product design consultancies.

#### **8.4 Concluding thoughts:**

This work has been concerned with the ontological relationship between professional healthcare work and identity. In particular it has adopted, as a focus, the notion of productivity – a political panacea for the long-term future of the NHS. The research has sought to explore the macro and meso level discourses that frame productivity and productive healthcare. It has revealed that these discourses construct productivity as a contemporary professional duty, a form of governmentality whereby the HCPs themselves are required to assume responsibility for productive healthcare. By exploring productive healthcare within the ED, it has been possible to examine the identity work undertaken by ED staff in response to such discourses.

The data has demonstrated that on many occasions, HCPs would refer to productive practice within the ED as a *desirable* production line – the patient/client was placed at the centre, the interventions were on the conveyor belt, and the HCPs were collectively in control of the interventions available and the speed at which the belt moved. The endeavour was to maintain forward motion of the conveyor belt (for the good of both the patient and the organisation), but HCPs preserved considerable autonomy in the judicious adjustment of rate in order to meet the needs and complexities

of the clients. There was also an awareness that the end 'product' had to engender client satisfaction, incur minimal 'waste', and be of high quality, safe and economically viable. Successful productivity improvement strategies, both formal and informal, were designed and sustained (by HCPs) to support this model of productive work. In this manner, it could be argued that HCPs were accepting of self-governance and demonstrated the new 'productive' professionalism that was proposed in Chapter five.

Constructing notions of productivity that encompassed both occupational and organisational logics was an example of identity work that was significant in the assumption of this new professional subjectivity.

Translating this desirable production line into an organisational setting however exposed it to a number of *potential* problematics, in particular a different form of governance, one characterised by an alternative ethos, authoritarian and panoptic control, and influenced by numbers, clock time and targets. At this juncture, the nature of the production line was often perceived by HCPs as potentially *undesirable*. It was now believed (particularly during times of resource-demand mismatch or cases of high clinical complexity) to circulate around the organisation rather than the patient/client. HCPs were limited by the repertoire of interventions available, and whilst forward motion of the conveyor belt remained an essential criterion of productive work, it now marched to the beat of a different drummer – an organisational ethos geared towards a different temporality – one of clock time and targets. To this end, HCPs believed that productivity had become organisationally re-shaped and re-branded as being solely concerned with the 4-hour target. Here again there was evidence that this influenced professional subjectivities, for example, expressing fear of being

disciplined, and compliance with monitoring to avoid further scrutiny and discipline. Indeed, much of the time ED HCPs would strive to organise their work in such a way as to ensure that the 4 hour target was achieved.

HCPs had traditionally derived their identity in a particular way – imbued with notions of public service and ‘professional’ values bestowed by society. However, this study has demonstrated that a ‘form’ of professional identity existed in the ED that was influenced by both occupational and organisational discourses. For the ED HCPs at Rushton, a productive professional identity was a complex interplay of identity regulation and identity work. But rather than the resultant identity being a static hybrid, it was instead represented as a flux, not unlike the heuristic continuum (depicting the interplay between managerialism and professionalism) postulated by Noordegraaf (2011) and reproduced in Figure 2.1. In a similar manner to Halford and Leonard, I propose that this identity was continuously reconstituted. This process was not random but rather highly structured, depending primarily upon dominant discourses of governance, which in turn were influenced by a range of factors including place, time, resources and knowledge. These factors serve to “*interrupt, prevent or disturb the smooth insertion of individuals into the subject positions constructed by [influential] discourses*” (Hall, 1996:11). The work of Martin *et al.* (2013:8) provides some support for this premise in the suggestion that at micro-level the interaction of “*governmental and disciplinary power, constitutes a starting point for professional transformation – not a determinate process that either achieves the predefined ends of external authority or is foiled by individual resistance*”.

Tonkens *et al.* (2013) suggest that rather than chasing typologies of professionalism, the researcher's intent should be to capture the ways that professionalism is multifariously acted upon. This then permits an exposé of power dynamics that are inherently variable and contingent which may otherwise be elided were a static, ideal-typical model of professionalism pursued. Like Tonkens *et al.* (2013) this study has demonstrated how ED HCPs responded to the call for productive healthcare and productivity improvement in a multitude of ways, revealing dynamic, ever-changing power relations. In terms of the ontological nature of the relationship between work and identity, the findings do not support a traditional structure-agency dichotomy (Halford and Leonard, 1999). Instead what is suggested is a complex, non-linear picture whereby structural and agential elements interact and intersect with differing magnitudes and directions to create a range of possible subjectivities.

## **8.5 Theoretical and methodological limitations of the study**

The advantages conferred by adopting a governmentality perspective as a theoretical lens have been documented in Chapter two. However, as a theory it is not without its critics (Newton, 1998; Thompson and Ackroyd, 1995), and these will be represented here, together with the implications for the study findings. The concept of governmentality has been accused of determinism by insufficiently accommodating the ontological position of the subject: *"there has been a merger of the subject with a general ontology of discourse, power and historical events such that there is no longer anything self-defining or distinctive about this subject itself"* (Blackman *et al.*, 2008:8). Furthermore, some have suggested that although Foucault's work offers powerful accounts of the construction of subject positions, it fails to elucidate why some

individuals assume certain subject positions over others (Hall, 1996). In this way, the study findings could be accused of favouring a structuralist approach, paying insufficient attention to agency. Governmentality studies have also been criticised for a lack of empirical reality, with the suggestion that their outputs are diagnostic rather than descriptive (McKee, 2009). In an attempt to address both this criticism, and that of eliding the subject, an approach advocated by Stenson (1998) was adopted which cast an ethnographic gaze over the mentalities of rule *within* their local context:

*“By analysing the **interplay between discourse and its effects in the real**, it overcomes a narrow focus on text-as-evidence... and therefore addresses the potential disconnection between mentalities of rule and governing practices” (McKee, 2009:479, emphasis added).*

This approach also acknowledged that HCPs were reflexive in their self-construction (Barnett *et al.*, 2008) and could accommodate and adapt, contest or obstruct attempts at productivity governance. This is in keeping with Foucault’s later work where, under the pseudonym ‘Florence’, Foucault suggested that the subject was not a passive victim of subjugation, but rather one *“capable of knowing, analysing and ultimately altering reality”* (Foucault (under pseudonym Florence), 1984). Consequently, such an approach ensured sensitivity to temporal, spatial and social contingencies, and prevented other macro, meso and micro level factors (such as the co-existent mode of authoritarian governance) being overlooked by *“draw[ing] together the politics that inform the making of particular governmentalist regimes with the witches ‘brew’ of everyday practices”* (McKinlay *et al.*, 2012:9). In this fashion, Foucault’s work has been applied to this study in a way that acknowledges

employee subjectivity as a “*self-formation process*” (Knights and McCabe, 2000: 422) and preserves the notion of the individual as an active agent.

It is perhaps also worth considering other theoretical positions that might have been elucidatory. In the analysis of the multiple perspectives of productivity presented within Chapter six, I elected to use a theoretical perspective derived from the sociology of the professions. As the implementation of a change programme predicated on LT had been influential in HCPs representations, an adjunct to this approach might have been to adopt a position from the field of Science, technology and society (STS). This perspective accepts that technologies that are promoted at a global standard are often redefined at localised levels (Webster, 2007), with professional and inter-professional dynamics having a significant effect on the embodiment of technology within practice (Berg and Mol, 1998; Heath *et al.*, 2003; Tjora, 2000). Acceptance of new technology is driven by negotiations regarding ownership, role and jurisdictions, and may be used opportunistically, embedding values and beliefs that are not necessarily universally shared (Berg, 1999; Dent, 1990; Korica, and Molloy, 2010). Using a more relational, STS approach would have considered the ways in which productivity had been historically constructed within the ED via the introduction of ‘technologies’ such as LT, but also the influence of EDIS (and its pre-cursors), time targets, e-rostering systems, and design of the geographical space, the shifts and certain ED practitioners’ roles.

The nature of the ED as a complex and time-pressured environment has been well represented throughout this study. Whilst this complexity is undoubtedly an immanent feature of emergency medicine, it was also highly

influential in the methodological conduct of the study. The interviewees were recruited using a purposive sampling technique aimed at securing appropriate representation. The variability of workplace demands, however, rendered this approach difficult. Some prospective interviewees found it difficult to identify a suitable timeslot, and on many occasions, pre-existing arrangements had to be cancelled, or interviews foreshortened, because of competing pressures. Consequently, it would be entirely feasible to question the representation of certain groups via interview data alone. In particular, the junior doctors and less experienced EDAs proved to be particularly difficult cohorts to access. The ethnographic, multi-modal, approach did however go some way to mitigating these problems. Whilst I was unable to secure interviews with more than two junior doctors and one junior EDA, I chatted informally with, and observed the actions of many more. Despite this, a larger amount of interview data from these groups would have permitted greater comparison across occupations.

In designing this study, the decision was made to focus on the beliefs and experiences of those HCPs with a clinical responsibility. This meant that whilst a number of 'clinical managers' were interviewed during the course of this study, non-clinical managers or Trust executives were not. Consequently, the representations of 'organisational productivity' within this study arise from researcher observations and HCPs' perceptions. Whilst inclusion of these non-clinical managers and executives would have provided an interesting perspective, the intention of the study to investigate HCP identity substantiates their exclusion.



## 8.6 Contributions

In considering the potential contributions of the study findings, it is essential to briefly consider the generalisability of ethnographic data. Whilst it was not the intention of this ethnographic study to make broad-brush conclusions that could be translated wholesale from one environment to another, a more modest aspiration was to develop an understanding of power, professional subjectivity and contemporary healthcare organisation that might also be meaningful and have utility beyond Rushton (Doolin, 2002). Arguably, ethnographic studies are well suited to this approach as the provision of thick description allows the reader to draw relevant conclusions regarding inferential and theoretical generalisation (O'Reilly, 2012; Ritchie and Lewis, 2003). The following sections consider how the findings may be of relevance in the contexts of research and practice/policy.

### 8.6.1 For research

Ritchie and Lewis (2003:267) propose that the significance of new theory should be tested by further empirical study:

*“Rather than seeing theory as fixed and immutable, it is perhaps better understood as a fluid collection of principles and hypotheses. The relevance of these can only be asserted with varying degrees of certainty depending on the extent to which research... exists to support them”.*

This study's findings make potential theoretical contributions worthy of further investigation. Significantly, this work has proposed a model of productivity (as understood by ED HCPs) that is underpinned by both organisational and occupational logics. Further work to test this model in other EDs is indicated. Whilst Rushton could be considered representative of other EDs (thereby potentially supporting inferential and theoretical

generalisation), the same assumption cannot be made for other clinical specialisms. Indeed, provisional data emerging from a study within palliative care and neurology suggest that the organisational domains of productivity are much less pronounced (Field-Richards and Timmons, 2013). Exploring HCPs construction of productivity in a range of specialisms, and amongst a more diverse group of HCPs, would permit the construction of a more robust model of productive professional work and concomitant subjectivities.

The ethnographic findings have also served to support or develop earlier theoretical contributions. For example, the data builds upon Nugus' (2007) proposition of ED work as a notional carousel, in this case adapting it to a production line, and introducing the idea of a dualism – at times desirable, at other times undesirable. Nugus (2007:310) has suggested the construction of an “*international map*” in order to align models of EDs, and this work goes some way to responding to that call. The findings also contribute theoretically to the sociology of the professions literature by considering and extending the debate around ‘new professionalism’. Given the on-going commitment to exploring professionalism and the nature of autonomy in modern healthcare (Christmas and Millward, 2011), this work constitutes an important addition.

The data has also demonstrated empirically the existence of apparently ‘antagonistic’ modes of governance, and instead demonstrated how they can potentially co-exist in a negotiated balance, and even behave agonistically. This is in keeping with scholarly calls for studies that assume a more nuanced approach to organisational power dynamics (Noordegraaf, 2011),

and that include a range of HCPs rather than doctors alone (Reay and Hinings, 2009). As such, the findings elucidate in greater detail the relationship between professionals and the organisation in times that are increasingly characterised by fiscal constraint, and portray the daily realities of such relations. The study also reveals to some extent the nature of the '*quid pro quo*' between the two parties, that shapes both HCPs' behaviour and ultimately organisational culture (Christmas and Millward, 2011).

Furthermore, the study findings contribute to work on identity, supporting Halford and Leonard's (1999) hypothesis that construction of the 'self' is never complete, but rather a convoluted process of ante-grade, retrograde and tangential steps, in both space and time, that can be manifest even over the course of the patient's journey. How these multiple and shifting identities may trigger tensions (if perceived as contradictory or incompatible) is not entirely clear. Further work on the implications for HCPs, particularly emotional wellbeing and staff retention, would be illuminating.

### **8.6.2 For practice and policy**

It is anticipated that this work, and that which will follow, will have implications for future NHS productivity policy. A key premise underpinning this work has been the conjecture that ignorance of HCPs' notions and priorities in relation to productivity has been a significant contributor to the relative failure of many productivity improvement strategies. As Lim (2010:25) states:

*"The national mantra of productivity will have little resonance in a healthcare system already struggling to cope unless it can be redefined in terms viscerally understood and prioritised by healthcare professionals... Conversely, an inability to help policy makers understand the nuances of*

*healthcare and why the traditional metrics of productivity are insufficient will tar healthcare as belligerent and difficult”.*

Whilst only a single-site study of one medical specialism, this work has demonstrated how productivity improvement in healthcare is rife with complexities, contradictions and uncertainties, and perhaps goes some way to casting light on the, as yet, unrealised task of widespread engagement of HCPs in productivity improvement strategies. Evidence suggests that engaging and sustaining HCPs in a philosophy or culture of productivity and continuous improvement is difficult (Wilkinson *et al.*, 2011). An interesting debate raised is how to promote movement to the field of mutual gain and a professional-entrepreneurial identity. A reasonable starting point would be for policy, strategy and governance arrangements to conceptualise productive professional work in a way that is commensurate with that of HCPs; that is, ensuring that the five domains of ‘professional productivity’ are given credence. Valuing outcome criteria or metrics that relate to all five domains (especially those of the patient, the professional and the ED team/culture) would permit more professionally-meaningful, reflexive monitoring. In this way organisations might be better able to capitalise on the entrepreneurial and creative talents of ED HCPs vis-à-vis productivity, whilst the HCPs would preserve greater autonomy, or as Christmas and Millward (2011:74) suggest, *“the intrinsic motivations of professionals [would be] valued and enabled within an organisation without compromising organisational goals”.*

This work has also cast light on the knowledge and skills that a modern professional requires in order to underpin professionalism in healthcare organisations. In exposing HCPs’ beliefs that productivity improvement

constituted a contemporary professional duty (but one that many felt ill-prepared to deal with) it suggests a need to teach concepts related to productive healthcare, productivity improvement and problem identification as both an undergraduate and postgraduate competence. Such an approach is also clearly associated with ideas of pluralised leadership (Martin and Learmonth, 2011), a 'skill' deemed necessary to encourage and sustain engagement with quality improvement (Wilkinson *et al.*, 2011). Future work considering the nature of leadership and productivity improvement would be enlightening.

The issue of compassion within healthcare is a key focus of current policy. Some have suggested that commodification of health service provision, including the drive for ever-increasing productivity, has destroyed traditional notions of compassion (Ballatt and Campling, 2011), and there is evidence to suggest that the drive for productivity improvement was implicated in the profound failures of care at Mid-Staffordshire NHS Foundation Trust (Francis, 2010). However, this study suggests that it is not the HCP's notion of productivity that is the threat to compassion – indeed compassionate care is conceptualised as productive - but rather the context in which care is delivered, and specifically, the way in which productive practice is governed. This was exemplified by the way in which the ED production line changed from desirable to undesirable, from one that was swift and slick, to one that was dehumanising and industrialised. Consideration of the modes of governance, including the selection of appropriate outcome criteria, could permit productivity gains without jeopardising the provision of safe, empathetic and considerate care to patients. Policy makers also need to acknowledge space for process time if

compassionate care is to be preserved. For example, Colley *et al.*, (2012:391) state that:

*“[o]pportunities must be found at every level of decision making to explain how this type of work requires time to be generated differently; that... caring work should not be reduced to an industrial model of efficiency; that alternative rationalities based on use-values of caring for people should prevail; and that use-values of control... should be opposed. These discussions about time should become part of initial and continuing education for practitioners, integrated into their learning bodies about ethics; and they should be pursued vigorously by professional bodies, trade unions, and service user organisations”.*

EDs in the UK & Ireland are facing their greatest challenge in over a decade (College of Emergency Medicine, 2013), and it is likely that this escalating crisis (House, 2013) will make the focus on healthcare productivity yet more acute. Driven by escalating demands, finite resources, medical staffing issues and flat-line community and social care investment, ED services will inevitably be required to consider how they ‘do more with the same’. Further substantiation and development of the productivity model produced by this study could provide a valuable framework for HCPs and organisations to consider prospective productivity improvement strategies that complement existing process improvement technologies such as LT. In a recent report (‘How to achieve safe, sustainable care in our Emergency Departments?’), the College of Emergency Medicine (2013) proposes continued service/practice re-design and a more holistic quality improvement programme based on Clinical Quality Indicators and patient experience, rather than 4 hour target performance alone. This thesis, in illuminating the complex relationship

between 'productive' healthcare work, professionalism and professional identity, clearly provides valuable empirical support for such an approach.

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## Appendices

## Lean Thinking (LT)

Over the last decade, LT has been trialled across the NHS, and now constitutes a major political focus in terms of process improvement (Proudlove *et al.*, 2008, Crump and Adil, 2009). LT originated in high volume manufacturing Japanese workshops (principally Toyota), is predicated by the concept of providing customer value with minimal waste, and has been described as '*one of the most influential new paradigms in manufacturing*' (Hines *et al.*, 2004). Interest in LT within the west was ignited primarily by publication of the book, *The Machine that Changed the World* (Womack *et al.*, 1990). Five key philosophical concepts are represented in Figure 2.3. Wholesale acceptance of the significance of the '*enabling conditions*' (Lean philosophy or Lean value system) and the practical implementation tools is considered essential to long term success (Hines *et al.*, 2004, Radnor and Walley, 2008:15). LT has been advocated by a number of high profile supporters, namely the US Institute for Healthcare Improvement, the NHS Confederation and the NHS Institute for Innovation and Improvement. Lean is also an integral part of the NHS Institute's Productive Series (Wilson, 2009, Waring & Bishop, 2010). Lean has been demonstrated to make considerable reductions in waste within health care organisations (Fillingham, 2007, Radnor and Walley, 2008, Holden, 2011) however it has also been associated with variable sociocultural consequences, resistance to change (Waring and Bishop, 2010) and issues with ensuring sustainability (Massey and Williams, 2006). Despite its critics, Lean as a technology has systematically continued to grow and evolve since its inception, maintaining its core principles but exploring different organisational applications and contingencies (Hines *et al.*, 2004).

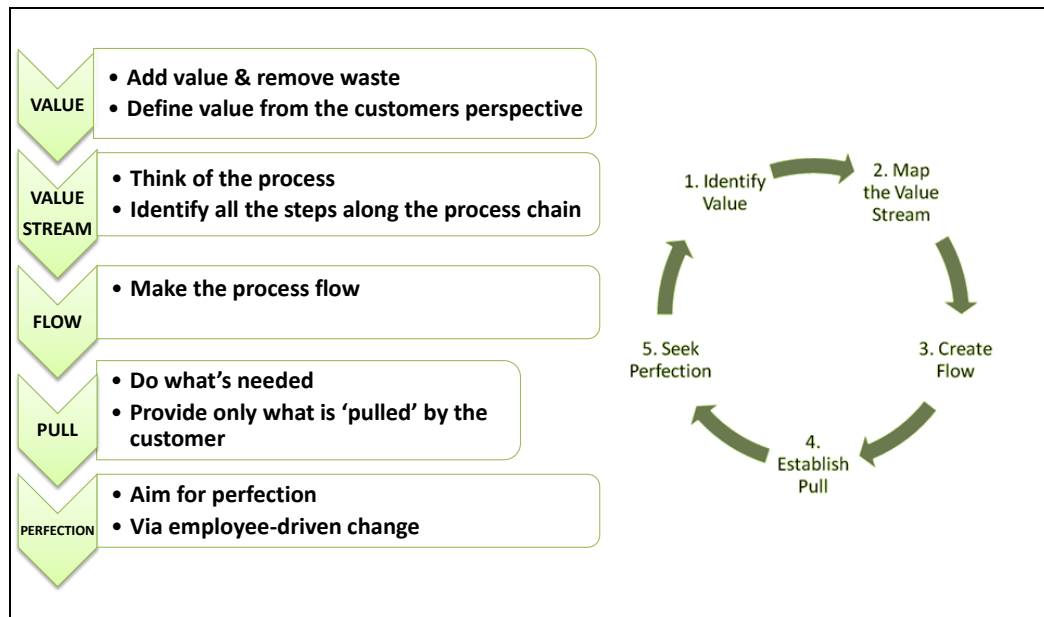


Figure 47: Representation of the Five Pillars of Lean (Lean Enterprise Institute, 2009)

In terms of meeting the productivity agenda, it is therefore apparent that LT, as a 'bottom-up' approach to managing both *value* and *waste* (i.e. addressing quality and costs), is a key contender. Furthermore, in promoting an outward gaze on value, and a collaborative culture of continuous improvement and sustained problem solving, LT has the potential to generate greater improvements in productivity than single-hit ventures. Whilst evidence of sufficient rigour is slowly accumulating, many believe that LT *'has the potential to generate some outstanding savings and changes in mind sets if it is considered as whole-system change that is implemented carefully, with realistic expectations about its impact and ease of adaptation'* (Radnor and Walley, 2008:14).

Direct line/e-mail  
+44 (0) 115 8231063  
Louise.Sabin@nottingham.ac.uk



24th October 2011

Fiona Moffat  
c/o Dr Stephen Timmons  
Associate Professor (Senior Lecturer)  
School of Nursing, Midwifery & Physiotherapy  
QMC Campus  
Nottingham University Hospitals  
Nottingham  
NG7 2UH

Medical School Research Ethics  
Committee  
Division of Therapeutics &  
Molecular Medicine  
D Floor, South Block  
Queen's Medical Centre  
Nottingham  
NG7 2UH

Tel: +44 (0) 115 8231063  
Fax: +44 (0) 115 8231059

Dear Fiona

**Ethics Reference No:** A13102011 HPNP SNMP –please quote on all correspondence

**Study Title:** Healthcare of Professionals' notions: An Ethnography of the  
Emergency Department.

**Lead Investigator:** Dr Stephen Timmons, Associate Professor, School of Nursing,  
Midwifery & Physiotherapy.

**Co Investigators:** Professor Paul Martin, Professor in Science & Technology  
Studies, Faculty of Social Sciences, Fiona Moffat, PhD Student, School of Nursing,  
Midwifery and Physiotherapy.

**Duration of Study:** 1/11/2011-31/07/2012 (9 months)

Thank you for your letter dated 20<sup>th</sup> October 2011 responding to the issues raised by  
the committee and enclosing the following revised documents:

- HPNP Protocol Draft 1.3 Final Version 1.0 date 19/10/2011.
- HPNP Focus Group Guidelines Draft 1.1 Final version 1.0 21/10/11
- Application form dated 10/24/2011.

These have been reviewed and are satisfactory and the study is approved.

Approval is given on the understanding that the Conditions of Approval set out below  
are followed.

#### **Conditions of Approval**

You must follow the protocol agreed and any changes to the protocol will require  
prior Ethics' Committee approval.

This study is approved for the period of active recruitment requested. The  
Committee also provides a further 5 year approval for any necessary work to be  
performed on the study which may arise in the process of publication and peer  
review.

You promptly inform the Chairman of the Research Ethics Committee of

- (i) Deviations from or changes to the protocol which are made to eliminate  
immediate hazards to the research subjects.

- (ii) Any changes that increase the risk to subjects and/or affect significantly the conduct of the research.
- (iii) All adverse drug reactions that are both serious and unexpected.
- (iv) New information that may affect adversely the safety of the subjects or the conduct of the study.
- (v) The attached End of Project Progress Report is completed and returned when the study has finished.

Yours sincerely



**Dr Clodagh Dugdale**  
**Chair, Nottingham University Medical School Research Ethics Committee**

***Healthcare Professionals' Notions of Productivity: An Ethnography of the Emergency Department***

Name of Researcher(s):     Dr Stephen Timmons (Chief Investigator)  
   Mr Frank Coffey (Co-investigator)  
   Professor Paul Martin (Co-investigator)  
   Fiona Moffatt (Principal Investigator)

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

**What is the purpose of the study?**

Healthcare productivity is a major focus of interest. The NHS has tried many methods to improve productivity, yet most fail to reach their full potential. There is virtually no research that explains how UK healthcare professionals perceive productive or efficient practice. We believe that understanding your views will better inform productivity improvement strategies of the future.

**Why have I been invited?**

You are being invited to take part because we feel that your experience as an Emergency Department doctor, nurse, assistant or support worker can contribute much to our understanding and knowledge of healthcare productivity. We are inviting other participants like you to take part.

**Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a

consent form (or give verbal consent in some instances). If you decide to take part you are still free to withdraw at any time and without giving a reason. This would not affect your legal rights.

### **What will happen to me if I take part?**

This research involves a variety of research methods:

- observation (the researcher will 'hang out' as part of the team, observing every day activities in the department, but NOT clinical encounters)
- one-to-one interview (of approximately 30 minutes, exploring your thoughts on productive or efficient practice)
- focus groups (6-10 participants, discussing their thoughts on productive or efficient practice, approximately 1 hour duration)
- document analysis (examination of documents that discuss productivity in the department e.g. training manuals, posters etc)

You can choose to participate in **all**, **some** or **none** of these research activities. The following section describes these activities.

#### *Observation:*

If you agree to participate in observation, you will permit the researcher to observe general daily practice (although this will NOT include clinical encounters). This will involve the researcher working with the ED team periodically (approximately 1 shift per week), where they will be available to help with errands and general admin duties. The process of observation will in no way interfere with your duties. The purpose of the observation is to allow the investigators an insight into the general daily practice of the team (rather than individuals) and how that may influence the way in which healthcare professionals understand workplace productivity. Any 'field notes' recorded during the observation will be confidential, and no-one will be identified by name in these notes. All observations will take place at the participants' discretion, and may be stopped by anyone involved if they feel that it is inappropriate for a specific event to be observed. If you are not willing to participate in the observation you will have opportunity to verbally decline at the start of every shift. In such circumstances, *no observation that includes you will be*



*undertaken*, although the investigator may still be present observing other members of the team working in different areas within the department.

#### *Interviews:*

If you agree to participate in an interview you will be invited to attend a 30 minute session either within a private room in the Emergency Department or at an alternative venue that is convenient for you. We will ask you questions about healthcare productivity and efficiency and give you time to share your knowledge, experiences and beliefs.

If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present (unless you would like someone else to be there). The entire interview will be digitally voice-recorded, but no one will be identified by name.

#### *Focus Groups:*

If you agree to participate in a focus group discussion, you will be invited to attend an hour-long session with 5-9 other people with similar experiences. We will ask you questions about healthcare productivity and efficiency and give you time to share your knowledge, experiences and beliefs. You do not have to divulge anything that you are not comfortable sharing. All focus group participants will be asked to keep what is said in the group confidential. The discussion will take place in the Emergency Department, and only the people who take part in the discussion and the researcher will be present. The entire discussion will be digitally voice-recorded, but no one will be identified by name.

#### *Document Analysis:*

During the course of the study, selected documents that relate to healthcare productivity and efficiency will be collected, and where relevant, extracts used to support other research findings. If you are the author of these documents we will approach you first in order to gain consent for their use.

The study will run from November 2011 until July 2012. The time commitment for participants will depend upon each individual's choice regarding degree of participation. The focus groups will be conducted at the latter end of the study (from April 2012).

## **Expenses and payments**

Participants will not be paid to participate in the study.

## **What are the possible disadvantages and risks of taking part?**

There is a very slight risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics. However, we do not wish for this to happen. You do not have to answer any question if doing so would make you feel uncomfortable.

## **What are the possible benefits of taking part?**

We cannot promise the study will help you, but the information we get from this study may help us find out more about how healthcare professionals perceive productive practice, and how this may influence productivity improvement strategies / policies of the future.

## **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details can be obtained from your hospital.

## **Will my taking part in the study be kept confidential?**

We will follow ethical and legal practice and all information about you will be handled in confidence.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of

confidentiality to you as a research participant and we will do our best to meet this duty.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. Any information about you which leaves the hospital will have your name removed (anonymised) and a unique code will be used so that you cannot be recognised from it.

Your personal data (name, profession, grade) will be kept until the end of the study at which point it will be destroyed. All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

If you take part in a focus group we will ask you and other participants **not** to talk to people outside the group about what was said during the discussion. You should know, however, that we cannot stop or prevent participants who were in the group from sharing things that should be confidential.

### **What will happen if I don't want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

### **What will happen to the results of the research study**

The results of this research will be published as a doctoral thesis in Autumn 2013. At the end of the study we will also present and publish the results via conferences and healthcare journals so that other interested people may learn from the research. An internal report will be made available for the host department. However, nothing will be attributed to you by name.

**Who is organising and funding the research?**

This research is being organised by the University of Nottingham and is being funded by The Foundation for the Sociology of Health and Illness.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The University of Nottingham Research Ethics Committee.

**Further information and contact details**

In the first instance please contact:

Principal Investigator, Fiona Moffatt: School of Nursing, Midwifery and Physiotherapy, University of Nottingham, Queen's Medical Centre, Nottingham NG7 2UH, Tel: 07909907660, email [ntxfm1@nottingham.ac.uk](mailto:ntxfm1@nottingham.ac.uk).

If this does not resolve the matter to your satisfaction then please contact:

Chief Investigator: Dr Stephen Timmons: Division of Nursing, University of Nottingham, Queen's Medical Centre, Nottingham NG7 2UH, Tel: 0115 8230897, email [stephen.timmons@nottingham.ac.uk](mailto:stephen.timmons@nottingham.ac.uk).

**CONSENT FORM FOR INTERVIEWS OR FOCUS GROUPS**  
(Final version 1.0: 01/09/11)

**Title of Study: Healthcare Professionals' Notions of Productivity: An  
Ethnography of the Emergency Department**

**REC ref: A13102011 HPNP SNMP**

**Name of Researchers:** Dr Stephen Timmons (chief investigator)  
Professor Paul Martin (co-investigator)  
Mr Frank Coffey (co-investigator)  
Fiona Moffatt (principal investigator)

**Name of Participant:**

**Please initial box**

1. I confirm that I have read and understand the information sheet version number 1.0 dated 01/09/11 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant sections of data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that the interview/focus group\* will be recorded and that anonymous direct quotes from the interview/focus group\* (\*delete as appropriate) may be used in the study reports. ☐
5. I agree to take part in the above study. ☐

<hr/>	<hr/>	<hr/>
Name of Participant	Date	Signature
<hr/>	<hr/>	<hr/>
Name of Person taking consent	Date	Signature

2 copies: 1 for participant, 1 for the project notes

**CONSENT FORM FOR DOCUMENT USE**  
(Final version 1.0: 01/09/11)

**Title of Study: Healthcare Professionals' Notions of Productivity: An  
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4. I understand that the document will be copied and that anonymous direct quotes from the document may be used in the study reports. ☐
5. I agree to take part in the above study. ☐

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

2 copies: 1 for participant, 1 for the project notes