Reconceptualising Professional Role Reconfiguration in Healthcare: Institutional Work and Influences Around Professional Hierarchy, Accountability and Risk

PhD Student: Nicola Bergin

Supervisors: Dr Hugh Middleton & Prof Graeme Currie

Abstract: This thesis explores the phenomenon of workforce modernisation through the reconfiguration of professional roles, which represents a policy priority in healthcare systems in the United Kingdom (UK) and globally. Heavily informed by conflict or power accounts of professionalism, the literature presents attempts to reconfigure professional roles as opportunities for the reallocation of professional knowledge and expertise and therefore power and status. Existing work emphasises the strategic, competitive activity of professionals to establish, extend and defend jurisdiction in the face of such change. Utilising an organisational neoinstitutional approach this thesis provides a novel theoretical interpretation of the opportunities and threats that the renegotiation of roles presents to the professional groups involved, adding complexity to the accounts that dominate the literature. The thesis draws upon work that describes the evolving nature and function of professionalism to demonstrate that in the contemporary organisational environment, focussed on accountability and risk management, attempts to reconfigure professional roles are understood not only in terms of the transfer of professional knowledge and expertise but the concurrent transfer of accountability for the management of risk. This represents a more complex commodity potentially associated with professional risk in the event of untoward incidents. Using the case of changes to the roles of consultant psychiatrists in the UK National Health Service (NHS) that propose the redistribution of clinical activity and responsibility from psychiatrists across the wider mental health workforce, the thesis demonstrates that rather than competing for jurisdiction associated with the management of significant risk, professionals carefully renegotiate their roles in a manner that ensures the protection, not just of their clients, but of the professionals involved. In this case, despite institutional work from professionals and managers to create change in established practice, concern with accountability for the management of risk drove adherence to traditional, readily accepted and organisationally sanctioned interprofessional boundaries, limiting the degree of change enacted. These findings have important practical implications for those involved in the management of change as well as theoretical implications for our understandings of professional role reconfiguration attempts and the nature of contemporary professionalism more broadly.

Contents

List of Abbreviations

BMA – British Medical Association
CPA – Care Pathway Approach
CPN – Community Psychiatric Nurse
CMHT – Community Mental Health Team
CRHT – Crisis Resolution/Home Treatment Team
DoH – Department of Health
GMC – General Medical Council
GP – General Practitioner
MDT – Multi-disciplinary Team
NHS – National Health Service
OT – Occupational Therapist
RC – Responsible Clinician
RMO – Responsible Medical Officer
SUI – Serious Untoward Incident
UK – United Kingdom

1. Introduction

> *"There is constant discussion of what is whose work in medicine and what part of it all is the physician's work, privilege and duty." (Hughes 1958, pp. 122)*

Over half a century following their publication, the words of Everet Hughes may be more relevant today than ever. The healthcare needs of modern society, as well as the economic and social environment in which they are addressed, are continually evolving and the development of a healthcare workforce able to adapt to the new challenges posed is a pressing concern. Increasing demand for services in the midst of shortages in the availability of many categories of health workers and constrained financial resources are ongoing problems experienced across the world (Global Health Workforce Alliance & World Health Organization, 2013). Informed by the increasing application of managerialist principles to the organisation of healthcare, policy-makers worldwide have responded by promoting flexibility in the workforce, endorsing the reconfiguration of professional boundaries based on staff availability, competencies and accomplishments rather than traditional roles (Nancarrow and Borthwick 2005, Currie, Finn et al. 2009).

This issue is particularly evident in the United Kingdom (UK) where there is serious concern regarding the ability of the National Health Service (NHS) workforce to provide quality healthcare for the current and future needs of the population, and recognition of the need for new approaches to the delivery of care (Imison and Bohmer 2013). Representing a "fast mover in policy-driven workforce development" (Currie, Lockett et al. 2012, pp. 938), UK policy regarding the NHS has consistently and actively promoted the reconfiguration of professional roles in order to "modernise" the workforce since the labour government of the late 1990's, (Department of Health 2000, Department of Health 2001, Nancarrow and Borthwick 2005, Martin, Currie et al. 2009), with "old fashioned demarcations between staff" cited as one of the "systemic problems" contributing to the failure of the NHS to meet expected standards (Department of Health 2000, pp.2). Policy has supported the development of reconfigured roles for clinical staff with a particular emphasis on supporting extended roles for non-medical workers.

The adaptation of the workforce to meet demand remains a concern and the development of a "modern workforce" continues to be identified as a top priority. This is reflected in the *NHS Five Year Forward View* (NHS England, 2014) which emphasises the need to move on from "outdated models of delivery" proposing a plan to "commission and expand new health and care roles, ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it." (NHS England, 2014, pp. 30). Again, the proposals point to the need to expand the roles and responsibilities of non-medical professionals in the pursuit of this goal (Lintern 2014).

While these suggestions may appear, at least to some, logical and achievable, the enactment of change in practice can be far more challenging. The continued appearance of this issue in policy documents almost 15 years after it was first raised indicates that change is slow. The professional roles that policy proposes to change are steeped in years of tradition and embedded within long-established organisational, professional and societal systems and power relations. In additional they are enacted in organisations that exist within an evolving and increasingly pressurised system in which myriad interrelated forces impact on professional work. The modernisation of the clinical workforce through the reconfiguration of professional roles is a complex social process and considering its current relevance it is vital that we understand the complexities associated with the enactment of such change within healthcare organisations.

Theoretical framework

This study adopts an organisational neoinstitutional theory framework. As a literature that focuses on the influences upon the structure and function of organisations and the activities of the actors associated with them, neoinstitutional theory is acutely relevant to the study of professional role reconfiguration within healthcare organisations. Through conceptualisation of the range of institutional pressures that guide social activity within the organisational field as well as the various forms of agency intended to influence such pressures, neoinstitutional theory provides a comprehensive framework through which to consider the activities, constraints and enabling factors relevant as professional roles are renegotiated.

Specifically, the study draws upon Scott's (2014, pp.56) conceptualisation of institutions as comprising "… regulative, normative, and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life". It is through these elements that the various institutions within a given organisational field exert influence and guide social activity. Recognition of the potential for strategic behaviour to influence institutional arrangements is maintained by utilising literature focussed on the agency of institutional actors. In particular, the study draws upon Lawrence and Suddaby's (2006) taxonomy of "institutional work: the purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions" (Lawrence and Suddaby 2006, pp. 215) and Zietsma and Lawrence's (2010) distinction between boundary work and practice work i.e., "the work of actors to create, maintain and disrupt the practices that are considered legitimate within a field (practice work) and the boundaries between sets of individuals and groups (boundary work)" (Zietsma and Lawrence 2010, pp. 189).

Viewed through this framework healthcare can be considered a highly institutionalised and complex field within which actors are influenced by various institutional pressures. As such, the enactment and reconfiguration of professional roles will be enabled and constrained by the institutional environment within which these activities takes place (Currie and Suhomlinova 2006, Chreim, Williams et al. 2007). It is therefore imperative to consider the institutional pressures at large within healthcare organisations and

their potential impact on the enactment of professional roles and their reconfiguration.

An institutional influence of enormous relevance within the field of healthcare is that of the professions and professionalism, and in particular medical professionalism. Therefore the thesis draws upon the sociology of the professions literature which provides a wealth of valuable theoretical work concerning the nature and function of professionalism. Often drawing upon the prototypical profession of medicine, early functionalist accounts of the professions emphasise their stabilising role within society (Carr-Saunders and Wilson 1933, Parsons 1939, Durkheim 1957) and attempt to articulate the defining traits of professionalism highlighting their possession of expertise, high ethical standards and mechanisms of self-regulation (e.g., Carr-Saunders and Wilson 1933, Goode 1957). The later dominant power or conflict lens however, focusses on the means by which professional groups secure and maintain their power and status within society, emphasising in particular control over knowledge and expertise and autonomy of functioning as sources of professional power (Freidson 1970b, Johnson 1972, Larson 1977, Freidson 1988) and interprofessional competition to create and maintain a secure jurisdiction (Abbott 1988). Drawing upon these insights a neoinstitutional view conceptualises the professions as institutions incorporating regulative, normative and cultural-cognitive mechanisms that direct professionalised social activity (Scott 2008a, Battilana 2011, Muzio, Brock et al. 2013). In turn the professions and professionals are conceptualised as institutional agents with the capacity to influence their own interests and jurisdictions through various forms of institutional work (Scott 2008a, Currie, Lockett et al. 2012, Lawrence, Leca et al. 2013).

These theoretical conceptualisations of professionalism, particularly the insights that emerge from the conflict or power accounts, have been applied to the study of professional role reconfiguration in healthcare. In line with this literature, attempts to reconfigure professional roles are seen as opening up the potential for reallocation of knowledge and expertise and therefore associated status and power. Change is presented as an opportunity for newly introduced or subordinate professional groups to establish and extend their jurisdiction and enhance their position and, conversely, as a threat to superordinate groups who could lose control over jurisdiction resulting in a weakened position. Empirical studies of professional role reconfiguration emphasise the strategic, competitive activity of professionals to defend and extend jurisdiction and therefore protect and enhance their status and rewards through the advancement of legitimacy claims (Timmons and Tanner 2004, Sanders and Harrison 2008), moves to control change (Allen 2000, Currie, Finn et al. 2009, Martin, Currie et al. 2009) and engagement in various forms of institutional work (Reay, Golden-Biddle et al. 2006, Currie, Lockett et al. 2012).

Emerging conceptualisations of professionalism however cast a new light on the accounts of professional role reconfiguration attempts that dominate the literature. Following calls to develop the professions literature by more fully incorporating the organisation as a site of professional activity (Davies 2003, Muzio and Kirkpatrick 2011, Muzio, Brock et al. 2013), such conceptualisations reflect the impact of new and ever increasing pressures

within the contemporary organisational context on the nature and function of professionalism (Evetts 2002, Scott 2008a, Evetts 2009, Bianic 2011, Muzio and Kirkpatrick 2011). Focussing particularly on the shift from professional autonomy and self-regulation to managerially informed professional evaluation and accountability (Scott 2008a, Evetts 2009, Liljegren 2012), and the connection of professional authority and expertise to the management of risk (Annandale 1996, Power 2004, Bianic 2011), this thesis presents a novel theoretical interpretation of attempts to reconfigure professional roles.

The primary aims of this thesis are to build upon practical and theoretical understandings of professional role reconfiguration attempts within healthcare organisations and, in doing so, inform theoretical debates regarding the nature of contemporary professionalism more broadly. The exploration of the micro-level enactment of professional role reconfiguration, informed by a neoinstitutional framework, provides the opportunity to consider a range of professional responses to potential alterations in their jurisdictions and responsibilities whilst fully considering the wider institutional and organisational arrangements that inform professional decision-making in the contemporary context. As a body of work carried out within a school of sociology and social policy, as opposed to a business school, the focus of this thesis is to develop sociological theory concerning the professions, with potential contributions to the organisational neoinstitutional literature a secondary concern. In line with this approach the work has been developed with the aim of submission to sociologically oriented as opposed to organisation studies publications.

Empirical context

Empirically, this study is set within the context of the UK NHS where, as described at the beginning of this chapter, for over two decades government policy has explicitly promoted the development of flexibility in professional boundaries (e.g., Department of Health 2000, NHS England 2014). Specifically, the thesis focuses on the case of changes to the roles of consultant psychiatrists and associated mental health professionals following the publication of the Department of Health report *New Ways of Working for Psychiatrists* (2005). The *New Ways of Working* document proposes the development of new roles for clinicians within which non-medical professionals take on aspects of the work previously within the remit of the medically qualified psychiatrist, and as such is typical of "modernisation" attempts aimed at creating flexibility in traditional professional boundaries. The following specific research questions will be addressed:

- How do individuals and/or groups work to change or maintain professional roles in the context of role reconfiguration attempts?
- What are the relevant challenges, barriers and enabling factors that inform this activity?

Methods

Utilising a case study approach the thesis presents a qualitative thematic analysis based on thirty-nine semi-structured interviews with mental health

professionals and managers working in the adult mental health services of an NHS mental health trust. Interviews were focussed on issues around change and maintenance of professional practice as well as boundaries in terms of decision-making responsibility, authority and hierarchical position. Particular attention was paid to the action taken to influence change and its consequences as well as perceived barriers and facilitating factors that informed this action. The approach to data collection and theory development was iterative involving elements of both induction and deduction in the recursive movement between emerging themes, research questions and theory (Miles and Huberman, 1994). The study became focussed upon four specific teams, purposefully selected for the variation they displayed in terms of the roles taken by consultant psychiatrists, as well as overarching management level activity.

Analysis and discussion

This thesis presents a case in which a senior professional group is complicit in policy and management drives toward role reconfiguration. Rather than engaging in defensive work within the workplace the senior professional group appear to support and encourage other groups to take on elements of work previously within their remit. Motivated by a heavy workload, as well as recognition of the value of an inter-disciplinary approach to care, the study illustrates how through engaging in specific forms of institutional work consultant psychiatrists, along with team leaders and managers, worked to create new practice and drive the delegation of clinical activity and decision-making responsibility from consultants to other members of the mental health workforce. The change generated was however limited by institutional and organisational influences related to understandings of interprofessional hierarchy, accountability and risk management that encouraged adherence to traditional role boundaries.

The analysis illustrates several forms of institutional work aimed at creating new practice in which clinical activity and decision-making was redistributed across the clinical team. Consultant psychiatrists and team leaders worked on "changing normative associations" through challenging the expectations of their colleagues regarding the role of the consultant as well as modelling and encouraging alternative ways of working. These actors also engaged in work around "embedding and routinizing" through the development of processes that supported new practices (Lawrence and Suddaby, 2006). By engaging in these activities these actors encouraged non-medical clinicians to work more autonomously, enabling distributed responsibility either in the day to day decision-making or within the context of non-medic led clinics thereby enabling the development of new practice within their clinical teams.

This activity was supported at management level where there was institutional work to encourage and embed new practice across the service more widely. Managers worked to legitimise new practice by "cultivating opportunities for change" through the identification and targeting of clinicians and contexts particularly receptive to change, and "proving the value" of new practice (Reay et al. 2006, pp. 977). Managers worked to prove the value of the new practice by collating evidence to support the need for change through "auditing and

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monitoring" both established and new practice (Lawrence and Suddaby 2006). Finally, these actors engaged in "cultural work" to provide the changes with some degree of normative legitimacy (Perkmann and Spicer 2008). This took the form of "constructing normative networks" through establishing connections with a similar organisation that had successfully implemented change and "theorizing" work through associating change with the currently prevalent and influential rhetoric of "recovery" in mental health services (Lawrence and Suddaby 2006).

Although the institutional work described was successful in generating new practice, the changes created were enacted in a manner that maintained the interprofessional boundaries associated with the institutionalised model of medical professionalism, in which medics are positioned at the apex of the interprofessional hierarchy as "key decision makers", holding "authority over all other NHS professionals." (Batillana 2011, pp. 820). Consultant psychiatrists continued to be viewed by themselves, their colleagues and their managers as holding a special position of authority and responsibility within the service that differentiated their contribution to care from that of other professionals. Even when practice work was coupled with elements of boundary work in the form of attempts to "define" and "advocate" new boundaries of responsibility (Lawrence and Suddaby 2006) through formal reallocation of case-holding from the consultant to the team to which the patient was assigned, traditional role boundaries in terms of medical responsibility, authority and seniority were retained.

Consequently whilst there were changes in practice, e.g., the development of nurse-led clinics, consultant psychiatrists remained involved in major decision-making around cases. Within the newly created division of labour non-medical professionals were willing and enabled to take on more of the relatively routine elements of clinical work and decision-making previously carried out by consultants; however, consultants remained involved in any decision-making involving high levels of biomedical complexity and/or risk in terms of the risk that a patient was judged to pose to themselves and/or others. Cases high on either dimension were viewed as requiring the involvement of the most senior authority: the consultant psychiatrist.

Contrary to the what the professions and workforce development literature may predict, this renegotiated division of labour in which consultant psychiatrists retained their position at the top of the interprofessional hierarchy did not result from assertive maintenance work on their part. There was a notable absence of claims from consultants as to their superior risk management skills and expertise, within the workplace at least. This was simply not necessary. Rather, the motivation to divide work in this manner stemmed from a number of inter-linked organisational and institutional level influences that created concern across the professions and some managerial colleagues with accountability for the management of risk and drove adherence to the safety of the established interprofessional hierarchy when managing that that risk.

The findings from this thesis reflect literature that describes the evolving nature of professionalism and professional work under the pressure of the

contemporary organisational environment, particularly the increasing focus on professional accountability and the management of risk (e.g., Power 2004, Evetts 2009, Bianic 2011, Liljegren 2012). This study suggests that, within this context, proposals to reconfigure professionals roles that suggest the transfer of clinical activity are interpreted by professionals and managers in terms of the concurrent transfer of accountability for the management of risk associated with that activity. Whilst the transfer of clinical work, expertise and knowledge across professional boundaries is associated with the potential transfer of professional resource and power, the transfer of responsibility for risk management in the contemporary organisational context also represents a potential risk for the individual professionals involved that they are driven to protect against. Consequently, as opposed to professional competition for jurisdiction over the management of risk this study illustrates the careful renegotiation of responsibility for risk management to ensure the protection, not just of the patients, but of the professionals involved.

In this case adherence to the established hierarchy through the involvement of consultants in major decision-making, particularly around risk, provided a form of protection from the perceived "secondary risks" presented to professionals following adverse incidents (Power 2004): a function that was informed by a number of inter-linked influences. Firstly, professionals described an acute awareness of the scrutiny their decision-making would undergo in the event of a negative incident and a particular concern with the evaluations arising from the organisational Serious Untoward Incident (SUI) process and the Coroner's inquests. A particularly dominant influence was a widely held perception that such authority figures expected and required the involvement of the consultant, the professional viewed as most senior and expert, in complex decision-making including the management of risk and would potentially criticise practice in which this had not occurred. Under circumstances in which risk presented a serious concern professionals reverted to the safety of the readily accepted hierarchy.

Secondly, the consultant's position as Responsible Medical officer (RMO) in relation to a patient was also frequently cited by professionals in order to explain the need for the involvement of consultants in decision-making. This functioned as an additional and related field and organisation level influence that served to represent and reinforce medical authority and responsibility and limit the extent of change. Although occasionally used to refer to the consultant's legally sanctioned right to detain patients under the Mental Health Act (1983), this term was more commonly used interchangeably with the term "named consultant" to refer to the doctor with whom a patient becomes associated when they enter secondary mental health services. The routine allocation of a "named consultant" to each patient was standard practice within the service investigated and represented a powerful organisational level influence that reinforced assumptions of medical authority and responsibility limiting the degree of change achieved. Paradoxically these organisational arrangements appeared to place the consultant in a position of responsibility in the context of organisational drives toward the redistribution of clinical activity and responsibility from consultants across the wider clinical team creating tension and contradiction. Finally, these influences reflect and

reinforce the deeply engrained understandings of professional hierarchy inherent in the dominant model of medical professionalism (Batillana 2011).

This thesis clearly demonstrates the risk focussed environment in which professionals now work where risk holds "forensic functions" (Douglas 1992, pp. 27), closely associated with notions of accountability and the auditing of clinical decision-making. Within this context concerns around accountability for risk management are high and inform the enactment of professional work. The data suggests that in the context of various pressures and expectations around consultant responsibility and authority, adherence to the traditional interprofessional hierarchy functioned as a defensive strategy used by professionals, and that movement away from such hierarchy presented a professional risk that clinicians were not willing and enabled to take. Concern with accountability for the management of risk represented a powerful influence that informed the manner in which professionals in this organisational setting reconstructed and enacted their professional roles limiting the extent of change.

The analysis did however illustrate one exceptional context, provided by a clinical team responsible for delivering specific, short-term crisis care to patients, in which non-medical professionals carried out extended roles including the management of risk. Whilst issues of accountability and judgement of professional decision-making around risk remained a concern, this did not drive adherence to traditional professional role templates. One of the features differentiating this team from the others was the meaning attached to the clients' problems: a feature identified within the professions and neoinstitutional literatures as central in legitimising jurisdiction and connecting particular groups of actors to their activities (Abbott 1988, Freidson 1988, Zilber 2002, Scott 2014). More so than in any of the other teams investigated, the problems experienced by the clients were constructed as predominantly psychosocial as opposed to emanating from a medically defined mental illness. With the issues of the clients largely viewed through an alternative, demedicalised cultural-cognitive framework, the norms associated with the model of medical professionalism failed to exert such a powerful influence. The team also operated a shared caseload model in which a patient was allocated to the care of the team as opposed to a particular named consultant, which could be seen to reflect and reinforce the legitimate distribution of responsibility. Within this context, non-medics were enabled to enact extended roles in which they could legitimately lead in clinical decision-making.

Theoretical contributions

This thesis presents a theoretical reconceptualisation of professional role reconfiguration attempts, the opportunities or threats that such change potentially represents to the professionals involved, and the organisational barriers to change. The findings presented demonstrate that in the contemporary organisational environment, heavily focussed on accountability and risk management, attempts to reconfigure professional roles can be understood not only in terms of the transfer of knowledge, expertise and resource across professional boundaries but, in many circumstances, the concurrent transfer of accountability for the management of risk. Such a

reconceptualisation, founded on emerging (Evetts 2002, Scott 2008a, Evetts 2009, Bianic 2011) as opposed to traditional understandings of professionalism (e.g., Larson 1977, Abbott 1988, Freidson 1988), explains and predicts an alternative professional interpretation of, and response to, role reconfiguration attempts to those commonly set forth within the literature (e.g., Allen 2000, Sanders and Harrison 2008, Currie, Finn et al. 2009, Currie, Lockett et al. 2012).

Whereas knowledge and expertise represent sources of professional power and status, responsibility for risk management within the modern organisational context represents a more complex commodity potentially associated with risks to professionals themselves should they be held accountable for risk mismanagement in the event of an untoward incident. This thesis makes a contribution to the literature by applying these insights to the phenomenon of professional role reconfiguration, demonstrating that extending or maintain ones jurisdiction may not simply represent the opportunity that it once did but the accumulation or retention of potentially high risk responsibility, particularly in organisational settings where risk management is a central aspect of professional practice. This thesis demonstrates that rather than competing for jurisdiction associated with the management of significant risk, professionals carefully renegotiate their roles in a manner that ensures their own protection from blame in the event of an untoward incident, which in this case involved adherence to the safety of the traditional, readily accepted and organisationally reinforced medical hierarchy.

The exceptional case presented, in which more extensive role reconfiguration was described, further supports the conclusion that, under the pressures of the contemporary organisational context, attempts to reconfigure professional roles are likely to be interpreted in terms of the transfer of responsibility for risk management and informed by concern with accountability for this responsibility. Crucially, this case also allows elaboration of the connection between accountability for risk management and the interprofessional hierarchy in the context of role reconfiguration attempts. This case demonstrates that the manner in which these pressures connect to the interprofessional hierarchy is influenced by the construction of client issues and organisational representations and expectations of the responsibilities of the professional groups involved. In organisational sub-contexts in which client issues are constructed in terms of an alternative, in this case demedicalised, framework and organisational representations and expectations around traditional hierarchy removed, pressures around accountability for the management of risk do not necessarily promote adherence to established role boundaries enabling the potential for the creation of new roles.

In providing this primary contribution to the workforce development literature these findings also make a number of secondary contributions to the professions literature more generally, including contributing to the emerging neoinstitutional conceptualisation of the professions. Firstly, the thesis responds to calls to more fully integrate the role of organisations into the study of the professions (Davies 2003, Muzio and Kirkpatrick 2011, Muzio, Brock et al. 2013), demonstrating how powerful institutional pressures within the organisational field around accountability and risk influence professional role

enactment. Further, the study builds on a limited body of micro-level evidence (Bianic 2011, Liljegren 2012, Correia 2016) for the emergence of evolved forms of professionalism within the context of the contemporary organisations (Evetts 2002, Scott 2008a, Evetts 2009, Muzio and Kirkpatrick 2011, Muzio, Brock et al. 2013), a particularly intriguing and important area of study (Evetts 2009). Finally, the thesis supports and replicates literature that identifies the professions and professionals as institutional agents capable of engaging in institutional work to influence their practices, boundaries and beyond (e.g., Reay, Golden-Biddle et al. 2006, Scott 2008a, Currie, Lockett et al. 2012, Lawrence, Leca et al. 2013), in this case to begin to create new professional practice.

Thesis structure

The remainder of the thesis is structured as follows. The subsequent literature review chapter is split across three sections. Section 2.1 outlines the neoinstitutional theory literature which is presented as the overarching theoretical framework for the thesis. This describes work that addresses the impact of the institutional environment on organisations and the activities carried out within them, culminating with a description of Scott's (2014) "three pillars" framework of institutional influence. The section then goes on to review empirical work that demonstrates a shift in focus from the determining influence of the institutional environment on organisational form and function to the agentic and strategic behaviour of institutional actors. The review highlights the importance of Lawrence and Suddaby's (2006) taxonomy of "institutional work" in drawing together these insights and providing a framework to conceptualise the range of actions through which actors may exert influence upon their institutional environment.

The review then turns to focus on the institutional influences of relevance to the field of healthcare organisations, namely the professions and the state policy that impacts publically funded healthcare systems. Section 2.2, *The professions*, describes the defining features of the professions and the means by which professional jurisdiction is established and maintained. Attention is paid to both the early functionalist and traits accounts and the subsequent power or conflict accounts of the professions before describing the key features of the developing neoinstitutional approach to the study of the professions and the manner in which this draws upon and develops traditional sociological accounts. This chapter highlights the emphasis that dominant understandings of professionalism place upon the development and maintenance of professional control, monopoly and secure jurisdiction over particular areas of professional work, knowledge and expertise in the pursuit of professional power and status.

The final section of this chapter, *The professions within the contemporary organisational context,* reviews literature that considers the impact of the organisational environment within which professions now function upon the professions and their activities. This section describes contemporary workforce development policy within pubic healthcare systems and empirical literature that addresses its enactment, emphasising the activity of professional groups to defend and extend professional jurisdiction over clinical activity and expertise

and therefore status and power within the context of role reconfiguration attempts. The review then moves on to consider literature that describes the evolving nature of professionalism under the pressures of the organisational context, particularly in relation to professional accountability and risk management, using this work to reassess the theoretical accounts and interpretations of professional role reconfiguration attempts that dominate the literature and highlight the need for further study.

Chapter three describes the methodology and methods employed to address the stated research aims and questions. The study adopts a qualitative approach to investigation founded on assumptions of ontological realism and epistemological constructionism. More specifically, the study employed a case study design focussed on the enactment of professional role reconfiguration following the publication of the government document *New Way of Working for Psychiatrists* (Department of Health 2005). Selected as an exemplary case of attempts to modernise the clinical workforce, details of this specific initiative are provided. This is followed by a description and explanation of the sampling of four embedded cases and the individual clinicians and managers who took part. The chapter then describes the collection of data through semi-structured interviews and the development of a coding structure and a final interpretation of the data.

Chapters four and five present an analysis of the data obtained. Chapter five focuses on data pertaining to the activity of key actors within this setting to create new practice for consultant psychiatrists and their colleagues. The chapter illustrates work on the part of consultants and team leaders to enable the distribution of responsibility through challenging norms and modelling alternative ways of working to encourage and establish new practice. The work of managers to create and build upon change in practice through identifying opportunities, collating evidence, utilising examples of successful change in a similar organisation and aligning change with the "recovery" agenda is also described. Chapter six then describes data that illustrates the dominant influences that constrained the extent to which professional roles were reconfigured, demonstrating how understandings and representations of medical authority interact with concern with professional accountability and pressure to manage risk to maintain established patterns of interaction. Finally the enabling influence of demedicalised construction of client issues within an exceptional context is discussed.

Chapter six provides a theoretical interpretation of the data presented, situating this work within existing literature and frameworks. The chapter identifies forms of institutional work to create new practice evident at team and management level as well as work to influence the boundaries of professional authority and responsibility. The chapter also identifies institutional and organisational level influences around assumptions of medical authority, accountability and risk management pressure that interact with this micro-level agency to constrain role reconfiguration, limiting it to change in practice in the absence of change to core professional boundaries. Finally the chapter draws out additional theoretical insights from an exceptional case in which the demedicalisation of work enabled a greater degree of change.

Chapter seven provides a conclusion to the thesis reiterating the main findings and theoretical contributions. This chapter also addresses the practical implications for those involved in the planning and/or implementation of role reconfiguration attempts and healthcare policy. These refer to the importance of considering the impact of the wider organisational and institutional context on micro-level role reconfiguration attempts, as demonstrated by the influence of organisational structures and processes and an increasing focus on accountability and risk management in this setting. The thesis concludes by discussing issues around the limitations of the study, generalisability of the findings and directions for future work.

2. Literature Review

The following chapter reviews literature relevant to professional role reconfiguration in healthcare organisations with the aim of collating work that addresses the key research questions posed within this thesis: how do individuals and/or groups work to change or maintain professional roles in the context of role reconfiguration attempts, and what are the relevant challenges, barriers and enabling factors that inform this activity? In essence these are questions about the enactment of roles within highly structured organisational settings and as such are questions to which the organisational neoinstitutional theory literature is acutely relevant. This literature comprises a rich body of work addressing the influences upon the structure and function of organisations as well as the activities of those who work within them. The aim of the literature review presented over the following three sections is to outline key theoretical frameworks and assumptions from this and related bodies of work and their application to the field of healthcare.

The first section of the review *Neoinstitutional theory* presents key theoretical frameworks, drawn from the neoinstitutional literature that aid the conceptualisation of the structural elements acting within organisational settings as well as activities intended to influence them. The chapter begins by reviewing work that addresses the impact of the institutional environment on organisational form and function. The review charts key studies that laid the foundations for our understandings of the elements and mechanisms of institutional influences (Meyer and Rowan 1977, DiMaggio and Powell 1983) before focussing on Scott's (2014) prominent and encompassing "three pillars" framework. The regulative, normative and cultural-cognitive pillars of institutional influence are outlined along with the mechanisms through which they guide action and contribute towards social stability. This conceptualisation is presented as a comprehensive framework through which to explore and understand the varied pressures that influence and inform the activity of organisational and individual actors.

Attention is then turned to the issue of agency in institutional theory reviewing literature that describes the ability of social actors to engage in purposive, strategic activity within their institutional environment and in doing so exert their influence upon it. This section of the review covers the work of institutional scholars who began to foreground the concepts of interest and agency, with discussion of the role of institutional entrepreneurs in the creation of new institutions as well as work that began to encompass a wider range of institutional action (e.g., DiMaggio 1988, Oliver 1991, Maguire, Hardy et al. 2004). The review then highlights work that aims to consolidate these insights and provide useful frameworks with which to theorise and understand the various forms of action by which actors may aim to influence institutions. The review focuses on describing Lawrence and Suddaby's (2006) taxonomy of "institutional work" and Zeitsma and Lawrence's (2010) conceptualisation of practice and boundary work.

Neoinstitutional theory emphasises the impact of the influences at large within a particular field on social functioning within it, therefore the review then considers the dominant influences within the field of healthcare. The review focuses particularly upon the key institutional influence within this field relevant to the phenomenon of professional role reconfiguration: that of the professions or professionalism. The professions represent distinctive occupational groups characterised by particular structures, functions, principles and activities. As such understanding the professions and the manner in which they operate is central to understanding the enactment of clinical roles in healthcare including their reconfiguration. These occupational groups have been extensively studied by sociologists and the sociology of the professions literature represents a rich body of work highly relevant to the questions addressed within this thesis. Section two of this review, *The Professions,* therefore considers this literature in detail.

The sociology of the professions literature considers the very nature and basis of professionalism in terms of its normative, cognitive and regulative elements (Larson 2013). The review begins with the first systematic sociological attempts to capture the essence of the modern professions from the 1930's onwards (Abbott 1988). These early insights were informed by functionalist and traits based approaches focussing on the stabilising function of the professions within society (Parsons 1939, Durkheim 1957), and the defining features of professionalism in terms of the acquisition of expert knowledge and skills, a service orientation and high ethical standards, and licensure and associations to ensure appropriate conduct (e.g., Carr-Saunders and Wilson 1933).

This review then describes a shift in the manner in which the professions and professionals were studied and conceptualised in the literature, highlighting the seminal work of Everet Hughes (1958, 1963) followed by the major theorists associated with development of power or conflict approach: Eliot Freidson (1970a, 1970b), Terence Johnson (1972) and Magali Sarfatti Larson (1977). The focus of the literature became the power and privileges possessed by the professions and the means by which their status and position were achieved, emphasising the attainment of monopoly and control over knowledge and expertise in the pursuit of professional power. The review also highlights the work of Abbott (1988) who subsequently provided particularly detailed and relevant insights on interprofessional relations within a competitive system of professions and the activity associated with jurisdictional disputes within the workplace and beyond.

This section concludes by outlining the developing neoinstitutional approach to the study of the professions. Within emerging literature that combines sociological insights on the professions with neoinstitutional theory the professions are viewed as powerful institutions and the professions and professionals as institutional agents with the potential to shape their institutional and organisational environment (Scott 2008a, Lawrence, Leca et al. 2013, Muzio, Brock et al. 2013). The review outlines work that explicates the key features of the neoinstitutional approach to the professions and the manner in which this extends more traditional sociological conceptualisations

through the development of a more balanced view able to conceptualise a wide range of potential actions, motivations and structural influences including the impact of location of professional work within the pressures of contemporary organisational environments.

The final section of the literature review, *The professions within the contemporary organisational context,* considers in detail the manner in which location within increasingly large and dominant organisations impacts upon the professions and the manner in which they enact their roles. In line with the empirical concerns of the thesis, the focus is on the impact of neoliberal government policy and the associated principles of managerialism in public services, particularly healthcare organisations. Firstly, the review reiterates the aims of workforce development policy in terms of creating flexibility in the workforce and includes empirical work on role reconfiguration attempts in healthcare settings (e.g., Sanders and Harrison 2008, Currie, Lockett et al. 2012). The review highlights the focus upon professional activity to establish, extend and defend control over territory and expertise in the context of challenges to established jurisdiction reflecting the central themes within the professions literature and traditional conceptualisations of professionalism (Freidson 1970b, Johnson 1972, Larson 1977, Abbott 1988, Freidson 1988).

Finally, the review outlines theoretical work that describes important changes to the nature and function of professionalism under the pressures and demands of modern organisations (Evetts 2002, Scott 2008a, Evetts 2009, Bianic 2011, Muzio and Kirkpatrick 2011) and considers the implications for our understandings of professional role reconfiguration attempts. The review highlights two central themes within literature that considers the evolving nature of professionalism within contemporary organisations: increasing pressure toward professional accountability and the function of professional work in the management of risk. Through presenting work that describes and demonstrates the impact of such pressures on professionalism and the enactment of professional work within organisations it is argued that we need to develop further our understandings of the opportunities and challenges that attempts to reconfigure professional roles present to the various groups involved in order to achieve theoretical and practical advances.

2.1 Neoinstitutional Theory

The Impact of the Institutional Environment

Definitions of institutions emphasise their stabilising impact on the social world and an important enterprise of institutional theorists has been the conceptualisation of the sources and mechanisms of that stabilising influence. Early discussions within neoinstitutional theory emphasised the determining effects of the institutional environment on organisations. This work focussed on the influence of institutional pressures on organisational structure and action, describing the phenomenon of isomorphism within established organisational fields (Meyer and Rowan 1977, DiMaggio and Powell 1983). This work described the necessity of organisations to conform to particular forms and activities, not primarily to improve efficiency but to gain the legitimacy required to succeed.

Meyer and Rowan (1977, pp. 340) proposed that organisations exist in highly institutionalised environments in which "professions, policies and programs are created along with the products and services that they are understood to create rationally." In such a setting "organizations are driven to incorporate the practices and procedures defined by prevailing rationalized concepts of organizational work and institutionalized in society" not to improve efficiency but to gain legitimacy and resources. Counter to prevailing understandings at the time this paper suggested that formal organisational structure reflects the, often ceremonial, adoption of "powerful myths" or "institutionalized rules".

In line with this argument DiMaggio and Powell (1983, pp. 147) described the tendency of organisations within structured fields to become more similar in terms of "structure, culture and output": a process driven by forces other than a desire for efficiency. In this paper these authors identify three mechanisms by which the process of institutional isomorphic change occurred: "1) coercive isomorphism that stems from political influence and the problem of legitimacy; 2) mimetic isomorphism resulting from standard responses to uncertainty; and 3) normative isomorphism, associated with professionalization" (DiMaggio and Powell 1983, pp. 150). It is proposed that through various combinations of such mechanisms the institutional environment within a given field exerts pressure to which organisations conform.

Drawing upon DiMaggio and Powell's (1983) seminal description of the powerful "coercive, normative and mimetic" institutional influences, since the mid-1990's Scott has developed a comprehensive conceptualisation of institutions asserting that:

> "Institutions comprise regulative, normative and cultural-cognitive elements that, together with associated activities and resources, provide stability and meaning to social life." (Scott 2014, pp. 56)

From this perspective institutions are viewed as "multifaceted, durable social structures made up of symbolic elements, social activities and material

resources", the central elements of which provide the "elastic fibres that guide behaviour and resist change" (Scott 2014, pp.57).

According to this conceptualisation institutions comprise "three pillars" or elements through which they exert institutional pressure: the regulative, the normative and the cultural-cognitive pillars. Within this three pillars framework the regulative element refers to "rule-setting, monitoring and sanctioning activities" that are legitimised through legal sanction (Scott 2014, pp 59). The regulative pillar operates through the development of rules, checking of adherence to those rules and the administration of rewards and penalties accordingly, in an explicit attempt to influence behaviour. The processes associated with this pillar may be informal or undertaken in a formal manner through particular authorities e.g., the courts (Scott 2014, pp. 60). As well as constraining particular social action and actors, regulatory influence also enables and empowers others "conferring licenses, special powers and benefits" (Scott 2014, pp. 61). Compliance associated with this pillar is linked to coercion and assumes that actors behave rationally and according to their own interests after evaluating the potential consequences of their actions; however, more recent work has begun to attend to the emotional impact of encountering regulative forces and the role of affect in the power of this pillar (Scott 2014).

The normative pillar refers to values and norms which "introduce a prescriptive, evaluative and obligatory dimension into social life" and gains legitimacy through moral authorisation (Scott 2014, pp. 64). Values dictate ideals and standards within a given field and norms dictate how these should be achieved. This pillar is associated with the concept of roles which impose specific values and norms upon specific actors. "These beliefs are not simply anticipations or predictions, but prescriptions—normative expectations— regarding how specified actors are supposed to behave. The expectations are held by other salient actors in the situation, and so are experienced by the focal actor as external pressures. Also, and to varying degrees, they become internalized by the actor." (Scott 2014, pp. 64) With particular social positions come powerful expectations. Compliance associated with this pillar is not simply linked to coercion and the best interests of the actor but to the obligations and expectations placed upon them; actors conform because they feel that it is their duty (Scott 2014).

The final, cultural-cognitive element refers to "the shared conceptions that constitute the nature of social reality and create the frames through which meaning is made" and is legitimised through cultural support (Scott 2014, pp 67). "Cultural-cognitive frameworks provide the deeper foundations of institutional forms. In formulating the classificatory systems, assumptions, and premises that underlie institutional logics, they provide the infrastructure on which not only beliefs, but norms and rules rest" (Scott 2008b, pp. 429). The emphasis here is on cognition and interpretation: the processes through which social reality is constructed. Conformity associated with this pillar occurs because prevailing ways of operating become taken for granted and alternatives inconceivable (Scott 2014).

A given institution can be composed of various combinations of these three pillars with different elements dominant in different institutions, or within a particular institution at different moments in time (Scott 2008b). In addition, each element may exert influence from the micro to the macro level of analysis. "An important task of the institutional scholar is to ascertain what elements are at play in a given context and the extent to which they work to reinforce or undercut one another." (Scott 2008b, pp. 429) This conceptualisation then provides a broad and flexible framework through which to consider the pressures acting within a given field, aiding consideration and theorisation of a wide range of influences and the mechanisms by which they impact upon social actors.

Institutional Agency

Early neoinstitutional work was criticised for presenting accounts of institutional influence that were overly deterministic (Scott 2008b). Institutional actors were presented as responding in a largely passive manner to the pressures exerted upon them from above, with change explained predominantly in terms of change to the institutional environment e.g., technological, socioeconomic and regulatory change (Meyer, Brooks et al. 1990). The role of human agency was neglected (DiMaggio 1988, Seo and Creed 2002).

Led by the influential writings of DiMaggio (1988), issues of power, agency and interest became increasingly dominant topics of discussion in the neoinstitutional literature. In his influential essay *Interest and agency in institutional theory*, DiMaggio (1988) focussed attention on agency highlighting the role of actors and their desired influence in the process of institutionalisation, a phenomenon later demonstrated through his analysis of the institutionalisation of the field of art museums in the USA (DiMaggio 1991). This focus on strategic agency was continued by Oliver (1991) who asserted that organisations within a given field do not simply conform to the pressures of the institutional environment but may engage in a variety of strategic responses dependent upon their "willingness and ability" to do so (Oliver 1991, pp. 159).

Numerous publications followed that addressed the impact of agency on institutions, the majority of which focussed on the phenomenon of institutional entrepreneurship i.e., "the activities of actors who have an interest in particular institutional arrangements and who leverage resources to create new institutions or to transform existing ones" (Maguire, Hardy and Lawrence 2004, pp 657). Notable empirical descriptions came from Maguire et al. (2004) who demonstrated the range of activities in which motivated and enabled actors engage to create new practice within the emerging field of HIV/AIDS treatment in Canada. In addition Greenwood and Suddaby (2006) demonstrated the entrepreneurial activity of elite accountancy firms within the field of professional business services to introduce a radical new organisational form: the multidisciplinary practice.

Whilst providing a valuable contribution to understandings of institutional agency and a necessary balance to the determinism of earlier neoinstitutionalism, scholars began to comment that descriptions of the activity of these highly rational and powerful actors to create new institutions could account for only a limited and specific form of institutional action (Lawrence and Suddaby 2006, Meyer 2006). Drawing on insights from Leblebici (1991) Lawrence and Suddaby (2006, pp. 217) assert the belief that the practices associated with institutionalisation "go well beyond those of institutional entrepreneurs—the creation of new institutions requires institutional work on the part of a wide range of actors, both those with the resources and skills to act as entrepreneurs and those whose role is supportive or facilitative of the entrepreneur's endeavors."

Lawrence and Suddaby (2006) also draw upon Oliver's (1992) discussion of deinstitutionalisation to highlight the role of institutional actors not only in the creation of new institutions but also in the disruption and maintenance of existing institutions. In her paper *The antecedents of deinstitutionalization* Oliver (1992, pp. 563) describes the conditions under which "the erosion or discontinuity of an institutionalized organizational activity or practice" are likely to occur. Although not focussed specifically on institutional agency, the article makes reference to the role of action in both challenging and maintaining institutions.

By combining the theoretical insights on institutional agency provided by DiMaggio (1988) and Oliver (1991, 1992) with related empirical work Lawrence and Suddaby (2006) make a valuable contribution to this literature by introducing the concept of "institutional work". Defined as "the purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions" (Lawrence and Suddaby 2006, pp. 215), this concept serves to consolidate related but previously unconnected research concerning the effect of actors' behaviour on institutions as well as providing a framework to guide future work. Through a review of empirical studies addressing institutional work the authors identify examples of various forms of institutional work associated with institutional creation, maintenance and disruption and in doing so produce a useful preliminary typology of this phenomenon.

Work associated with the creation of institutions is divided into three sub-categories: Political work, work on belief systems, and work on meaning systems. Political work, which could take the form of activities termed "vesting", "defining" and "advocacy", occurs when "actors reconstruct rules, property rights and boundaries" (Lawrence and Suddaby 2006, pp. 220-221). Work on belief systems is focussed on changing these systems and includes "constructing identities", "changing norms" and "constructing networks" (Lawrence and Suddaby 2006, pp. 221). Work on meaning systems aims to "alter abstract categorizations in which the boundaries of meaning systems are altered" and may involve "mimicry", "theorizing" and "educating" (Lawrence and Suddaby 2006, pp. 221).

Work associated with maintaining institutions "involves supporting, repairing or recreating the social mechanisms that ensure compliance." (Lawrence and Suddaby 2006, pp. 230) This is divided into two categories: work to promote compliance with existing rules through "enabling", "policing" and "deterring"; and work to maintain institutional norms and beliefs through "Valorizing/demonising", "mythologizing" and "embedding and routinizing" (Lawrence and Suddaby 2006, pp. 230). Finally, work associated with the disruption of institutions "involves attacking or undermining the mechanisms that lead members to comply with institutions" by "disconnecting sanctions/rewards", "disassociating moral foundations" and "undermining assumptions and beliefs" (Lawrence and Suddaby 2006, pp 235).

Zietsma and Lawrence (2010) further develop theoretical conceptualisations of the forms of institutional agency through their distinction between practice work and boundary work i.e., "the work of actors to create, maintain and disrupt the practices that are considered legitimate within a field (Practice work) and the boundaries between sets of individuals and groups (boundary work)" (Zietsma and Lawrence 2010, pp. 189). For the purposes of this distinction practices are defined as "shared routines of behaviour" (Whittington, 2006, pp. 619) that conform to particular social norms and guide the activity of certain groups in certain situations whereas boundaries refer to "the distinctions among people and groups" (Zietsma and Lawrence 2010, pp. 190).

Zietsma and Lawrence (2010) assert that the relationship between boundaries and practices as well as the activities directed towards altering and maintaining them are crucial to understanding institutional stability and change. In their empirical work concerning developments in the British Columbia coastal forest industry they demonstrate the influence of specific combinations of boundary and practice work on the institutional lifecycle which is divided into 4 stages and articulated as follows: "(1) institutional stability, involving boundary and practice maintenance; (2) institutional conflict, involving breaching and bolstering the boundary and disrupting and defending practices; (3) institutional innovation, involving establishing experimental boundaries that were protected from institutional discipline and inventing new practices; and (4) institutional restabilization, involving cross boundary connecting and practice diffusion" (Zietsma and Lawrence 2010, pp. 201).

The concept of institutional work represents a useful framework through which to explore the activity of organisational actors to influence institutions, offering a number of particularly valuable theoretical contributions to the literature. Firstly, it encourages, and provides the theoretical concepts necessary for the creation of more balanced accounts of structure and agency (Lawrence, Suddaby et al. 2009):

> "Thus, a significant part of the promise of institutional work as a research area is to establish a broader vision of agency in relationship to institutions, one that avoids depicting actors either as "cultural dopes" trapped by institutional arrangements, or as hypermuscular institutional entrepreneurs." (Lawrence, Suddaby and Leca 2009, pp. 1)

Within this conceptualisation of agency Lawrence, Suddaby and Leca (2009) maintain an appreciation of the effect of institutions on action but simply refocus attention on the myriad ways in which actors and action have the potential to affect institutions. Consistent with the neoinstitutional approach to organisational studies the central concern with the relationship between institutions and actions remains, as does the "structurationist notion that all action is embedded in institutional structures, which it simultaneously produces, reproduces and transforms"; however, the focus is transferred to the activity and experience of actors (Lawrence, Suddaby and Leca 2009, pp. 52).

Furthermore, this focus is not limited to the dramatic and influential activities of institutional entrepreneurs but widened to include a far more encompassing range of human activity:

> "Missing from such grand accounts of institutions and agency are the myriad, day-to-day equivocal instances of agency that, although aimed at affecting the institutional order, represent a complex melange of forms of agency—successful and not, simultaneously radical and conservative, strategic and emotional, full of compromises, and rife with unintended consequences. The study of institutional work takes as its point of departure an interest in work—the efforts of individual and collective actors to cope with, keep up with, shore up, tear down, tinker with, transform, or create anew the institutional structures within which they live, work and play, and which give them their roles, relationships, resources and routines." (Lawrence, Suddaby et al. 2011, pp. 52-53)

Finally an additional and related contribution of the concept of institutional work, as alluded to in the above quote, is the conceptual space it creates for the "lived experiences of organizational actors", a focus that has been neglected within the institutional approach to the study of organisations (Larwence, Suddaby and Leca 2011, pp. 52) . Without such work organisational theorising remains overly structural and abstract and can fail to resonate with our experiences of organisational life (Bechky 2011). The concept of institutional work then provides a means to conceptualise a broader view of institutional agency at the level of individual actors answering the calls of numerous institutional scholars for increasing attention to micro-level phenomena in institutional theory that connect the experiences, perceptions and activities of individual and collective actors with the institutions that both influence and are influenced by them (Reay, Golden-Biddle et al. 2006, Bechky 2011, Lawrence, Suddaby et al. 2011). Institutional work represents a resonant, dynamic and developing concept and research area within organisation studies that continues to aid theorising into the various way in which actors influence their institutional environment (Lawrence, Leca et al. 2013).

When combined, the theoretical insights reviewed concerning the influence of institutions on action and the influence of action on institutions provide a comprehensive framework through which to explore the activities of organisational actors as they enact their roles. Whilst Scott's three pillars framework provides a means to conceptualise the institutional pressures acting

upon individuals to behave in prescribed and established ways, the concept of institutional work facilitates the consideration and categorisation of the means by which they may influence those institutions according to their particular interests and motivations.

As described, institutional theory's central assumption is that organisational structures and practices are influenced by societal institutions which operate through three key mechanisms or pillars to dictate action, or the choices of action that are conceived as possible and legitimate (Scott, 2014). Healthcare organisations and the individuals who work within them exist within a highly institutionalised and complex field and like any other organisational activity professional role enactment is constrained and enabled by the institutional environment in which it occurs (Currie and Suhomlinova 2006, Chreim, Williams et al. 2007). In order to understand the activities and challenges associated with the reconfiguration of professional roles it is necessary first to conceptualise the field within which this takes place. We must understand the institutional arrangements within which actors enact, interpret and negotiate their working practices and roles.

Therefore the review now moves on to consider the institutional influences of relevance to healthcare organisations and the individuals who work within them. A powerful institutional influence within the field of healthcare is that of the professions and in particular medical professionalism. The remainder of this chapter thus describes the key theoretical insights concerning the professions and the reconfiguration of professional roles elaborated within the sociology of the professions literature and the developing neoinstitutional view of the professions. The final section of the review then describes literature that situates these insights within the wider institutional arrangements governing the contemporary healthcare field, focussing particularly upon the impact of government policy concerning the management of healthcare organisations on professional role enactment and the professional institution more generally.

2.2 The Professions

The professions are highly influential social groups that shape the manner in which a wide range of human problems are addressed in our society. Comprising particular social structures, norms and understandings that guide important aspects of human activity they can be productively viewed through an institutional lens (Scott 2008a, Muzio, Brock et al. 2013). Professionalism provides the normative, cognitive and regulative elements that enable and constrain the enactment of professional work (Larson 2013) influencing professional practice, boundaries, jurisdictions and relationships. Understanding the pillars of the professional institution and the manner in which they influence and are influenced is therefore crucially important to addressing the phenomenon of professional role reconfiguration attempts in a highly professionalised organisational field such as healthcare.

The developing institutional view of the professions is founded on the rich sociological work that has preceded it. From the early traits accounts of professionalism to the power or conflict accounts that continue to influence the literature, this work describes the key characteristics of the professions, the basis of their enduring influence within society and the activity associated with the creation and maintenance of their jurisdictions. The following section therefore reviews the central insights developed within the sociology of the professions literature, with a particular focus on the theoretical concepts of professional expertise, autonomy and interprofessional competition, before the major features and additions of the neoinstitutional approach are outlined.

Functionalism and the Traits Approach to the Professions

In the early to mid-twentieth century the sociology of the professions literature was dominated by functionalist theory (Carr-Saunders and Wilson 1933, Parsons 1939, Durkheim 1957). From this theoretical perspective the professions were viewed as particularly important social groups who exerted a stabilising influence on society, organised and operating in a manner that served to meet human need and maintain social order (Macdonald 1995). Early work from this school of thought appeared from Carr-Saunders and Wilson (1933) who in their study of the English professions emphasised their role in perpetuating traditional practices and values in the midst of forces for change. Later Parsons (1939) identified the professions as having a position of particular importance in the functioning of modern industrial societies. The professions were viewed as crucial pillars of modern society and the values on which it was based.

Particularly influential in this regard was the work of Durkheim. In *Professional Ethics and Civic Morals,* in which Durkheim (1957) considered issues of moral regulation and social rights, the professions were regarded as social groups of utmost importance functioning between the level of the state and the individual. Durkheim emphasised the function of the professions as collectives within which particular "professional ethics" or systems of morals develop and are upheld. It is only to a specific professional group that their

associated system of "professional ethics" is strictly applied and enacted and as such "it is imperative that there be special groups in the society, within which these morals may be evolved, and whose business it is to see they be observed" (Durkheim 1957, pp. 7). Through the development and enforcement of their relative systems of professional ethics the professions were viewed as performing a key function in underpinning the moral foundations of society.

A central and related endeavour of sociologists of the professions during this era was to define what it meant for an occupation to be a profession, creating criteria or typologies that distinguished a profession from other variably less professional occupational groups. This perspective is commonly referred to as the "traits" approach (Macdonald 1995). In an early attempt to capture the essence of professionalism in this manner Carr-Saunders and Wilson (1933) presented case studies of the emergence and establishment of the English professions with the aim of delineating the typical characteristics of a profession. They take as their starting point the "ancient" and "acknowledged" professions of law and medicine (Carr-Saunders and Wilson 1933, pp. 284). Following the presentation of their case studies it is asserted that these archetypal professions are marked by a complex of key characteristics. Firstly, "the practitioners, by virtue of prolonged and specialized intellectual training, have acquired a technique which enables them to render a specialized service to the community" and it is the acquisition of such techniques from which professionalism emerges (Carr-Saunders and Wilson 1933, pp. 284). In addition these professions "…develop a sense of responsibility for the technique which they manifest in their concern for the competence and honour of the practitioners as a whole" (Carr-Saunders and Wilson 1933, pp. 284). This is represented in the development of associations charged with the assessment of professional competence and maintenance of standards of conduct and ethical codes.

Many authors followed, producing various lists of attributes, classifications and scales of professionalism (e.g., Goode 1957, Greenwood 1957). Although there was considerable variation in the precise approach and criteria published there was general agreement in terms of the primary defining characteristics of the professions: the specialist training in, and application of, a formal and esoteric body of knowledge and skills; the adoption of a service orientation and an ethical code; and, on the basis of these aforementioned characteristics, the freedom of self-regulation and autonomy within their work (Larson 1977, Abbott 1988, Scott 2008). The defining characteristics of a profession therefore included key cognitive, normative and regulative elements:

> "The cognitive dimension is centred on the body of work and techniques which the professionals apply in their work, and on the training necessary to master such knowledge and skills; the normative dimension covers the service orientation of professionals, and their distinctive ethics, which justify the privilege of self-regulation granted them by society…" (Larson 2013, pp. xi)

Within this body of work the existence and authority of professional groups was viewed largely as the result of the expertise that they possessed. The

possession of specialist knowledge positioned the professions as experts whom, with the insurance of professional associations, licenses and codes of ethics, their clients and society more broadly could trust to work in the interest of those they served (Abbott, 1988).

Informed by such a view of professionalism early accounts of the process of professionalisation emphasised movement through a naturalistic series of events by which an occupational group create the structures and characteristics of an ideal-typical profession. In his assessment of the established American professions Wilensky (1964) presents a typical chronology of key events beginning with the establishment of the work with which the profession is concerned as an area of full-time occupational activity. This is followed sequentially by the establishment of the first training school, the first university school, the first local professional association, the first national professional association, the first state licence law and finally a formal code of ethics (Wilensky 1964, pp. 143). It was the adoption of these particular forms and structures that marked the development of a true profession as distinguished by the technical nature of their work "based on systematic knowledge or doctrine acquired only through long prescribed training" (Wilensky 1964, pp. 138) and adherence to professionally defined moral norms in line with a service orientation prioritising client over personal or financial interest.

The Conflict or Power Approach to the Professions

By the middle part of the century the traits approach to conceptualising the professions and functionalism more generally had begun to attract significant criticism. Scholars began to note the bias apparent in the manner in which some occupational groups were granted the title of profession whilst others were not and a lack of consensus in terms of the traits to be included in definitions of the professions (e.g., Millerson 1964). In addition an alternative, and later highly influential, interactionist approach to the study of the professions was developing in America. In particular, the writing of Hughes (1958, 1963) began redirecting attention from the characteristics of an ideal-typical profession to the day-to-day interaction of professionals as they construct, interpret and negotiate their social worlds.

Hughes is credited with initiating a critical change in the manner in which sociologists approached the study of professions, shifting attention from structure to action and from questions concerning what qualities and arrangements define a profession to how professions act to create and maintain their status as privileged occupational groups (Larson 1977, Macdonald 1995). This laid the foundation for other sociologists from this school of thought and to a tradition often termed the "power" or "conflict" approach within the sociology of the professions (Freidson 1994, Macdonald 1995, Scott 2008a). Within this tradition professions came to be viewed, not as altruistic, ethical groups dedicated to serving society, but groups who obtain control over a particular area of activity on the basis of claims to specialist knowledge and expertise resulting in enhanced status and rewards (Freidson 1970b, Johnson 1972, Larson 1977, Freidson 1988).

In his seminal works *Profession of Medicine: a study of the sociology of applied knowledge* (1988 [1970a]) and *Professional dominance: the social structure of medical care* (1970b), Elliot Freidson uses the case of American medicine to produce new insights into the basis of professionalism and professional power. Freidson sets the medical profession apart from others as *the* elite modern profession having risen through the centuries to become one with the defining characteristic of "preeminance" in terms of both prestige and expert authority; "medical knowledge about illness and its treatment is considered to be authoritative and definitive….It has an officially approved monopoly of the right to define health and illness and to treat illness." (1988, pp. 5). According to Freidson the medical profession represents the "prototype" of professional privilege and as such the study of medicine provides valuable insights into the concept of professionalism more broadly.

In this work Freidson is concerned not with the defining professionalism in the manner in which many of his predecessors had, but in analysing "the significance and consequences of some of the elements common to most definitions", particularly the organisational or institutional elements that relate to "the organization of practice and the division of labour" (Freidson 1970b, pp.133). Through his analysis of medicine, Freidson (1988) demonstrates that a profession's "occupational organization" "constitutes a dimension quite as distinct and fully as important as its knowledge, and that the social value of its work is as much a function of its organization as it is of the knowledge and skill it is said to possess" (Freidson 1988, pp. xi).

Central to his thesis is the concept of autonomy or self-direction, which when considering professions concerns "control over the content and the terms of work" (Freidson 1970b, pp. 134). For Freidson this is the defining characteristic of a true profession. It is argued that the institutional characteristics commonly comprising definitions of a profession can almost all be considered as resulting from the profession's autonomy or as arrangements that facilitate and enable autonomy. For example, self-direction of work is enabled by prolonged training within specialised professional schools, controlling knowledge and thereby positioning the judgement of those outside the profession as illegitimate. Autonomy is further supported by the legal monopoly provided by licencing. Codes of ethics can be viewed as a means to justify and gain autonomy, proclaiming the trustworthiness of the profession.

Freidson emphasises self-regulation as a particularly important professional privilege, justifying and testing a profession's autonomy. Freidson (1988, pp.137) notes three claims used by professions to justify such a privilege:

> "First, the claim is that there is such an unusual degree of skill and knowledge involved in professional work that nonprofessionals are not equipped to evaluate or regulate it. Second, it is claimed that professionals are responsible—that they may be trusted to work conscientiously without supervision. Third, the claim is that the profession itself may be trusted to take the proper regulatory action on those rare occasions when an individual does not performs his work competently or ethically."

By advancing such claims the profession positions itself as the only group legitimately able and competent to pass judgement on professional work as well as a group with the moral and ethical standing that guarantees its commitment to do so. Having achieved self-regulation the profession has gained immunity from outside control and therefore its autonomy.

Freidson therefore reconceptualises the normative and cognitive elements of traditional definitions of professions as social constructions utilised to justify and secure a monopoly over the provision of particular services and autonomy of function. In doing this he draws attention to the fact that the professions must exert effort and influence to attain their prestige and privileged position within society. It does not simply emerge as a natural consequence of their knowledge and skill. He also centralises the function of the state in granting and supporting this monopoly and autonomy, which once attained allows the profession to develop even greater independence and control over their own work.

According to Freidson (1988), medicine's rise to preeminance as a consulting profession can be tracked through a number of important developments. First was the development of university training for physicians beginning in the middle ages, which provided the first officially recognised qualification in the practice of healing. The establishment of the university medical school provided the means to create and accredit physicians as a recognised and unified occupational group. It also set these individuals apart as experts within this field of knowledge, paving the way for the profession to gain state support as "the arbiters of medical work" and in doing so to attain ultimate control over the professions' activities (Freidson 1988, pp. 23). This combined with the development and application of the scientific and technological advancements that followed provided medicine with the necessary foundations to convince the laymen that physicians offered a valuable solution to their problems that was superior to other forms of healer.

An additional factor of paramount importance for the medical profession's success in the western world is the relationship it has cultivated with governing states (Freidson 1970b, 1988). According to Friedson (1970b, pp.83) "the foundation on which the analysis of a profession must be based is its relationship to the ultimate source of power and authority in modern society—the state". It is the state, through various licencing systems, that ultimately grants exclusive legal right to practice and that endorses the physician as the arbiter of medical work. For example, in the United Kingdom, a crucial milestone in the development of the professional power of medicine was the introduction of the The Medical Act 1858. The creation of this Act of Parliament saw the introduction of the General Medical Council to regulate doctors and the Medical Register which listed all those legally qualified to practice medicine in the UK, both of which still function today. Similar state endorsed bodies exist to regulate and licence the medical profession in countries across the world including Europe and North America. It is through this state endorsed monopoly and self-regulation that the medical profession obtain much of their professional power. It is important to note here however that whilst emphasising its importance Freidson (1988) acknowledged the

inherent tension in this relationship in which paradoxically the autonomy of a profession is granted and maintained by the state upon which it is therefore to some degree dependent. The relationship between the medical profession and the state represents an issue of enormous contemporary relevance, particularly in state funded health services such as the National Health Service (NHS) where the state have an influence upon determining the terms of medical work: an issue which is discussed in depth in the following section of the review.

According to Fredison (1970, 1988) the medical profession's monopoly and autonomy has subsequently enabled them to dominate and control the development of other occupational groups functioning within the healthcare arena. Such dominance in the medical division of labour is not seen to be reflected primarily in the actual tasks carried out by the various occupational groups, many of which overlap with those carried out by doctors, but by the doctor's "control of the division of labor" (Freidson 1988, pp. 48). Medical dominance is evident in the professions' control over the production and oversight of the knowledge used in the content of allied health professions' training courses, their control over determining diagnosis and the course of treatment for patients, and their role in directing and supervising the work of other professional groups. It is also reflected in the enhanced "prestige" associated with the medical profession in the view of the public, never matched by the various other professional groups within the medical division of labour. (Freidson 1988, pp. 49)

Freidson (1988, pp. 48) describes the non-medical occupational groups working within the medical division of labour as "paramedical" i.e., "occupations organized around the work of healing which are ultimately controlled by physicians." These occupational groups fail to attain the status of a fully-fledged profession due to medical control and are characterised by "their relative lack of autonomy, responsibility, authority and prestige." (Freidson 1988, pp. 49). The medical profession is able to influence and oversee the work of allied occupational groups but is subject to no such influence and evaluation itself; there exists a "hierarchy of institutionalized expertise" in which paramedical professions are subordinated by medicine. (Freidson 1970b, pp. 137).

Thus, for Freidson it is autonomy that makes the professions distinctive, separating them from other occupational groups and affording them their social power. Professions can be understood as a form of "organized autonomy" protected and stabilised by the institutional arrangements that are constructed around them with the support of the state. Through the establishment of a particular social structure based on the acceptance of their claims to particular knowledge, skills and ethicality, professions not only create a monopoly over their area of practice but also render interference and judgment from those outside of the profession illegitimate, enabling an independence of function unachievable for other occupational groups.

Following the influential work of Freidson other sociologists continued to develop the conflict or power approach to the study of the professions emphasising professional control of knowledge and expertise, the rewards

associated with professional status and the effort involved in attaining this position. Larson (1977) built upon the work of Freidson through her application of Weberian and Marxist theory to the study of the professions linking them to the class system of capitalist societies. Drawing particularly on Weber's concepts of stratification and the economic and social order Larson (1977) demonstrates how professionalisation can be viewed as an effortful "attempt to translate one order of scares resources—special knowledge and skills—into another—social and economic rewards" (Larson 1977, pp. xvii). The process of professionalisation is described in terms of the strategic pursuit and development of market control and social mobility, achieved through the marketing and monopoly of expertise and the use of the educational system.

Meanwhile in the UK Johnson (1972) also made an important theoretical contribution to the power approach to the professions focussing on the producer-consumer relationship. Johnson (1972) highlights the function of professionalism as an arrangement empowering the producer in relation to the consumer. This work describes the manner in which the development of specialised skills and esoteric knowledge within an occupational group creates the capacity for such a relationship based on consumer dependence upon the skills of the group and "social distance" in terms of common experience and knowledge between producer and consumer. Where social distance creates uncertainty and indeterminacy an occupational group is able to take a position of power over the consumer and function with an increased level of autonomy. Professionalism is conceptualised as a means of controlling work in which "the producer defines the needs of the consumer and the manner in which these needs are catered for." (Johnson 1972, pp. 45)

The 1970's thus represented a "critical period" for the sociology of the professions during which major theoretical contributions appeared from the authors reviewed (Freidson 1994). These contributions clearly represented a departure from the functionalist and traits accounts that preceded them shifting the focus to professional status and rewards and the means by which these are achieved (Freidson 1970b, Johnson 1972, Larson 1977, Freidson 1988). This work highlights the manner in which through, the development of control over knowledge and expertise, occupational groups are able to attain and maintain professional power.

In the following decade an additional and highly influential contribution to the sociology of the professions literature came from Abbott's (1988) *The System of Professions*. Like the power or conflict theorists before him Abbott found traditional definitions of professionalism, and particularly theory concerning the process of professionalisation, to be lacking. Previous sociological theory on the professions was viewed as being overly focussed on "organizational pattern" and a universal process of professionalisation by which this was achieved (Abbott 1988, pp. 1). Such work "ignored who was doing what to whom and how, concentrating instead on associations, licensure, ethics codes" (Abbott 1988, pp. 1-2). Abbott's writing also focusses on the issue of how professions control their knowledge and its application, emphasising the importance of abstract knowledge and the development of social structures that confer exclusive rights in this process (Abbott 1988, pp. 59). An important

concept in this regard used by Abbott is that of professional jurisdiction i.e., the "social tie .... that binds profession and task—a recognized right, a legitimate link between the two" (Abbott 1988, pp. 33)

Abbott (1988) particularly labours the critique that early literature failed to fully consider the wider context within which individual professions developed, following the shift made by conflict scholars from the study of individual professions to the population ecology level. As the title of his book suggests, Abbott's (1988) thesis is that the professions exist in an interdependent system in which they compete for jurisdiction over particular areas of activity and that interprofessional competition within this system is the analytical key to studying the professions. According to Abbott (1988), it is only by considering competing professions systematically that the development of the professions and the nature of professional life can be fully understood:

> "Control of knowledge and its application means dominating outsiders who attack that control. Control without competition is trivial. Study of organizational forms can indeed show how certain occupations control their knowledge and its application. But it cannot tell why those forms emerge when they do or why they sometimes succeed and sometimes fail. Only the study of competition can accomplish that." (Abbott 1988, pp. 2)

Abbott emphasises that a profession's jurisdictional boundaries in relation to those occupations that surround it are in continual negotiation at both the micro and macro levels of day to day practice and national developments and it is these "jurisdictional disputes" that shape the development of the professions. He also acknowledges that these negotiations and disputes are shaped by the system within which they take place:

> "Each profession is bound to a set of tasks by ties of jurisdiction, the strengths and weaknesses of these ties being established in the process of actual professional work. Since none of these links is absolute or permanent, the professions make up an interacting system, an ecology. Professions compete within this system, and a profession's success reflects as much the situation of its competitors and the system structure as it does the professions' own efforts. From time to time, tasks are created, abolished, or reshaped by external forces, with consequent jostling and readjustment within the system of professions." (Abbott 1988, pp. 33)

Abbott's (1988) discussion of jurisdiction and competition to maintain control over it adds complexity and detail to previous accounts of professional control considering different forms of jurisdiction as well as providing a detailed consideration of "the actual claiming of jurisdiction—where the claims are made, what different types of claims are made, and how they depend on professional structure" (Abbott 1988, pp. 33-34). In particular, Abbott's (1988) detailed consideration of the micro-dynamics of interprofessional negotiation in the workplace, including the jurisdictional blurring associated with "workplace assimilation", is a contribution that has had an enduring impact on accounts of micro-level professional role reconfiguration in healthcare and is

therefore of significant relevance to the focus of this thesis. The following paragraphs explicate Abbott's detailed insights concerning the foundation of professional jurisdiction and the manner in which this is claimed with a particular focus on these theoretical concepts.

Like the theorists that had gone before him Abbott centralises control over knowledge and expertise in his study of the professions. In Abbott's (1988) terms the "cultural machinery" or "cognitive structure" of a profession's jurisdiction are made up of their "claims to classify a problem, to reason about it, and to take action on it: in more formal terms, to diagnose, to infer and to treat." (Abbott 1988, pp. 40). This is the basis of the professional knowledge system. These three activities capture the essence of professional work and provide the means by which professionals recreate and assign the "subjective qualities" to their tasks and guide action (Abbott 1988, pp. 40).

During the act of diagnosis professionals collect the information they deem relevant regarding the nature of a client's problems then assign a particular label from their professionally approved classification system. Once classified the client's problem can be treated, although a clear and direct connection between diagnosis and treatment is rare, and as discussed later, not professionally desirable. Treatment also relies on a classification system dictating the range of potential treatments. A number of factors related to diagnosis and treatment influence the security of professional jurisdiction including the "clarity" and "strictness" of diagnostic systems (Abbott 1988, pp. 44), the "acceptability" of treatments to clients (Abbott 1988, pp. 58) and the "efficacy" and "measurability" of treatment outcomes (Abbott 1988, pp. 46).

Of particular importance to jurisdictional security is the step linking diagnosis and treatment: professional inference i.e., the relation "of professional knowledge, client characteristics and chance…undertaken when the connection between diagnosis and treatment is obscure" (Abbott 1988, pp. 48-49). The level of inference or discretion required when making professional decisions is crucial in determining jurisdictional security with claims that rest upon either minimal or extensive inference dangerous to the profession. According to Abbott, the maintenance of a secure professional jurisdiction is dependent on striking the right balance between too much and too little inference. Professions' claims for the need for extensive inference are unconvincing, lacking the ability to demonstrate the coherence and logic required to gain legitimacy. On the other hand, a lack of inference makes a profession's work vulnerable to "routinization", opening up the possibility that it can be legitimately carried out by others (Abbott 1988, pp. 51). Activities that require little professional inference either in the connection of diagnoses to treatments, or in the diagnostic or therapeutic procedures themselves, are therefore dangerous to professions, providing "an obvious target both for poaching by other professions and for compulsory deprofessionalization by the state." (Abbott 1988, pp. 51)

Within Abbott's (1988) thesis the creation of a convincing construction of professional work is only part of the activity necessary to successfully claim jurisdiction. An additional and crucial element of this process involves

achieving societal recognition of this construction in the form of exclusive social rights; "Jurisdiction has not only a culture but also a social structure." (Abbott 1988, pp. 59) Abbott (1988) identified three key arenas in which professions make claims to secure societal recognition and therefore jurisdiction: the public, the legal and the workplace.

According to Abbott (1988) gaining jurisdiction in the public and legal arenas are closely linked. The legal protection so important to professions is gained through first securing legitimacy in the eyes of the public, or due to the power of the state in the European context, in the eyes of those who influence state decision-making. The type of claims that can be made in this arena must take a specific form. They refer to homogenous groups of professions between whom exist clear and defining boundaries and jurisdictions. They are not concerned with individual variation amongst professionals or the peculiarities of particular cases or circumstance; "Differences of public jurisdiction are differences between archetypes" (Abbott 1988, pp. 61). This limited and specific approach to jurisdiction is even more pronounced in the legal arena where groups, activities, language and rights are rigidly defined. Once secured these public and legal jurisdictions defining clear interprofessional boundaries are extremely durable (Abbott 1988).

The workplace arena is markedly different from the public and legal arenas in terms of the nature of the claims made and the durability of jurisdictional boundaries. Claims are less concerned with the construction of professional work and more about the practicalities of who can and should do which elements of the work to be completed, as well as who should control it and supervise it (Abbott 1988, pp. 64). The definite and clear boundaries between professional groups conveyed in the public and legal arenas become blurred in the complexities, demands and realities of the workplace, where individuals from one occupational group may carry out work formally within the jurisdiction of another. These workplace jurisdictions are considerably less durable than those secured in the public and legal arenas involving a process of ongoing "negotiation" in the context of a changing workplace environment. (Strauss, Schatzman et al. 1963, Strauss, Schatzman et al. 1964, Abbott 1988).

Abbott (1988, pp. 65) recognises that the phenomenon of "workplace assimilation", which refers to the blurring of professional jurisdictions, is particularly pervasive where professionals work in organisations. The necessity for the organisation to function and for organisational aims to be met requires that the division of labour be renegotiated accordingly, "with the common result that the boundaries of actual professional jurisdiction change to accommodate organizational imperatives" (Abbott 1988, pp. 65). In many workplaces, particularly public sector organisations with a high workload, the extent of this "workplace assimilation" is high and essential for effective functioning (Abbott 1988, pp. 65).

Crucially, Abbott (1988) emphasises that the blurring of professional boundaries within the workplace presents a major challenge to established professional jurisdiction. Such blurring can undermine public and legal claims to jurisdiction which rely on maintaining the legitimacy of clear

interprofessional boundaries. This is a particular threat to the position of professional groups who are superordinate in a publically and legally defined hierarchy in which subordinate occupations also function. Subordinates are described as occupational groups who have not secured full control over their area of work but occupy a more limited "settlement" within a jurisdiction controlled by a dominant group (Abbott 1988, pp. 71). Conversely jurisdictional blurring may represent an opportunity for subordinates to extend their jurisdiction, gain access to more interesting work and potentially enhance their position in the system of professions.

Abbott (1988) highlights the tendency of subordinates who stand to benefit from blurred jurisdiction to emphasise their ability to carry out those tasks officially within the remit of the more senior group, whilst superordinates draw upon the clear distinction between themselves and their subordinates as it exists in the public and legal arenas. For example:

> "…since doctors dominate the medical division of labor, they invoke their clear public relations with everyone else in the hospital. Nurses, on the other hand, emphasize their formal separation from their subordinates, but emphasise, vis-à-vis physicians, the functions and knowledge that both groups share. Public clarity applies below; workplace assimilation applies above." (Abbott 1988, pp. 67)

Abbott (1988, pp. 73) stresses that in order to achieve continued subordination of another occupational group in the face of workplace assimilation the dominant profession must reinforce the more formal distinctions between the two groups within the workplace: a pervasive activity which involves the use of symbolic distinctions and exclusionary behaviours. Superordinates employ a wide range of approaches to achieve these ends. Symbolic distinctions may take the form of "dysfunctional monopolies (as medicine's of prescription), distinctions of dress and speech (the use of white coats and honorifics), the maintenance of artificial educational distinctions (the teaching of unnecessary basic sciences), and so on" (Abbott 1988, pp. 67). This "complex symbolic order" is reinforced by "countless acts of exclusion ("nurses don't need to know why") and of coercion ("we do it because the doctor ordered it"). Subordinate professions are in some sense a contradiction in terms. Maintenance must be constant" (Abbott 1988, pp. 72-73). Whilst Abbott did acknowledge the potential advantages of jurisdictional blurring for superordinate groups, particularly in relation to delegating routine work that may undermine the position of the profession, the emphasis is placed upon the threat it presents and the effort required in maintaining control and status.

The significance of Abbott's contribution therefore lies in the importance he places on interprofessional competition within an interdependent system of professions upon professional control of knowledge and jurisdiction. Abbott (1988) centralises the ongoing engagement of the professions and professionals in disputes that shape the way their jurisdictions emerge and evolve. He also centralises the constraints that are placed on this activity by the system within which it occurs, detailing the specific arenas in which claims can be made and the forms that these may take. Of particular relevance to this

thesis are Abbott's (1988) insights into the workplace arena and the day to day activity of professionals to extend and defend their territory as it is occupied and encroached upon by competing occupational groups.

The Neoinstitutional Approach to the Professions

Organisational neoinstitutional theory has long incorporated the study of the professions (Leicht and Fennell 2008). For example, professional schools and associations provide the classic example of collectives that through the socialisation of their members into a particular system of beliefs create normative pressure towards particular ways of enacting and organising professional activities within an organisational environment. In addition, the professions and professionals have been identified as institutional agents capable of creating change within organisations and the wider organisational field (e.g., Greenwood, Suddaby et al. 2002, Zilber 2002). However, it has not been until relatively recently that there have been attempts to clearly articulate an institutional approach to the study of professions (Leicht and Fennell 2008, Scott 2008a, Muzio, Brock et al. 2013).

An important element of this development has been the conceptualisation of professions as institutions (Scott 2008a, Muzio, Brock et al. 2013). According to Scott (2008, pp. 233) "the notion of profession is itself an institutional model specifying the characteristics of the social structures of those actors performing knowledge work in our society." The mastery of a base of formal knowledge and possession of expertise, norms founded on high ethical standards and a service provision and professional autonomy and self-regulation emphasised in traditional sociological accounts of the professions can be seen as key characteristics of the institutional model of professionalism (although as discussed in detail in the following chapter these characteristics are evolving under the influence of various external social forces) (Scott 2008a).

Further the process of professionalisation can be seen as a form of institutionalisation. Drawing on insights from the professions literature (Johnson 1972, Larson 1977), and following the work of other neoinstitutional theorists who connect the two processes (e.g., Suddaby and Viale 2011), Muzio et al (2013) explicate the manner in which the process of professionalisation can be viewed as a process of institutionalisation: "professionalization is a subset or a particular flavour of the broader category of institutionalization insofar as it represents one of several ways to give order, structure, and meaning to a distinctive area of social and economic life (the production of expertise)." (Muzio et al, 2013, pp. 705).

As we have seen, definitions of institutions highlight their function in providing stability and order to social life, and the taken-for-granted nature that institutionalised activity attains. The institutional approach to the professions therefore highlights the institutionalised nature of professional activity (Muzio, Brock et al. 2013). Professionalism can be viewed as the dominant institutional model for organising expert work within contemporary societies (Freidson 2001) providing the guiding, and widely accepted, principles for

carrying out such work. Particularly important for the focus of this thesis, the institutionalised nature of professional activity can also be understood to extend to the interprofessional relations and hierarchy within a given area of professional activity.

Focussing on the healthcare arena specifically Batillana (2011) describes the "model of medical professionalism" that provides the dominant institutional template that guides the relationship between key actors within healthcare systems across the western world. In terms of role division across the healthcare professions the model is based on the principle of medical dominance over all other groups emphasising the position of medical specialists at the top of the hierarchy as "key decision makers", holding "authority over all other NHS professionals in the clinical and in the administrative domains" (Batillana 2011, pp. 820). Within this model "nurses act as physicians' assistants" and "allied health professionals act as medical auxiliaries" (Batillana 2011 pp. 820). Managers or administrators are positioned "....as "diplomats" facilitating the work of physicians" (Batillana 2011, pp. 820).

As described in the previous section neoinstitutional theory frameworks recognise that the allocation of roles conveys powerful normative influences upon the actors enacting those roles:

> "These beliefs are not simply anticipations or predictions, but prescriptions—normative expectations—regarding how specified actors are supposed to behave. The expectations are held by other salient actors in the situation, and so are experienced by the focal actor as external pressures. Also, and to varying degrees, they become internalized by the actor." (Scott 2014, pp.64)

Thus, when an individual enters the workplace with the title of doctor, nurse or any other professional, they do so under the influence of powerful normative forces that dictate what it means to hold that title. They will have their own beliefs about what a doctor or nurse *should* do, how they should interact with the other categories of actors around them and what responsibilities are theirs. They will also be influenced by the expectations of other actors' beliefs in this regard, both those within and outside the organisation including colleagues, patients, managers, the media, the public, the state and the coroner.

In line with the agentic turn in the neoinstitutional theory literature the professions and professionals can also be seen as institutional agents involved in the creation and maintenance of institutions. In his seminal paper, *Lords of the Dance: Professionals as Institutional Agents* Scott (2008a) identifies the professions as "the preeminent institutional agents of our time", shaping the institutions in which we live through their ability construct the cultural-cognitive frameworks through which we understand our worlds, "devise normative prescriptions to guide behaviour" and "exercise coercive authority" (Scott 2008, pp. 219). Institutional agency is exerted by the professions in their efforts to obtain and maintain jurisdiction, monopoly, autonomy and control over specific areas of activity as emphasised within traditional conflict or

power approaches in the sociology of the professions literature (Freidson 1970b, Abbott 1988, Freidson 1988) but also extends beyond this to their influence in society more broadly (Scott 2008a, Suddaby and Viale 2011).

The concept of institutional work (Lawrence and Suddaby 2006, Lawrence, Suddaby et al. 2009) is particularly well placed to understand various forms of professional agency (Muzio et al., 2013) and the professions and professionals are identified in the literature as key actors in the performance of institutional work. Indeed in their review of the institutional work literature Lawrence et al (2013, pp. 1025) state that in scholarly considerations of *"who* engages in institutional work. A prominent answer to this question is: professionals and other actors associated with the professions."* Studies highlight the ability of professionals to utilise the construction of expertise as a form of institutional work (Lefsrud and Meyer 2012) and demonstrate the institutional work carried out by professionals from the societal (Suddaby and Viale 2011) to the intraorganisational level in healthcare settings (Currie, Lockett et al. 2012) and beyond (Zilber 2002).

It has been argued that the emerging institutional conceptualisation of the professions provides a development to the traditional sociological approaches. Specifically this approach enables movement beyond the idealised view of the professions that characterised much of the traits approach as well as the focus on power, monopoly and self-interest that dominates the conflict approach. It is Scott's (2008) view that in taking an institutional view of the professions we are able to accommodate aspects of these approaches to achieve a more balanced view of the professions and their activities; an institutional view…

> "….. permits us to argue that the knowledge claims advanced by professionals can be both somewhat arbitrary and sincerely advanced, that professional jurisdictions can be contested and changing without being a simple matter of political clout, and that in many circumstances the advancement of professional interests is not inconsistent with attention to client welfare." (Scott, 2008, pp. 221)

The neoinstitutional approach to the study of the professions therefore encapsulates and develops the key insights to emerge from the sociology of the professions literature, situating them within an organisational neoinstitutional framework. The defining traits of a profession in terms of expertise, service, ethics and autonomy can be understood as characteristics of an institutional model of professionalism and the process of professionalisation as akin to the broader process of institutionalisation; professionalism represents a specific way of enacting work that has become institutionalised over time obtaining social power and a taken-for-granted quality, providing structure and meaning to the production of expertise and the conduct of knowledge work within organisations and our society more broadly (Scott 2008a, Muzio, Brock et al. 2013). This can relate to specific forms and elements of professionalism including the interprofessional relations within professional groups for example, those dictated by the model of medical professionalism (Battilana 2011). Within this conceptualisation the professions and professionals are also viewed as powerful institutional agents capable of influencing the institutional

environments within which they act in line with various interests and objectives (Scott 2008a, Lawrence, Leca et al. 2013).

An important additional contribution to the neoinstitutional approach to the professions is the importance it places on the wider institutional and organisational context on the development of the professions and their work. Sociological literature on the professions has been critiqued for its focus on professional power and monopoly and its relative neglect of organisational context and there have been numerous calls from scholars interested in the professions to more fully incorporate the organisation into studies of the professions (Davies 2003, Muzio and Kirkpatrick 2011, Muzio, Brock et al. 2013). It has been argued that:

> "….traditional approaches in the sociology of the professions have not been able to fully cope with the shift of professional work to organizational settings…In this context, existing theories have not been able to fully grapple with the evolution, hybridization, and co-penetration of occupational logics and with the transformation of practices as professional jurisdictions are reshaped by exogenous forces." (Muzio, Brock et al. 2013, pp. 701)

An institutional approach to the professions emphasises the need to consider organisational and societal level influences, endogenous and exogenous to the professions themselves, on the enactment of professional work (Chreim, Williams et al. 2007, Scott 2008a). The neoinstitutional theory literature provides a means to explore the structural elements that help define professional jurisdiction and practice emanating from the professional institution itself, as well as the concurrent impact of wider influences and pressures within the institutional field emanating from policy and beyond.

Following increasing recognition of the importance of the organisation in professional work, a particularly important theme to emerge from both sociological and neoinstitutional literature concerns the impact of the location of professional work in managed organisational environments on the nature and concept of professionalism. It has been argued that a new form (Evetts 2002, Evetts 2009) or an evolving institutional model of professionalism (Scott 2008a, Muzio, Brock et al. 2013) is emerging that combines the traditional concerns and imperatives of the professions with those of the organisations in which they now work and are heavily influenced by. This important theoretical development raises interesting questions concerning the nature of contemporary professionalism and its impact on micro-level role enactment, including the reconfiguration of professional roles that will be explored in the following section.

2.3 The Professions within the Contemporary Organisational Context

This section of the literature review focuses on the organisational context within which contemporary professionalism is now located, specifically focussing on public health services. Firstly, this section describes workforce development policy that promotes the reconfiguration of professional roles within healthcare, and empirical work that considers the enactment of change attempts. Attention is draw to the dominant theme within this literature that describes professional activity to establish, extend and defend jurisdiction over particular areas of work and expertise and therefore maintain or enhance status and power. Such conceptualisations of attempts to reconfiguration professional boundaries reflect traditional understandings of professionalism and emphasise the potential for reallocation of expertise, knowledge and resource and therefore associated status and power. Change is therefore presented as an opportunity for new or subordinate professional groups to establish and extend their jurisdiction and enhance their position and, conversely, as a threat to superordinate groups who could lose control over jurisdiction resulting in a weakened position.

In line with an organisational neoinstitutional approach, and in answer to calls to more fully connect the study of the professions and organisations, the review then moves on to consider the wider organisational and institutional context in which professionals now work and in doing so reassess the dominant theoretical conceptualisation of professional role reconfiguration attempts. This section incorporates literature that describes important changes in the nature of professionalism and the use of professional expertise under the pressures within contemporary organisations that have implications for the enactment of professional roles, focussing particularly on the concepts of professional accountability and the management of risk. It is proposed that despite their lack of consideration in the workforce development literature these interconnected concepts are of central importance in drives toward the reconfiguration of professional roles that shift the boundaries of professional responsibility, raising questions concerning the interpretation of such change to the various professional groups involved.

Workforce Development and Professional Role Reconfiguration

The institutional environment within which the professions exist has undergone profound change over the past three decades. Professional work has increasingly been drawn into large organisations where it has been brought under tighter managerial control and scrutiny with demands for increasing efficiency, transparency and accountability. The rise of managerialism and its influence on the professions has received attention in the literature, particularly in relation to public sector professionals who are subject to greater influence

by the state (Gleeson and Knights 2006). New public management and the associated principles of managerialism arose in developed countries, including the UK, in the 1980's, and aimed to make public service organisation more efficient and customer focussed, and professional practice more explicit, flexible and controllable (Ferlie, Ashburner et al. 1996). The influence of New Public Management has meant that professionals have come under increasing pressure to work in new ways dictated by state and organisational policy and imperatives.

As outlined in the introduction one response of policy-makers to pressures upon healthcare systems both within and outside the UK has been to "modernise" the clinical workforce through the development of flexibility around professional boundaries and reconfigured roles (Nancarrow and Borthwick 2005, Martin, Currie et al. 2009). Policy has proposed the movement away from traditional interprofessional boundaries towards the development of new roles that are more responsive and suited to the demands placed upon modern healthcare services. The proposal of such change in which elements of clinical work and responsibility are shifted between professional groups challenges established professional boundaries and opens up the potential for the renegotiation of jurisdiction. As we have established, according to traditional conceptualisations of professionalism control over knowledge and expertise is key source of professional power (Freidson 1970b, Johnson 1972, Larson 1977, Freidson 1988) which professional groups will compete to attain and maintain (Abbott 1988).

A number of empirical studies explore the reconfiguration of professional roles and boundaries in healthcare settings (Allen 2000, Norris 2001, Timmons and Tanner 2004, Sanders and Harrison 2008, Currie, Finn et al. 2009, Martin, Currie et al. 2009, Salhani and Coulter 2009, Bach, Kessler et al. 2012, McIntyre, Francis et al. 2012). This work reflects the central theme of the professions literature, particularly that inherent in conflict or power accounts of professionalism, centralising the activity of professions to secure, extend and defend jurisdiction. Following a systematic review of studies of "disputed boundaries in health professions" King, Nancarrow, Borthwick and Grace (2015, pp.5) state that:

> "The common theme derived from the use of discourse to discredit the competitor profession, either on the basis of their approach to clinical care or their skills or competence."

The literature suggests that subordinate groups may draw upon a range of legitimising discourses to extend their scope of practice. Sanders and Harrison (2008, p. 303) for example, demonstrate the use of claims to "expertise, competence, organisational efficiency and patient-centredness" by newly introduced specialist heart failure nurses to carve out and legitimise their boundaries within previously medical territory. For nursing, claims to "patient-centredness" and "holism" in approaching clinical work appear particularly important in outlining their distinctive contribution to care when defining emerging boundaries in relation to medicine as well as other professional groups (Allen 2000, Timmons and Tanner 2004, King, Nancarrow et al. 2015).

Senior professional groups, particularly medical professionals, on the other hand appear to utilise claims around their unique possession of specialist expertise and knowledge to defend their territory and position (Sanders and Harrison 2008, Currie, Finn et al. 2009, Martin, Currie et al. 2009). Research demonstrates the tendency of senior medical groups to control and constrain the remit of extended roles taken on by subordinate groups that attempt to encroach into their areas of work e.g., through casting nurses with newly extended duties in the role of "technician" or "operative" who require the use of protocols (Allen 2000 pp. 343). This has also been reflected in the context of the redevelopment of genetics services in which the enactment of the newly introduced General Practitioner with Specialist Interest (GPSIs) role was constrained by the specialists geneticists' claims to indeterminate knowledge which justified the need to audit the work of any clinically active GPSI (Currie, Finn et al. 2009, Martin, Currie et al. 2009).

This theme is also reflected in the neoinstitutional literature concerning the enactment of professional role reconfiguration, to which the theoretical concept of institutional work has been fruitfully applied. Drawing upon sociological literature, elements of this work reflect the key themes within the traditional conflict or power accounts of professionalism in terms of the work of professionals to extend and maintain occupational jurisdiction through various claims to legitimacy. Importantly, the concept of institutional work also provides the theoretical apparatus to conceptualise a wider range of situated activity intended to influence institutionalised professional roles, boundaries and activities. A number of studies demonstrate the activity of healthcare professionals and managers as they negotiate the development of new working arrangements within contemporary healthcare organisations (Reay, Golden-Biddle et al. 2006, Currie, Lockett et al. 2012, Reay, Chreim et al. 2013). This work goes beyond the focus on the deployment of legitimacy claims by professional groups that characterises accounts of such change within the sociology of the professions literature to provide detailed accounts of a range of forms of situated action.

Empirical work has begun to demonstrate the micro-level activity of actors in healthcare systems to promote both institutional change and maintenance in the context of professional role reconfiguration. Drawing insights from the introduction of new roles in the Canadian healthcare system Reay and colleagues (Reay, Golden-Biddle et al. 2006, Reay, Chreim et al. 2013) provide detailed accounts of the activities and processes by which new practices become institutionalised within an established system, emphasising the work of nurses and managers in implementing and legitimising extended roles for non-medical professionals. Currie et al. (2012), drawing upon change in the UK system, make a further contribution by highlighting the manner in which senior medical professionals control the implementation of role change, supporting change in practice whilst maintaining the boundaries associated with the established interprofessional hierarchy.

Reay, Golden-Biddle and GermAnn (2006) provide a novel insight into the micro-level processes evident when a new role is introduced in a healthcare

context in their study of the legitimisation of the nurse practitioner (NP) role in the Canadian healthcare system. In this system the title of nurse practitioner is given to registered nurses who are granted the authority to diagnose and treat illness and to prescribe medication, practices previously carried out by physicians. The role was originally created to provide staff to cover areas where there was a shortage of medical staff in the 1970's and was limited to this situation only. However, nurse practitioners have now become a common and accepted part of many multidisciplinary healthcare teams in which they work alongside medical staff.

Over a four-year period the study identified the involvement of key actors (i.e., nurse practitioners and their managers) in three micro-level processes: "cultivating opportunities for change", "fitting a new role into prevailing systems" and "proving the value of the new role" (Reay et al. 2006, pp 984). By simultaneous engagement in these processes the actors created and consolidated small steps towards acceptance and legitimisation of the new role, moving from isolated examples of new ways of working to more widespread use and acceptance. The nurses and managers studied demonstrated considerable effort and persistence to enable the enactment and acceptance of the new role using the knowledge and connections gained from their "embeddedness" within the system to achieve change (Reay et al. 2006, pp. 977).

Cultivating opportunities for change describes the manner in which actors were "alert for situations or events that they could use to introduce and increase the visibility of the new role." (Reay et al. 2006, pp. 984) This began by utilising the "initial opportunity" provided by the shortage of junior medical staff to introduce the role followed by seizing "subsequent opportunities" to legitimise the role (Reay et al. 2006, pp. 985). Fitting the NP role into prevailing systems describes "the actors' efforts to represent and classify the role, so that it became hooked into the work procedures, resource allocations, and structures in healthcare organizations in Alberta." (Reay et al. 2006, pp. 986) Specifically this involved "classifying the role as nursing, not medicine" e.g., by situating the role with nursing rather than medical department of the organisations in order to prevent the use of the nurse practitioners as simply short-term substitutes for medics during the physician staffing problems. (Reay et al. 2006, pp. 986-7) It also involved "Incorporating the job description for NP into HR systems" and "ongoing efforts to remove system barriers" (Reay et al. 2006, pp. 988).

Finally, proving the value of the new role "related to actors' attempts to get others, especially professional colleagues, to recognize the value of the new role." (Reay et al. 2006, pp. 988) Through their day to day interactions with co-workers nurse practitioners worked to slowly demonstrate how the new role could be enacted in collaboration with colleagues demonstrating the mutual benefits to all involved. Nurse practitioners and their managers anticipated and overcame some initial concern and scepticism regarding the new role from both nursing and physician colleagues by taking a gradual approach to integrating the role, providing reassurance and emphasising positive outcomes associated with its enactment.

Reay, Chreim and colleagues (2013) make a further contribution to the literature by examining the role of managers in the introduction of reconfigured professional roles in healthcare systems. In their case study of the introduction of "interdisciplinary teamwork" to sectors of the Canadian healthcare system Reay et al. (2013) combine data exploring the introduction of the nurse practitioner role as well as the adaptation of the physician role. Driven by "general dissatisfaction with physicians seeing large numbers of patients, and research evidence that care could be improved by integrating services employing interdisciplinary teams" the proposed new practice suggested "change from autonomous physician roles to a team approach where multiple healthcare professionals provided appropriate services." (Reay, Chreim et al. 2013, pp. 970) Both changes required the reconfiguration of professional roles and the development of new practices.

Reay et al (2013) identify three phases of activity in which managers engaged to create new practice: "(1) Micro-level Theorizing, (2) Encouraging 'Trying It', and (3) Facilitating Collective Meaning-Making." (Reay et al. 2013, pp. 973) By drawing upon literature describing the transfer of ideas across contexts and the concept of habitualisation (Berger and Luckmann 1967) this study illustrates how the concept of interdisciplinary teamwork is "transformed" from an idea at the organisational level into frontline practice, highlighting the importance of "disrupting previously habitualized behaviours in transforming ideas …. into practice." (Reay et al. 2013, pp. 967) In the process model developed, phases one and two contribute to the dehabitualisation of established practice whilst phase three facilitates the re-habitualisation of new practice. The study illustrates the adoption of new practice across the four sites investigated with two achieving sustained change and the new practice becoming "taken-for-granted" (Reay et al. 2013, pp. 982).

Micro-level theorizing involved two key activities: "framing and justifying (explaining and presenting the rationale for) interdisciplinary teamwork, and proselytizing (spreading the message) to all potentially important audiences." (Reay et al. 2013, pp. 976) Managers worked "to carefully frame the desired new practices in a manner that fit with the context and explained the desirability of adopting the new practice", emphasising the role of interdisciplinary team working in improving care and meeting "unmet need". (Reay et al. 2013, pp. 977) The managers in this case then took all available opportunities to translate this organisation-level message to the front-line across their services.

The managerial approach to encouraging professionals to try new practice involved managers "co-locating professionals" and "identifying non-financial incentives" (Reay et al. 2013, pp. 978). By encouraging professionals to work alongside each other the managers allowed clinicians to experience the new practice in action as well as facilitating communication between the various professional groups involved. This strategy was combined with work to highlight incentives to encourage clinicians, particularly doctors, to engage with interdisciplinary team working. In the absence of the ability to control financial remuneration these had to be non-financial incentives which

emphasised the potential for reduction in work load and improvements in patient care (Reay et al. 2013, pp. 979). The authors highlight that it was through the enactment of new practice that clinicians generated their own individual sense of the practice of inter-disciplinary team working (Reay et al. 2013, pp. 980)

The final activity identified, facilitating collective meaning making, involved "creating cross-disciplinary and cross-site opportunities for group discussion and reflection" and "introducing organizational structures" (Reay et al. 2013, pp. 981). In setting up opportunities for clinicians to discuss changes with each other they facilitated the diffusion of practice across the organisation as well as the standardisation of practice. The desire for consistency of practice across the services was also pursued by managers by developing standards and job descriptions for the NP role (Reay et al. 2013, pp. 982). This activity enabled managers to "gradually reshape the new practices to better fit with the original macrolevel theorization that drove the desirability of interdisciplinary team-work." (Reay et al. 2013, pp. 982)

Together these two studies provide a detailed account of the purposive activities involved in the creation of new practice around reconfigured roles in healthcare systems, specifically an extended role for nurses and a collaborative team-based role for physicians. Reay et al. (2006) demonstrate the strategic, persistent, situated actions of nurses on the frontline, in collaboration with their managers, to establish and legitimise their new role. Reay et al. (2013) augment this understanding of the development of new practice by highlighting the role of managers in the translation of ideas from the organisational level to the enactment of new established practice on the frontline.

Currie et al. (2012) provide further evidence of the institutional work of professional actors within the context of healthcare role reconfiguration attempts through their in-depth case study of the implementation of the mainstreaming genetics policy within the UK NHS (Department of Health 2003), which sought to transfer elements of specialist genetics services from tertiary to secondary and primary care. The study examined the introduction of new roles to deliver genetics services in novel areas across three policy work streams: cancer genetics and non-cancer service development which introduced genetics nurse roles to secondary care, and the general practitioner with specialist interests (GPSI) role which enabled GPs to develop specialist genetics knowledge in order to deliver education and/or services within primary care (Currie et al. 2012, pp. 942). These suggestions therefore represented a potential threat to the jurisdiction and professional power of medical specialists and a divergence from institutionalised roles.

In contrast to the papers authored by Reay and colleagues (Reay, Golden-Biddle et al. 2006, Reay, Chreim et al. 2013) that focus on the activity required to create new practice in the form of extended roles for subordinate workers, Currie et al. (2012) highlight the activity of senior professional groups to maintain their position and power in the interprofessional hierarchy in the context of role reconfiguration. Across the three work streams the study

illustrates several forms of institutional work including 'theorizing', 'defining', 'educating', 'policing', 'embedding and routinizing' and 'constructing normative networks' in which clinical geneticists engaged to ensure new practice was enacted in a manner that maintained their senior position in the division of labour (Currie et al. 2012, pp. 946)

An example of the manner in which these forms of institutional work were used for maintenance in this setting is provided by the service development work stream in which marked differences between the approaches to maintenance work enacted by geneticists at different sites are contrasted by the authors to draw intriguing theoretical insights. The clinical geneticist within site A took a conservative approach to the developments, working to retain control and constrain the reconfiguration. Through "theorizing" and "defining" the initiative as one in which the geneticists would lead and retain ultimate authority this was established from the initiation of the project and reflected in the development of a "bounded" nursing role defined by the geneticists rather than mainstream doctors (Currie et al. 2012, pp. 947). This approach was continued in the "educating" and "policing" work enacted at this site in which the geneticists dictated the content of training to reflect a more limited nursing role and made arrangements to ensure close supervision and "checking" of the nurse's activities; work but not responsibility was delegated with the nurse gaining little clinical autonomy.

Within site C the clinical geneticist took a different approach toward the development of the new genetics services. Firstly, the initiative was "theorized" and "defined" as one that should be led and developed not by the geneticist, but from within the mainstream medicine area in which it would be enacted. The geneticists also viewed the new nursing role "as needing to transcend the traditional boundaries associated with nursing. Specifically, the clinical geneticist saw the need to enhance the capacity of the nurse to take a lead in the day-to-day management of the pilot, *and* that the nurse should have the autonomy to play a key role in defining and developing that role for herself as the pilot progressed" (Currie et al. 2012, pp. 947). This approach was also reflected in the "educating" and "policing" work carried out which allowed the nurse "choice and autonomy" (Currie et al. 2012, pp. 948) in pursing training as well as "supportive and facilitative" supervision "with a large degree of trust placed in the genetics nurse by the clinical geneticist" (Currie et al., 2012, pp. 949).

Despite the activity of the geneticist to cede control of the initiative and support the development of an autonomous nursing role this activity was presented by the authors as "the most subtle, concealed and, arguably, most effective form of institutional maintenance." (Currie et al. 2012, pp. 947) The authors argue that by enabling the mainstream doctors and genetics nurse to develop an extended scope of practice the geneticist was able to focus on work requiring a high level of expertise achieving specialisation and the maintenance of their most senior position in the established interprofessional hierarchy. This method avoided the power struggles between professional groups evident in case A and allowed the geneticist to "build normative networks" in which the new practice became "embedded and routinized"

resulting the successful adoption of the new, mutually advantageous arrangements (Currie et al. 2012, pp. 950).

In this paper Currie et al. (2012) highlight the ability of powerful professionals to constrain and control change, allowing change in practice only in a manner that maintains core boundaries as dictated by the model of medical professionalism (Battilana 2011). They highlight that institutional maintenance is not simply about defending the "status quo" but the engagement in creative action to control change. Whilst new roles were introduced and practice changed the institutionalised hierarchy was maintained due to the politically informed, strategic action of powerful institutional actors.

The studies reviewed in this section illustrate the activity of professional groups to extend and defend control over their particular areas of professional jurisdiction in the context of professional role reconfiguration attempts. Proposals of such change create the potential for subordinate groups to extend their jurisdiction and enhance their position and power therefore these groups work to legitimise and secure control over new areas of activity and knowledge. Conversely, these proposals present a potential threat to superordinate groups who work to ensure their continued power through the use of legitimacy claims around expertise and knowledge to justify their seniority and control of work within their area. Studies informed by the sociology of the professions literature emphasise the use of professional legitimacy claims in this process. Scholars taking a neoinstitutional approach make a further contribution to this area illustrating additional forms of institutional work utilised by professionals to change and maintain professional boundaries to enhance and maintain their power, status and position in the interprofessional hierarchy.

Reconceptualising Professionalism: Professional Accountability and the Management of Risk

The work reviewed above is consistent with seminal sociological theory that conceptualises the professions as special occupational groups who, by making claim to possession of specialist expertise, secure control and power within a particular area of work; Control over knowledge and expertise defines professionalism and represents the source of professional power and status (e.g., Freidson 1970b, Johnson 1972, Larson 1977, Abbott 1988). With issues of professional control, power and competition central within this literature it follows that any attempt to alter professional jurisdiction by blurring professional boundaries and reallocating work, expertise and resource will trigger professional disputes and competition over territory and the associated rewards. However, emerging theoretical insights concerning the changing nature and function of professionalism under the various pressures of the contemporary organisational context suggest the need to reconsider dominant understandings of professional responses to role reconfiguration attempts, particularly in terms of the nature of the activity being transferred across boundaries and its value to and implications for the professions involved.

A major feature of the contemporary organisational context, and one that this thesis will argue is highly relevant to issues of workforce development and professional role reconfiguration, is increased pressure for accountability and risk management on professionals. Traditional foundations of professional responsibility based on autonomy and self-regulation have been replaced with pressures for hierarchical accountability within organisations (Annandale 1996, Hanlon 1998, Power 2004, Evetts 2009). In additional, the growing appeal for professionals to utilise their expertise to perform risk management within organisations represents an additional, and particularly complex, function for which professionals are held to account (Bianic 2011). It has been suggested that such shifts have altered the function of professional work within organisations and the nature of professionalism more broadly. The following section of the review presents literature that considers the changing manner in which professionals are held to account for their decision-making and their function in the management of risk before reviewing the impact of such change on the micro-level enactment of professional work and the implications for role reconfiguration attempts.

As described, neo-liberal managerialist policy, under the banner of New Public Management, has exerted pressure within healthcare organisations and other public services to increase efficiency and accountability (Hanlon 1998, Newman 2001). The aim of such policy is to efficiently manage cost and quality of the service provided. Such a view presents accountability and quality assurance as issues that the professions, including the medical and allied professions, cannot adequately attend to themselves through traditional mechanisms and organisation and that therefore should be managed at least in part by external means (Dent 2006, Evetts 2006). As a result the decision-making of healthcare professionals in the UK and beyond is now directed and evaluated in terms of managerially informed guidelines, protocols, targets and criteria (Kirkpatrick, Ackroyde et al. 2005, Dent 2006).

The influence of employment within the public sector, and organisations more broadly, has triggered much discussion within the literature, a large body of which has focussed on a process of deprofessionalisation or proletarianisation in which the professions are subordinated and disempowered (e.g., Dingwall and Lewis 1983, Macdonald 1995). The argument presented is that when employed in bureaucratic organisations professionals are placed in a position where the objectives and values of the employer take precedence over those of their profession and the professions more braodly (Muzio and Kirkpatrick 2011). Other authors have proposed the emergence of new forms of professionalism that develop within the context of the organisational environment and diverge from traditional definitions of professionalism, for example *organisational* professionalism (Reed 1996, Evetts 2009). From a neoinstitutional perspective the professions are recognised as existing in a complex institutional environment influenced and evolving as a result of various exogenous pressures that exist within the organisational field (Leicht and Fennell 2008, Scott 2008b, Muzio, Brock et al. 2013).

Within the contemporary organisational context, in which neoliberal policy exerts increasing pressure on the enactment of professional work, a number of

authors have proposed the development of new forms of professionalism within which the concept of professional accountability is fundamentally changed. The literature makes a distinction between the professional autonomy and self- or collegial- regulation and evaluation associated with traditional models of professionalism and the hierarchical, managerial forms of evaluation and accountability associated with a new form of professionalism emerging as a result of pressure within the organisational environment (Evetts 2002, Scott 2008a, Evetts 2009, Liljegren 2012). For example, for Scott (2008a) the rise of the neoliberal concepts of market power and managerial control have contributed to the evolution of the institutional model of the professions in which: "an emphasis on individual autonomy and collegial controls has given way in many circles to a greater reliance on hierarchical and managerial controls" (Scott, 2008, pp. 233-234).

Of particular relevance to the impact of New Public Management on professionalism including professional accountability is the work of Evetts (2002, 2009). Evetts (2002) discusses the changing nature of contemporary professionalism focussing specifically on the ideal-typical characteristic of autonomy. Attention is drawn to claims in the literature around the decline in professional autonomy as professions are increasingly employed within organisations and, in the public sector, brought under a greater degree of state control. The defining characteristic of professional autonomy is problematised and it is proposed that professional discretion as opposed to autonomy may represent a more fitting description of the nature of contemporary professionalism and its connection to employing organisations.

According to Evetts (2002) whist professional discretion continues to allow professionals to apply their judgment and treatment to individual cases it also requires that this is done with consideration of the priorities and requirements of the wider organisational and institutional context. Unlike the absolute professional control over work inherent in Freidson's notion of professional autonomy, the exercise of discretion "requires the professional to make decisions and recommendations that take *all* factors and requirements into account. These factors and requirements will include organizational, economic, social, political and bureaucratic conditions and constraints" (Evetts, 2002, pp. 345). Importantly, professional discretion creates space for the inclusion of forms of evaluation of professional work emanating externally from the professions themselves.

Evetts (2009) considers the evolving nature of contemporary professionalism by connecting the development of New Public Management with the concept of organisational professionalism as an ideal-typical form of professionalism distinct from the occupational professionalism traditionally described in the sociology of the professions literature. The characteristics of this emerging form of professionalism are described as follows:

> "As an ideal-type organizational professionalism is manifested by a discourse of control, used increasingly by managers in work organizations. It incorporates rational-legal forms of authority and hierarchical structures of responsibility and decision-making. It

involves increasingly standardized work procedures and practices, consistent with managerialist controls. It also relies on external forms of regulation and accountability measures…" (Evetts, 2009, pp. 248)

As stated by Liljeren (2012, pp. 297-298) the concept of accountability is important in both traditional and emerging definitions of professionalism, however there are crucial differences: " In occupational professionalism, accountability entails entrusting professionals to deliver and justify that which is best for their clients on the basis of their academic and practical training and professional code of ethics. In organizational professionalism, however, accountability is achieved through the trust that is engendered through measurable means….."

Thus, scholars have described the impact of institutional pressures around managerialism and neoliberal policy on the evolution of the professional institution and the emergence of new forms of professionalism. This literature acknowledges a new focus on professional accountability within organisations. Traditional understandings of professional responsibility founded on trust in professional groups to self-regulate and ensure the provision of safe, quality services to their clients have been challenged by the managerialist ideology inherent in neoliberal policy. Such policy is characterised by moves to make professionals accountable for their decisions. Professional responsibility has been replaced with a focus on professional accountability (Annandale 1996, Hanlon 1998, Power 2004). Thus, within contemporary organisations professionals, including health and welfare professionals, are functioning under new managerial pressures associated with the evaluation of professional decision-making. Accountability is a central feature of this environment within which professional are held to account for the outcomes of the clinical activity that they engage in and the decisions that they make.

Empirical work has begun to provide micro-level connections and evidence around theoretical models of an evolved form of professionalism that reflects the pressure and objectives of modern organisations. Liljegren (2012) for example, demonstrates the manner in which particular groups of Swedish social workers draw upon organisational professionalism in the construction and enactment of their roles referencing and utilising bureaucratic structure in relation to knowledge orientation, boundary legitimisation and justice. In addition, In a study of the decision-making of hospital doctors within the Portuguese Public Health system, Correia (2016) describes reference to organisational and managerial processes in addition to the ethical commitment to patients and collegiality more traditionally associated with the concept of medical professionalism (Freidson, 2001) demonstrating the infiltration of managerial and organisational influences within the institutional environment into the normative value system of medicine. However, there remains a paucity of work that connects emerging theoretical models of professionalism with micro-level empirical work, particularly work focussed on the concept of accountability specifically. Further such theoretical models have yet to be connected to accounts of professional role reconfiguration within the healthcare organisations.

An additional and related feature of the contemporary professional context that is highlighted within the literature is the pressure and expectation placed upon professionals to manage risk. The connection between accountability and risk is well documented within the sociological literature within which prominent theorists construct risk as a political resource associated with the assignment of blame and responsibility for negative events (Lupton 1999). In his *Risk Society* thesis Beck (1992) asserts that the process of modernisation with its focus on individualisation, science and democracy confronts social actors with myriad threats as well as choices to make regarding the appropriate management of such threats. "People are seen to both cause risks and be responsible for their minimization." (Lupton 1999, pp. 12)*.* In addition Douglas (1992, pp. 27) asserts that risk performs "forensic functions" in society where it is used in the investigation of negative incidents to hold individuals to account for their decisions. From this perspective the notion of blame is an inevitable consequence of viewing issues in terms of risk. As articulated by Green (1997) "There are no longer accidents only risks". Negative outcomes are viewed in terms of risk management failures for which there will be a potentially accountable party.

Within contemporary organisations the management of risk is a central concern and pervasive activity. Healthcare services as well as other public sector organisations have come under pressure to demonstrate robust, transparent and auditable risk management processes, which have become synonymous with good organisational governance (Power 2004, pp. 40). According to Fine (2005 pp. 258):

> "Ideas about risk are increasingly widely applied to social policy and health care, and are a major factor shaping the future response to care needs. It is argued that this process is already well established, and that risk is replacing need and equity as the central concept of the system of public services…..Risk, in this way, is intricately and inevitably tied to the development of new organizational forms and logics, that underlie the way that services are organized, managed and held accountable for the way that care is provided."

Within this context, professionals are faced with formalised accounts and practices surrounding risk management with which they are required to engage (Kemshall 2000, McLaughlin 2001, Waring and Currie 2009). The management of risk has for some time formed an inevitable part of professional work across many fields and has become a central element of many professionals' roles, responsibilities and working lives (Godin 2004, Horlick-Jones 2005, Lankshear, Ettorre et al. 2005, McDonald, Waring et al. 2005).

It has been argued that within this organisational context risk assessment and management forms a central purpose of the work that professionals perform. As illustrated by empirical work within the French prison system Bianic (2011) argues that:

"professional expertise is no longer required per se—i.e., for the outcomes it is likely to produce for 'end users' defined as patients, clients or citizens—but is increasingly required as part of procedural mechanisms of audit and controls designed to address risk in organizations and to limit exposure to blame in high risk policies." (Bianic, 2011, pp. 821-822)

Whilst it is acknowledged that the literature has long identified the role of the professions in the identification and management of risk, for example Castel's (1991) interpretation of the function of medico-psychological assessments, Bianic (2011) suggests that this role is increasingly being fulfilled by professionals within, and to meet the objectives of, modern organisations. This trend and function is seen to be reflected in particular through organisational requirements for professionals to produce official documents or "certified expertise" associated with risk management as evident within prison services (Bianic 2011) as well as social work (Munro 2004), medicine (Dent 2006, Kendall and Wiles 2010) and nursing (Annandale 1996).

A particularly important observation made by Bianic (2011) concerns the implications of his findings and proposals for the notion of expertise as it is used within theoretical conceptualisations of professionalism. Sociological accounts of professionalism including those proposed by traits, conflict and subsequent theorists such as Abbott (1988) emphasise the possession of esoteric expertise as a defining feature of the professions. It is by virtue of the specialist knowledge and expertise that professionals have acquired through prolonged training and practice that they are considered qualified to address the needs of their clients. However, Bainic (2011, pp. 822) argues that "It seems that today, professionals are experts in a quite different sense, which can be better understood through a judicial metaphor. They are experts because they are mandated by an external authority to certify, attest or validate certain facts or events. The important dimension here lies in the *official* character of expertise: professionals act on behalf of some external source of authority— judicial, political, organizational" (Bianic, 2011, pp. 822). In this sense, it could be suggested that modern day professionals are managing risk on behalf of organisations that mandate them to do so, a responsibility for which they can then be held to account.

Thus accountability for the management of risk is an increasingly important and explicit element of the clinical activity that professionals carry out within contemporary healthcare organisations. It therefore follows that role reconfiguration attempts that propose to redistribute clinical work also inherently propose the redistribution of accountability for the management of risk associated with that work. This insight represents a novel reconceptualisation of the nature and value of the activity that role reconfiguration attempts to shift across professional boundaries and raises important questions concerning its impact on the enactment on change. Within the contemporary context taking on additional risk management responsibility presents both a potential opportunity for professionals as well as a potential risk to the professional themselves.

As we have seen, risk is a prevalent and powerful concept within today's organisations which various groups may deploy with various intentions. Currie et al. (2012) point to the power of risk as a persuasive discursive tool with which professionals and other stakeholders can influence institutional arrangements. For example, in their study of the introduction of GPSIs an important factor that contributed to the geneticists' ability to control change and maintain their position in the interprofessional hierarchy was their use of the concept of risk in "theorizing" and "defining" change. They presented themselves as "arbiters of risk" claiming "to be able to mediate risk through tacit knowledge, which is based upon their extensive formal education and, more importantly, their occupational socialization and experience" and in doing so justified their control over and continued involvement in the application of genetics knowledge (Currie et al. 2012, pp. 956).

However, within a context in which professionals are increasingly held to account by those outside the profession and required to engage in managerially informed, arguably reductionist assessments of risk, taking responsibility for such activity can present a risk to the professionals themselves. Whereas professionals commonly interpret negative outcomes as an inevitable expression of the risk inherent in practice (Freidson 1988, Waring 2005) and risk as an indeterminate phenomenon, managers and policy-makers generally construct risk as a predictable and manageable entity (Kemshall 2000). Professionals are therefore increasingly vulnerable to being held to account for perceived risk management failures in the event of negative outcomes arising following a professional judgement (Bianic 2011).

The association between contemporary risk management culture and accountability gives rise to what Power (2004) describes as the "pathology of risk management" where professionals are driven "to focus on their personal, legal and reputational risks, rather than on the primary risks embodied in their formal mission" i.e., the best interests of their clients (Power 2004, pp. 15). These risks are very real to professionals and organisations negotiating complex, multi-factorial decision-making and are particularly salient in services required to assess and manage "risky others" (Kemshall 2000, pp. 152). Concern with "secondary risks" encourages engagement in strategies designed to avoid negative appraisal in the event of undesirable incidents (Power 2004) and empirical work demonstrates professional concern the with ascription of responsibility in the event of negative events and associated defensive behaviours in the contexts of hospitals (Annandale 1996) and psychiatric prison services (Bianic 2011).

This phenomenon was recognised by Annandale (1996) in a paper that, although published 20 years ago, remains acutely relevant to the debates around the pressures upon healthcare professionals today. In this paper, Annandale (1996) vividly illustrates nurses' and midwives' perceptions of the accountability and risk culture within the UK NHS and the influence of these perceptions upon their clinical practice. Her analysis reveals the "climate of risk" within which practitioners feel they operate (Annandale 1996, pp. 419), an acute awareness of their professional accountability and "the self-protective strategies that emerge to cope with this pressure" (Annandale 1996, pp. 417).

Annandale (1996 pp. 419) presents the perceptions and feelings of nurses about the environment within which they work with respect to legal accountability. The excerpts provided indicate a constant awareness of professional accountability, particularly in relation to potential mistakes e.g.,

> "…as far as accountability is concerned ….you see it's something you think about *all* the time. It's not here in the front of your head, it's in the *background* and I think until something comes up, a mistake has been made, then you're made aware of it; that's when you start thinking about it (staff nurse)." (Annandale 1996, pp. 419-420)

Annandale (1996 pp. 420) interprets these comments as revealing that "…risk surrounds practice, it is in the *background*, there is *an atmosphere*: it is always there. As one staff nurse explained, it is "always on your mind that you may be held responsible for a legal dispute for actions or words."".

Although it is acknowledged that dealing with human illness has always been associated with clinical uncertainty and that this has long been a concern of practitioners the concerns and pressures described by participants in this study were felt to be "of *recent* origin" (Annandale 1996, pp. 421). The pervasive focus on risk and accountability described is associated with the rise of consumerism and managerialism in the form of New Public Management that "…force risks to the surface that were previously veiled (such as errors of practice) evoking a new vigilance and heightened concern." (Annandale 1996, pp.417):

> "Nurses and midwives increasingly talk of working in a climate of fear and uncertainty. The risks that they confront emanate not only from the long-standing concern with clinical uncertainty that has traditionally marked practice, but also from the great emphasis that healthcare organisations now place on nurses' and midwives' individual accountability." (Annandale 1996, pp. 416)

Nurses responded to working in such an environment by changing their practice to protect themselves from the perceived risks that they were faced with. The paper highlights that engaging in "covering" or "watching your back" was something that the participants were continuously aware of in their daily working practices (Annandale 1996, pp. 436). These "defensive strategies" for risk reduction took a number of forms including checking and double checking details and extensively documenting their activities and decisions (Annandale 1996, pp. 439). It also influenced the manner in which they interacted with their colleagues, particularly doctors.

Nurses in this paper described how they communicated with doctors, as well as documenting that communication to reduce the risk of being held accountable for potential future problems:

"There is much more contact with doctors to ensure that anything is passed on that is needed straight away in order to cover oneself (staff nurse)." (Annandale 1996, pp.442)

"Staff nurse: I tend to write everything down. If I've called a doctor I write down when I've called him; I write down what I've told him; I write down what I've said to him. Especially if I realise that the situation is serious, then I would go back to the records and say "doctor said that he would come up, document the time and put "he didn't come up" and "bleeped again", "said he would be up", "bleeped again", and then I would go on and go further up [the medical hierarchy]. I would do that because they won't cover you if you were held accountable." (Annandale 1996, pp. 442)

Crucially Annandale (1996 pp. 443) states that "by documenting their contacts with doctors, nurses and midwives are marking the boundaries of responsibility" at a time when these boundaries are increasingly flexible and unclear. This study therefore makes an important association between the pervasive focus on risk and accountability in modern healthcare settings and the practices of professionals, demonstrating the tendency of subordinate workers to use communication with colleagues more senior within the interprofessional hierarchy as a defensive strategy to guard against the risks of being held accountable for any potential negative outcomes of clinical activity. Although not the focus of the paper this work begins to link the issues of risk and accountability and defensive practice with professional hierarchy and boundaries.

The impact of professional accountability and risk management on professional practice is also addressed by Bianic (2011) in his study of the use of psychiatric expertise in French Prisons. Bianic (2011) notes the manner in which professionals have been increasingly drawn into practices designed to demonstrate the management of risk within organisations. Crucially, it is noted that the evidence and documentation produced in this process can serve to both protect practitioners as well as to ascribe responsibility in the event of negative outcomes. The study describes a feeling of vulnerability and "more 'defensive attitudes' from professionals, who strictly abide by the organisation's rules in order to avoid being held responsible for unfortunate decisions." (Bianic, 2011, pp. 824)

This section of the literature review therefore presents and problematises the theoretical conceptualisation of professional role reconfiguration attempts that dominates the literature. Such accounts reflect the central themes of seminal literature from the sociology of the professions which highlight professional knowledge and expertise as sources of professional power over which occupational groups will compete to claim and control. Suggestions of role reconfiguration are conceptualised as opening up the potential for the renegotiation of professional jurisdiction and therefore power presenting an opportunity to subordinate and a threat to superordinate groups. Drawing upon literature that describes changes to the nature and function of professionalism within the contemporary organisational context, this thesis proposes the need

to reconsider the manner in which role reconfiguration attempts are theorised highlighting the need to consider the implications of attempting to transferring accountability for the management of risk across professional boundaries. Risk represents a particularly powerful, ubiquitous and complex concept within the field of healthcare and other professionalised fields, the management of which represents both opportunities and risks to professionals. The implications of these insights for professional role reconfiguration attempts remain under-investigated and unclear.

3   Methods

The aim of this chapter is to provide an account of the methods along with the methodological underpinnings on which this study is based. It will begin with a summary of the empirical and theoretical research aims and questions that have been developed through the initial chapters of the thesis. It will then go on to describe how these aims were addressed through the development of a case study design describing the process and logic of case selection, sampling, data collection and analysis. The chapter concludes with a discussion of the ethical issues considered throughout the research process.

The approach to research taken within this study reflects assumptions of ontological realism and epistemological constructionism associated with forms of "soft" constructionism. Central to this approach is the belief in an independent world or reality with the acknowledgement that access to that world can never be direct or untainted. The research process is shaped by the researcher from the outset, in the framing of the research questions, through data collection, analysis and dissemination. Acknowledgment of the influence of the researcher means that the production of quality, comprehensible qualitative work is dependent on the provision of a reflexive, detailed and transparent account of the research process. The pursuit of transparency and reflexivity through explication of perspective and process are necessary to allow the reader to follow the steps taken by the researcher and thus assess the plausibility of the final interpretation (Kvale 1996), and it is with this aim that this chapter is written.

Research rationale and objectives

The broadest aim of this study is to explore the complex, and contemporarily relevant issue of professional role reconfiguration in healthcare. More specifically, this study aims to understand more fully the activities and influences associated with the micro-level enactment of professional role reconfiguration under the pressures of contemporary healthcare organisations, particularly within the public sector. In a context where healthcare services globally are under pressure to adapt to the demands of modern society it is necessary to understand the enactment, challenges and outcomes associated with the development of the clinical workforce (Nancarrow and Borthwick 2005, Martin, Currie et al. 2009). The following specific research questions will be addressed:

- How do individuals and/or groups work to change or maintain professional roles in the face of role reconfiguration attempts?
- What are the relevant challenges, barriers and enabling factors?

Research Approach & Strategy

The aims and research questions outlined concern the exploration of the actions of individuals within a naturally occurring social setting, as well as the associated meanings of those actions and therefore lend themselves to a

qualitative approach to investigation (Denzin and Lincoln 2005). More specifically a case study approach was selected, which is appropriate when addressing research questions that "require an extensive and in-depth description of some social phenomena" with consideration of the contextual conditions within which those phenomena occur. (Yin 2009, pp.4) This method of research is extremely valuable for informing healthcare practice and policy providing an approach to investigation that combines both flexibility and rigour (Baxter and Jack 2008). It is also an ideal method for investigating the micro-level institutional work of social actors within organisations (Reay, Golden-Biddle et al. 2006, Lawrence, Suddaby et al. 2009, Currie, Lockett et al. 2012)

The research strategy employed could be described as iterative or abductive incorporating elements of both induction and deduction in the recursive movement between research questions, emerging themes and existing theory (Eisenhardt 1989, Miles and Huberman 1994, Blaikie 2007). In contrast to more heavily inductive approaches such as grounded theory, abduction takes "a pragmatic approach which involves using existing theoretical explanations to make inferences about data, and accommodating surprising or anomalous patterns by modifying the existing theory" (Sinkovics and Alfoldi 2012, pp. 825). Abductive logic permits a process of "progressive focussing" which involves refinement of the research focus in the process of fieldwork, enabling researchers to capture and explore emergent factors of contextual relevance (Stake 1995, Sinkovics and Alfoldi 2012). This approach is reflected throughout the research design in the sampling strategy, interview content and analysis process. As the research progressed there was ongoing consideration of how new data and themes contributed to a developing empirical and theoretical understanding of the context, which informed the direction of subsequent work.

Sampling

The logic of sampling in any type of research is dependent on the aims of the research being carried out, specifically in terms of the manner in which the researcher hopes to generalise the findings (Silverman 2013). In quantitative research the aim is often to generalise, through the use of statistical inference, from a sample to a target population: an aim that dictates the random sampling of individuals from that target population. Qualitative research on the other hand operates according to a different logic. The aim of this type of research is not to generalise to a target population but to theoretical propositions (Yin 2009). The logic of sampling is not therefore based on random sampling from a particular population but on the theoretical sampling of instances likely to illustrate the phenomenon of theoretical interest (Silverman 2013).

The primary goal of case study research is "analytic generalization, in which a previously developed theory is used as a template with which to compare the empirical results of the case study" (Yin 2009, p.38). According to this logic the case selected should be one appropriate for addressing the research aims and questions and where access to the required information is possible (Yin, 2009). The specific case identified for this study was the changing role of consultant psychiatrists and associated healthcare professionals working within

UK NHS mental health services following the publication of the *New Ways of Working for Psychiatrists* document (DoH 2005), a case particularly appropriate for addressing the stated research question for a number of reasons.

Firstly, the UK NHS provides an ideal context to study professional role reconfiguration generally. This setting represents a pressurised system in which professionals face extremely high demand for their services within a context of limited resources and active policy support for workforce flexibility. As outlined throughout the preceding chapters the UK government has sought to modernise the clinical workforce through developing a more flexible workforce specifically endorsing the extension of non-medical roles (e.g., Department of Health 2000, NHS England 2014). The UK NHS is a "fast mover" in this regard and as such provides an ideal context to explore the phenomenon as well as to develop insights applicable to other western healthcare systems with similar policy objectives (Currie et al. 2012, pp. 938). The case of *New Ways of Working for Psychiatrists* (DoH 2005) specifically was selected as it exemplifies policy attempts to change institutionalised clinical roles and working practices in healthcare, proposing the renegotiation of professional boundaries, such that non-medical professionals take on aspects of the work previously within the remit of the medically qualified psychiatrist.

New Ways of Working for Psychiatrists

New Ways of Working for Psychiatrists (Department of Health 2005) was published with the aim of altering the roles of consultant psychiatrists to more effectively meet the demands of modern mental health services. Within the context of National Health Services (NHS) mental health services general consultant psychiatrists most commonly work as part of a multi-disciplinary team comprised of various other mental health professionals including mental health nurses, psychologists, social workers, occupational therapists and possibly others depending on the needs of the client group. Traditionally consultants have functioned as the clinical lead within such teams taking on responsibility for new referrals, assessments, follow-ups and emergency appointments, a function that has become increasingly problematic and unmanageable (Kennedy and Griffiths 2001). Subsequently these changes were driven in part by "a huge groundswell of opinion amongst psychiatrists that their jobs had become undoable, which had led, in turn, to dissatisfaction and burnout." (DoH 2005, pp. 7)

The problems associated with traditional consultant model and recognition of the need for change has been precipitated by a number of factors. Firstly there has been growing pressure on mental health services as a whole, dealing with increasing demand year on year (DoH 2005). Secondly, this pressure has been exacerbated by recruitment and retention difficulties within the psychiatric profession, a problem potentially linked to reported long working hours, high stress levels and low job satisfaction amongst psychiatrists (Kendell and Pearce 1997, Kennedy and Griffiths 2001). Thirdly, there has been increasing recognition of the value of psychosocial aspects of mental healthcare and the need for a holistic, person-centred and recovery-focussed approach from a multi-disciplinary team (DoH 2005).

The culmination of these factors prompted the Department of Health in collaboration with the Royal College of Psychiatrists, the National Institute for Mental Health in England and other major stakeholders to develop and publish *New Ways of Working for Psychiatrists* (DoH 2005). The document was written with the aim of providing "a framework for mental health services to help them develop new roles for psychiatrists, which both support the delivery of modern person-centred care and provide satisfying and sustainable roles, making the best use of this valuable, finite resource." (DoH 2005, pp. 3) The document proposes a more limited, manageable and focussed consultant role through "promoting distributed responsibility and leadership across teams to achieve a cultural shift in services" (DoH 2005, pp. 5).

Underpinning these changes in professional roles was the concept of "recovery". When outlining the "vision and values" associated *New Ways of Working for Psychiatrists* the document states:

> "This perspective should be underpinned by a positive attitude of hope and recovery that each person may continue to lead a self-defined life, thus reflecting their hopes and ambitions. The individual needs to be able to make their own choices, be the key person in interpreting what is happening to them and, therefore, in deciding on interventions they will engage with." (DoH 2005, pp. 8)

In sum, a solution to the problems encountered around the consultant role lies in the redistribution of clinical activity and responsibility from consultants to other members of the mental health team, more fully utilising the available non-medical skills and expertise. The document calls for professionals to accept and embrace change, developing an adaptable and flexible approach to their roles.

Rather than provide prescriptive direction on how to change consultant roles the document offers a framework to support change that can be adapted and applied to local need and circumstance. Prior to the publication of *New Ways of Working for Psychiatrists* (DoH 2005) new roles for consultants had been piloted at a number of sites across the United Kingdom which were presented within the document to illustrate the potential directions of change. There was considerable variation in the nature and scope of the changes made across sites. Some trusts made significant changes to the way teams dealt with new referrals as demonstrated by the changes within Avon & Wiltshire Mental Health Partnership NHS Trust. Within this trust episodes of care, previously defined by consultant, were defined by team and the referral and outpatient model traditionally used was replaced by a multidisciplinary assessment clinic. Under this system a new patient referred to the team is assessed by two clinicians from different professions. The implementation of multidisciplinary assessment clinics as well as consultant nurse and psychologist led clinics was reported at numerous sites.

At a number of other sites (e.g., Humber Mental Health Teaching NHS Trust) changes were implemented by altering the roles of consultant psychiatrists from a traditional "sector" model to a more specialised model. This meant that consultants would no longer work across multiple and varied services, often

engaging in low complexity, routine work but would focus on providing a more consultative role in a specific sector e.g., either inpatient or community care. This consultative role involved a reduction in direct patient contact and routine follow-up appointments, which were then taken on by other professionals within the multi-disciplinary team.

The proposals outlined in the *New Ways of Working for Psychiatrists* (DoH 2005) document are typical of government modernisation attempts in that they aim to develop a more flexible workforce in which activity is divided up according to skill and competency of workers, rather than traditional professional jurisdiction (Nancarrow and Borthwick 2005). This presents potential challenges to institutionalised professional practices, boundaries and hierarchy. Such circumstances are likely to instigate institutional work from stakeholders keen to influence developments and protect their interests, as well as illuminating the institutional barriers and pressures constraining the enactment of change.

The trust and the service

The particular trust in which the study took place is typical of an NHS mental health service provider organisation. This organisation is subject to the same pressures exerted across the wider field in terms of government policy objectives and legislation and employs individuals from the standard range of professional groups involved in mental healthcare provision more widely. In addition, this organisation was selected for pragmatic reasons that facilitated access i.e., locality and established links with the host university.

A decision was taken to restrict investigation to the trust's Adult Mental Health (AMH) Service. This was based on a number of factors. Firstly, considering that the research aims and questions concern activity and contextual issues around role reconfiguration attempts it was necessary to focus investigation on an area of the trust where attempts at change were evident. Following preliminary informal discussions with members of the organisation AMH services were identified as meeting this criterion in contrast to some other services where there appeared to be little discussion or awareness of role change attempts. In addition, limiting the study to a particular service provided a clearly defined section of the organisation on which to focus, allowing the development of a rich understanding of this particular context thus reflecting the aim of developing depth rather than breadth of understanding.

Participants and embedded cases

Once the case study services had been identified further sampling and data collection proceeded in two broad phases. The first functioned as an exploratory stage carried out with the aim of developing familiarity with the empirical context and enabling theoretical sampling during the second phase of data collection. The aim of the second phase was to focus in on individuals, groups and instances of particular relevance to role reconfiguration attempts within the service. The study sought to take advantage of the fact that individuals within this context work in naturally occurring "interactive units" (Gobo 2007) in their clinical teams to develop an embedded comparative case study design (Yin 2009).

Single case studies can be approached in a holistic manner or, as in this study, utilise embedded units of analysis (Baxter and Jack 2008, Yin 2009). The advantages of taking such an approach have been described as follows: "The ability to look at subunits that are situated within a larger case is powerful when you consider that data can be analyzed *within* the subunits separately (within case analysis), *between* the different subunits (between case analysis), or *across* all of the subunits (cross-case analysis). The ability to engage in such rich analysis only serves to better illuminate the case." (Baxter and Jack, 2008 pp. 550) The use of comparative analysis aids the development of more powerful theoretical conclusions providing the opportunity for replication and extension of conclusions drawn from one situation through their application and potential amendment in the next (Eisenhardt 1989, Eisenhardt 1991).

Phase one

The aim of this phase of the study was to develop an understanding of the consultant role in these services and how this had changed in the light of *New Ways of Working for Psychiatrists* (DoH 2005). Data collection was particularly focussed on gathering information that would inform the purposeful selection of participants and cases in phase two of data collection, which depended on identifying areas of activity around role change within the service. The aim was to collect information to address the following questions:

- What roles do consultants take in these services? Which teams do they provide input to and what form does this input take?
- How has this input changed, if at all, in the light of *New Ways of Working for Psychiatrist* (DoH 2005)?
- Who has driven change or maintenance and with what intention and effect?
- In which teams has change been driven or resisted?
- What are the factors that have influenced this change or maintenance?

Sampling began by extending an invitation to participate to all consultant psychiatrists working within Adult Mental Health (AMH) Services. Initial contact was made via email following discussion with the consultant acting as medical director at the time of the study. Eight consultants volunteered to take part and a decision was made to interview all those who came forward. Although in this sense this was an opportunity rather than a purposefully selected sample it was considered a varied and broad sample, including consultants who provided input to the full range of team types that made up AMH services and therefore met the requirements of this exploratory phase of the study. Two consultants also held a director level position within the service. This exploratory phase also included exploratory interviews with several non-medical professionals with whom the consultants worked, again carried out with the aim of developing an understanding of various professional roles and locations of theoretically relevant role reconfiguration attempts.

Phase two

This first stage of sampling and data collection was followed by preliminary analysis intended to enable the theoretical sampling of a selection of clinical teams to focus on in more detail. In the second stage, the research was focussed on building up a more detailed picture of the activity within specific clinical teams embedded within the service. By utilising the information elicited from the initial stage of interviewing it was possible to develop a basis for theoretical sampling of a selection of clinical teams on which to focus the next stage of the project.

The first criterion for case selection was evidence of attempts to change professional roles. It is worth reiterating here that the *New Ways of Working for Psychiatrists* (DoH 2005) document presents suggestions for change that may, or may not, be utilised rather than a change in policy that necessitated or enforced specific, or indeed any, professional role change. It appeared that in the case study service there were some clinical teams where there was little description of any change attempts either because they were not seen as areas where change was a priority or because change initiatives had not yet been extended to those areas. Teams where this was the case would be of little value in addressing the stated research questions so were excluded on this basis.

Of the teams where change attempts were evident, cases were purposefully sampled to exhibit variation in key contextual characteristics potentially relevant to the research questions being addressed i.e., the activities and constraints informing the enactment of role reconfiguration. Specifically, the teams differed in terms of the level and type of responsibility formally held by consultants ranging from legally defined medical responsibility to organisationally defined, team-held responsibility. The cases selected therefore facilitated consideration of the influence of, and activity around, field and organisational level definitions of responsibility in this setting.

The sample included one case in which the team worked with some individuals formally detained under the *Mental Health Act 2007*. With respect to these individuals the consultant psychiatrist in the team holds legally defined responsibility for aspects of patient care as their allocated *Responsible Medical Officer* (*RMO) or Responsible Clinician*. Historically the RMO role, as defined in the *Mental Health Act 1983,* positioned consultants as the only professional legally able to detain and enforce treatment: an authority that was partially afforded to other suitably qualified professionals with the introduction of the *Responsible Clinician* role following the 2007 amendments. However, recommendations for initial detention under sections 2 or 3 of the Act remain a medical responsibility and as yet few non-medical professionals function as authorised *Responsible Clinicians*. Therefore decision-making regarding individuals detained under the *Mental Health Act 2007* remains an important, legally defined, area of psychiatric jurisdiction.

The sample also included cases in which consultant responsibility was documented through organisational systems within which each patient was allocated a named consultant psychiatrist. Finally the sample included cases

where responsibility was not formally allocated to the consultant but held across the wider clinical team. The characteristics of these cases can be summarised as follows:

- Case one (community mental health team) - This is a traditional CMHT providing medium to long term support to a range of clients in the community. Each patient on the team caseload has a formally documented link with a named consultant psychiatrist.

- Case two (rehabilitation unit) – This team provides residential care for patients with long term issues working towards a step down in care provision. The consultant has formal legal responsibility for some clients in relation to the *Mental Health Act 2007* and is organisationally recognised as the named consultant for all patients on the unit.

- Case three (acute care community team) – This was a newly formed team providing short term community care. Under the new format patients are not allocated a named consultant psychiatrist on entry to the team, rather they are allocated to the care of the team. In this sense the consultant psychiatrists involved did not have a formally documented link to every patient on the team caseload.

- Case four (crisis resolution/home treatment team) – This team provide short term help to patients experiencing a crisis period. The team operate using a shared caseload model where responsibility is held across the team, of which the consultant is a part.

Once these teams had been identified, participant sampling began by making contact with relevant team leaders/managers who facilitated contact with members of their clinical teams. Participants were sampled to ensure the inclusion of individuals from the full range of professional groups working in each team. The details of the sample, divided by case, are outlined in table 1.

During the course of the investigation the importance of the role of managers and organisational processes, particularly around accountability and risk management, in influencing role reconfiguration became evident. This prompted the sampling of individuals directly involved in the management of the service and included six individuals who collectively represented all levels of management from service manager to senior executive. Table 2 summarises the number of interviews undertaken as part of each phase and case within the study.

Table 1 – Case Sample Details by Professional Group

	Number of interviews by professional group
Case 1	1 consultant psychiatrist 1 team leader 2 nurses 1 occupational therapist **Total: 5**
Case 2	1 consultant psychiatrist 1 team leader 2 nurses 1 occupational therapist **Total: 5**
Case 3	1 consultant psychiatrist 1 team leader 1 nurse 1 occupational therapist 2 social workers **Total: 6**
Case 4	1 consultant psychiatrist 1 team leader 1 psychologist 2 nurses **Total: 5**

Table 2 – Interviews Conducted

Study Phase/Case	**Number of interviews**
Phase 1 only	12
Case 1	5
Case 2	5
Case 3	6
Case 4	5
Management	6
Total	**39**

Data collection

Semi-Structured Interviews

Data was collected through semi-structured interviews with key individuals identified through the sampling procedures described above. This form of interview represents probably the most commonly used method of data collection employed by qualitative researchers, utilised for its ability to generate in-depth accounts of individuals' perceptions, motivations, interpretations and experiences (Mason 2009). Semi-structured interviews provide the flexibility and space for interviewees to discuss aspects of the phenomenon of interest most relevant to them in their own terms (Kvale 1996,

Mason 2009). The information elicited is assumed to represent useful knowledge about the social world that the participants inhabit (Holstein and Gubrium 1997): ".. narratives which emerge in interview contexts are situated in social worlds, they come out of social worlds that exist outside of the interview" and therefore provide the opportunity to develop knowledge about aspects of those social worlds (Miller and Glassner 1997, pp. 105).

Despite the utility of qualitative interviews in producing detailed accounts of a participant's social world, many authors warn that the details provided cannot be interpreted as excavated "facts" (Kvale 1996, Mason 2009). This point is articulated by Mason (2009) as follows:

> "knowledge is at the very least reconstructed, rather than facts simply being reported, in interview settings. According to this perspective, meaning and understandings are created in an interview, which is a co-production, involving the researcher and interviewees." (Mason 2009, pp. 62-63)

Thus, whilst semi-structured interviews produce useful knowledge about the participant's social world, that knowledge is co-produced in collaboration with the researcher and therefore represents a unique construction associated with that particular interview context. It is crucial that the researcher appreciates and explicates their role in this regard when reporting and interpreting interview data, including positioning themselves in the field and articulating the focus and intentions of the interview (Kvale 1996).

The use of observation, often cited as the "gold standard" for investigation of social action (Dingwall 1997), was carefully considered as a complementary data collection method, however eventually deemed inappropriate for this particular study. These decisions were influenced by a number of theoretical, methodological and pragmatic considerations. Firstly, it was anticipated that the phenomena of relevance (activities to influence role reconfiguration) were unlikely to have been confined to one, or even several, geographical locations but dispersed across the case study organisation. Prediction of where and when these actions would occur would have been extremely difficult. In addition, considering the relatively short time available for data collection it is likely that institutional work taking place during the data collection period would have been part of a larger ongoing pattern of activity covering a period before the study began.

In such circumstances elicitation of accounts of the action of interest in a semi-structured interview provides a practical alternative in which the participant acts as a proxy observer (Murphy and Dingwall 2003). This conveys an obvious disadvantage in that the researcher relies on participants' accounts of action creating an additional layer of interpretation and distance between the researcher and the event being researched. In an effort to enhance validity and encourage a reflexive and comprehensive account of the case under investigation this research elicited accounts of events and developments from multiple perspectives through the interviewing of individuals from different

groups i.e., Individuals from a range of professional groups and managers (Mays and Pope 2000, Yin 2009).

In addition to pragmatic considerations, the selection of interview as the data collection method was also linked to theoretical concerns. The intention of an individual's actions are central to the theoretical concept of institutional work as explicated in its definition as "the *purposive action* of individuals and organisations *aimed at* creating, maintaining and disrupting institutions" (Lawrence and Suddaby 2006, pp. 215, italics added for emphasis). Therefore the concept of intentionality and motivation must be explored in the course of the study. It is unlikely that such intentions will be explicitly expressed in everyday interaction making inferences on the basis of observational data problematic. In addition participants' perceptions and understandings of barriers to change are of central importance. Semi-structured interviews are an ideal method for elicitation of participants' views, understandings, interpretations and motivations (Mason 2009). In sum, semi-structured interviews were utilised in this case as both an opportunity to explore participants' understandings of their context and actions as well as to elicit accounts of where, when and how these actions take place.

Interview conduct and content

Interviews were conducted in the participants' place of work within a meeting room or office where the requirements of confidentiality could be maintained. Interviews lasted between approximately 45 and 90 minutes with most completed in under an hour. All interviews were conducted between September 2011 and August 2012 by the author who is a female PhD student with no professional affiliation. In this sense the author could be considered an outsider from the field with some knowledge and an interest in the context developed through previous experience in other mental health services in care work or research focussed roles and an academic background in psychology. Participants were made aware that the research was being undertaken to provide the basis of a PhD thesis and the author was happy to answer any questions the participants had about her professional and academic background and interest in the topic, about which many participants did enquire.

 All interviews began by ensuring the participant had the opportunity to read the participant information sheet and ask any questions about the research process. Following this written informed consent was gained. All interviews were audio-recorded, with the participant's permission and later transcribed. The majority of interviews were transcribed in full, however in the latter phases of transcription, when the specific analytical focus of the project was clearly formed, the interviews were selectively transcribed to capture sections of relevance. Interviews were focussed on issues around change and maintenance of professional roles in terms of practices and responsibilities. Particular attention was paid to the action taken to influence potential role change and its consequences as well as perceived barriers to change. Although theoretical issues of potential relevance (e.g., professional hierarchy, institutional pressures, and institutional work) have been reviewed in the preceding section, this was done with the aim of heightening awareness of concepts of potential relevance and these concepts were not explicitly

addressed. The interviews were carried out with the use of a topic guide to ensure the information elicited was relevant to the research questions stated. This comprised the following broad topic areas:

Working context – The aim of this theme was to gain an understanding of the context in which the participants work.

- What types of team(s) do the participants work within?
- What client groups are served?
- What are the purposes and aims of the team?
- What professional groups provide input to the team?
- How is the team managed?

Nature of professional role change or maintenance – The aim of this theme was to gain an understanding of how professional roles may, or may not, have changed in the light of role reconfiguration attempts, with a specific focus on the role of the consultant psychiatrist. Particular attention was paid to the issues of professional practice and boundaries, especially around accountability and responsibility for clinical decision-making.

- How have your roles and responsibilities changed, if at all?
- What elements of your roles and responsibilities have changed?
- What element of your roles and responsibilities have remained the same?

Creation of professional role change or maintenance – The aim of this theme was to gain an understanding of how any change or maintenance of the roles of the participants and/or their colleagues had been created.

- What action was taken to create change or maintenance of roles?
- Who was involved?
- How were these actions explained and understood?
- What was the intention behind these actions?
- What were the consequences and outcomes of these actions?

Institutional or contextual influences – The aim of this theme was to gain an understanding of any factors that constrained or enabled the reconfiguration of roles.

- What made it difficult to change roles and responsibilities?
- Were there any organisational or institutional influences that limited the degree of change?
- What factors facilitated the creation of role change?
- Were there any organisational or institutional influences that enabled change?

Following each interview a brief summary was produced outlining any emergent themes from the interview with respect to the research focus and questions, identifying areas and questions for further investigation and aiding the formation of initial impressions of the data (Grbich 2007). This then allowed for modification of interview topic guides to develop and elaborate upon emerging themes. Although the general topics covered remained the same over the course of the interviews the specific content of these topics became more focussed as a clearer understanding of the context developed. Of particular note in this respect was the relevance of participants' understandings of their role in the management of risk. This emerged as a prominent theme highly relevant to the enactment of role reconfiguration. Therefore as the study progressed the interviews were used to explore this concept in more detail.

The analysis process

At intervals throughout data collection and finally following the completion of fieldwork a more formal and extensive categorisation or coding process was conducted. This began with repeated reading of the interview transcripts and notes to increase familiarity with the content and develop a holistic understanding of the data. This was followed by the development and application of "cross-sectional indexing categories" or codes designed to divide the transcripts into meaningful sections to address the research questions set out (Mason 2009).

The analysis focussed on addressing two broad questions reflecting the topics covered in the interview schedule. The first concerned activity intended to create change or maintenance of professional roles. Specifically, this part of the analysis focussed on identifying descriptions of activities aimed at either creating a new role for consultant psychiatrists or maintaining a more traditional role. The second analytical focus concerned factors that functioned to either constrain or enable change. The aim was to identify team, organisational and institutional influences that impacted upon the enactment of role reconfiguration.

The system of codes developed incorporated two levels of analysis i.e., first-order empirical codes as well as second-order theoretical codes (Pratt, 2009; Gioia et al. 2012). First order codes were developed initially to reflect, in an atheoretical sense, what the participant was describing in their own terms. The development and application of these first order codes was based on the process described by Maykut and Morehouse (1994) which draws on the basic logic of Lincoln and Guba's (1985) description of the constant comparative method. Firstly, the content of the interview transcripts was divided into "units of meaning", labelled to indicate the nature of the information provided by the interviewee. Next, initial codes were generated based on interview summaries, notes and general impressions from the data. Each unit of meaning was considered in relation to the codes and the units of meaning within them and allocated to an existing or new coding category accordingly. During the initial phase of analysis many codes were created then amended, consolidated or removed depending on their utility and applicability to the data as analysis progressed.

Figure 1 provides an example of the development of a first order code around the idea of "recovery" which was a key concept that emerged from the interviews with managers. This illustrates how this level of coding sought to represent the content of the interviews in atheoretical terms as they were articulated by the participants. It also provides an example of how the coding structure was refined throughout the coding process. In this case "recovery" began as a single coding category but was later subdivided into three more specific categories to capture the richness and nuances associated with the concept and the manner it was used by the interviewees.

Interview Excerpts	First Order Codes
..one of the things we have to try and drive as an ethos for us, is, is about recovery. You know we should not be about bringing people into a secondary mental health service and keeping them forever. You know our whole focus should be about recovery. (Manager two)	**Recovery:** Citing the "recovery" approach to care
I think part of our problem is that there are so many people that are only seen in outpatients and they are only seen every 3 or 6 months ….it is a sausage machine, as I said somebody comes in for 8 minutes, you know perhaps "How are you feeling, is everything ok? How is the medication working?" "OK." "Repeat prescription". (Manager three)	**Recovery:** Medical outpatient clinics retain patients within the service
We have got nurses who are taking people out of outpatients and actually doing a whole review of, you know where are you at, what are your goals, what might you need in terms of getting back onto a college course, or do you want to work, what might your options be urm…have you got an advanced statement? [yeah] You know, trying to actually give people some tools and some skills and contacts that should hopefully move them out of the service. (Manager one)	**Recovery:** Non-medic clinics promote movement out of the service

Figure 1. Example of first order coding development

The first-order codes developed were then evaluated in relation to the extant literature and the theoretical concepts and frameworks of relevance to develop second-order theoretical codes. This second-order coding was guided by, but not limited to, the theoretical concepts drawn from the institutional theory literature. Specifically, the indexing of descriptions of action intended to influence professional roles drew upon the taxonomy provided by Lawrence and Suddaby (2006) and Zeitsma and Lawrence's (2010) distinction between practice and boundary work. Similarly the indexing of institutional pressures drew upon the "three pillars" conceptual framework provided by Scott (2014). Indexing was not limited to the categories provided within these frameworks and allowed for the development of novel categories, for which the existing theory could not account, to arise inductively from the data. Finally, where

appropriate the second order codes were grouped into theoretical "aggregate dimensions" (Gioia, Corley et al. 2012).

Figure two provides an example of the movement from first-order codes, through to second-order codes and finally to the development of aggregate dimensions. Building upon the codes developed around the concept of recovery outlined in figure one, figure two demonstrates how with reference to existing literature these first-order codes were translated into theoretical, second-order codes which, when combined with the wider coding structure, became part of an aggregate dimension. In this particular example the theoretical coding developed draws upon the institutional work literature, with the second-order codes utilising forms of institutional work provided by Lawrence and Suddaby (2006) and Perkmann and Spicer (2008) and the aggregate dimension using Zeitsma and Lawrence's (2010) notion of practice work. The full set of first order codes, second order codes and aggregate dimensions developed in relation to this research question are presented in appendix A.
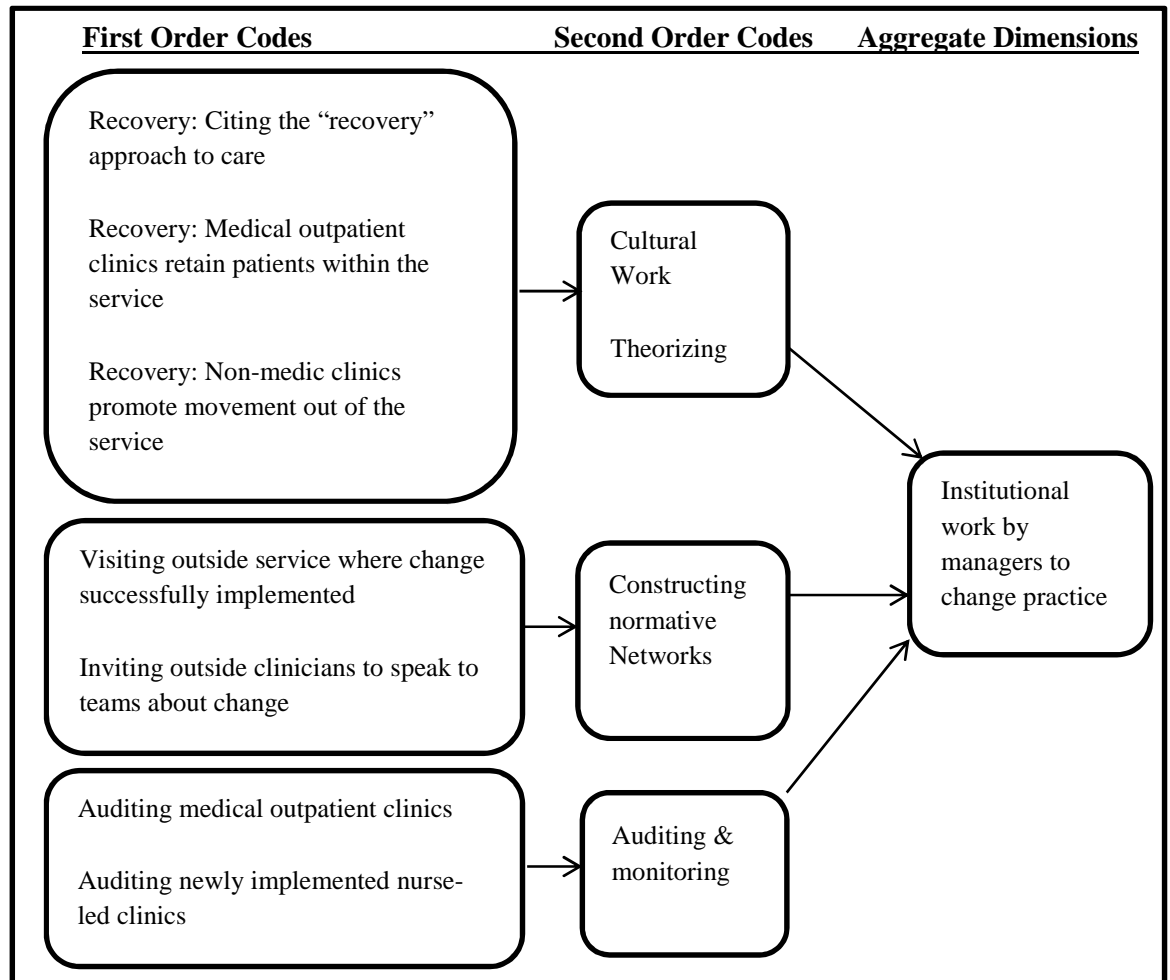
In addressing the second research focus i.e., the team, organisational and institutional level influences that constrained and enabled change, the same basic principles of coding were applied. However, this proved to be a far more complex process. Whilst coding for the facilitating factors remained relatively straight forward, coding for the constraining influences presented a greater challenge which required a slightly modified approach.

A particularly dominant theme when considering the constraining influences on role reconfiguration was the perceived need for the continued involvement of consultant psychiatrists in the management of cases that signalled heightened risk. Exploring the influences informing and maintaining the connection between consultants and risk management with participants in interviews tended to produce extended quotes in which participants cited several inter-linked, multi-level influencing factors. A simple set of codes was not sufficient to capture the complex dynamics and inter-related factors relevant to this issue. Therefore, rather than division in to discrete codes these excerpts were utilised in a more holistic manner to generate a diagrammatic depiction of the factors of relevance and the relationships between them as presented in appendix A.

The analysis process described was carried out within the groups of interviews that made up each case then followed by a comparative analysis that considered similarities and differences across the four cases. Next the process was repeated for the management level interviews which were then considered in relation to the cross-case analysis.

Analysis was carried out with the assistance of the computer aided qualitative data analysis software (CAQDAS) NVivo. This software was employed primarily to aid the collation, management, organisation and coding of data serving to speed the analysis process through reducing manual administration tasks (Seale 2013) and to maintain an audit trail linking data to coding (Sinkovics and Alfoldi 2012). The software was also used with awareness of

the limitations and potential pitfalls of using CAQDAS, particularly decontextualisation of data excerpts and the use of functions incompatible with research aims and philosophy (Mason 2009). These problems were avoided through developing a clear logic and rationale for the coding process and the consideration of codes within the context of the particular interview from which they were extracted as well as the entire interview set.

First Order Codes **Second Order Codes** **Aggregate Dimensions**

Recovery: Citing the "recovery" approach to care

Recovery: Medical outpatient clinics retain patients within the service

Recovery: Non-medic clinics promote movement out of the service

Cultural Work

Theorizing

Visiting outside service where change successfully implemented

Inviting outside clinicians to speak to teams about change

Constructing normative Networks

Auditing medical outpatient clinics

Auditing newly implemented nurse-led clinics

Auditing & monitoring

Institutional work by managers to change practice

Figure 2. Example of second order coding and aggregate dimension development

Throughout data collection and analysis elements of the coding structure and interpretations generated were reviewed and discussed in collaboration with both project supervisors who were able to constructively challenge the interpretations and conclusions drawn to encourage closer scrutiny of the data. This provided a basic form of triangulation and was considered particularly useful and challenging due to the divergent professional perspectives of the supervisory team. In addition, during the latter stages of the analysis, but prior to finalisation, a written summary of the key themes was fed back to a sample of the research participants who were asked to provide their opinion on the interpretation produced. This respondent validation or "member checking" was employed in an effort to assess the extent to which the researcher's interpretation of the data corresponded with the experiences of the participants working within the context studied and therefore evaluate the credibility and authenticity of the findings (Lincoln and Guba 1985, Mays and Pope 2000).

Ethics

Although formally addressed in the final section of this chapter, issues around ethics arose and were considered throughout all stages of the research process. As articulated by Kvale (1996) ethical issues are relevant through the seven stages of interview research including "thematising, designing, the interview situation, transcription, analysis, verification and reporting" (pp. 111). A number of bodies relevant to this research provide ethical guidelines which were consulted during the design and execution of this project e.g., the University of Nottingham Code of Research Conduct and Research Ethics (2010) and the Statement of Ethical Practice for the British Sociological Association (2002). Whilst these guidelines cannot provide direct guidance on all potential ethical dilemmas encountered they do provide and share general principles to guide good ethical practice. Chief among these are consideration of the value and consequences of the research in moral as well as scientific terms, protection of participants from coercion, deception, potential harm and breaches of privacy and confidentiality, and ensuring the integrity of the findings.

At the outset of the study ethical issues were considered in relation to each stage of the study protocol as it was developed. This began by setting out the research aims and questions which were deemed to have relevance to both theoretical knowledge as well as the contemporary social concern of healthcare workforce development, potentially aiding understanding of this issue from an organisational and management perspective. It is important to recognise that the results of social research may have implications not just for those directly involved but for the groups who they are taken to represent (Kvale 1996) and as the results of social research can be difficult to predict this represents an ongoing concern. At each stage of the study the results were considered in terms of their implications in this sense as well as in terms of their scientific and theoretical relevance.

The following issue to be addressed was the protection of participants. The protocol ensured that written informed consent was gained from all participants involved in the study. Participants were provided with an information sheet which made explicit a number of important points including: the purpose of the study, their right to withdraw, the nature of their involvement, the manner in which the data would be used and disseminated and the potential risks and benefits of taking part. It was important that consent was fully informed and voluntary and that participation occurred without deception or coercion. This was achieved not just through the provision of an information sheet but also by providing the participant with the opportunity to ask questions when interviewed and through the provision of study team contact details should any questions arise prior to or following the interview date.

Participant confidentiality and anonymity were also carefully considered and protected. Firstly, interviews were conducted in a location where confidentiality could be maintained. Secondly, participant information and data arising from the study was securely stored, with hard copies kept in a secure

locked cabinet and electronic information stored in password protected, encrypted format. In addition transcriptions were anonymised and stored separately from identifiable participant information. Participants were made aware that anonymised excerpts from their interviews may be used within research reports. Anonymity was an ongoing consideration which was particularly pertinent due to the small size of the case study service and the limited number of individuals working in particular roles e.g., senior management. Every effort has been made to balance the requirements to present data in a manner that maintains assurances of anonymity by rendering the sources of accounts unidentifiable whilst preserving relevant contextual detail.

An additional consideration was the impact of the interview situation itself. When conducting an interview study it is important to remember that the interview situation is not merely a data collection exercise but a social encounter between the researcher and the interviewee and that these encounters may influence those taking part. It is possible that some interviews may cover issues that the interviewee finds uncomfortable, creating a potentially stressful situation. It may also raise questions or issues that they had not previously considered, potentially altering their perspective or self-image. Considering the interview topics were restricted to the interviewees' professional roles no identifiable risks to participants were predicted, rather it seemed possible that the interview could serve as a beneficial opportunity for the participants to reflect on their working roles. In practice this did appear to be the case with interviewees apparently comfortable with, and in many cases enthusiastic about, discussing aspects of their professional role. Only in one instance did a participant appear uncomfortable with the interview situation, expressing concern around anonymity in relation to the use of direct quotes. This particular participant requested to view any such quotes prior to their use in publications, a request that could be accommodated.

In line with good ethical practice and organisational requirements, prior to commencement of the study the protocol was reviewed by a Research Ethics Committee (REC) and other relevant parties. Following application to the NHS National Research Ethics Service a review by a REC organised through this service was deemed unnecessary due to the fact that this research does not involve patients or patient data. Alternatively the protocol was reviewed, and given favourable opinion, by the University of Nottingham School of Sociology & Social Policy Research Ethics Committee. In addition the study protocol and all associated documents were reviewed and approved by the University of Nottingham Research Governance Service and the host NHS trust's Research Management and Governance team.

4 Data: Work to Enable a New Role

The analysis is presented across two chapters which broadly address the key research questions stated: How do individuals and/or groups work to change or maintain professional roles in the context of role reconfiguration attempts; and what are the relevant challenges, barriers and enabling factors? The present chapter focusses on the activity of key actors to influence the reconfiguration of professional roles, in this case to create change. Chapter six then moves on to describe the structural and contextual influences that enable or constrain role reconfiguration, in this case focussing on the role of the traditional interprofessional hierarchy and risk management pressures to constrain the development of new clinical roles.

There was considerable consistency across three of the four cases investigated in terms of the forms of activity carried out to create change, as well as the constraints and outcomes described. Therefore the analysis combines data from across these cases to demonstrate key analytical themes. Case four however, emerged as an exceptional case. This was not in terms of the activity carried out to create change, but in terms of the impact of the constraining influences evident in the previous cases and therefore the degree to which the roles enacted diverged from traditional templates. The constraining influence of interprofessional hierarchy and risk management pressures appeared negated in this case, in which more significant change was described. The peculiarities of this case are discussed within chapter six.

This chapter first describes the activity of consultant psychiatrists and team leaders to enable new professional roles within their individual clinical teams. This section outlines the forms of activity taken, illustrating work on the part of these individuals to: challenge assumptions around the role of the consultant, implement protocols and procedures to support change, remove formal associations between consultants and patients, and to explain and justify the changes made to key stakeholders and authority figures. The second part of the chapter focuses on describing the management level perspective and activity around the creation of reconfigured roles. This section highlights the work of managers to collate evidence to support change, utilise examples of successful change in a similar organisation, and align their changes with the influential rhetoric of "recovery" as part of a strategy of gradual change.

Finally, the chapter considers evidence around the outcome of these activities which suggests a moderate degree of change in which new practices were developed whilst maintaining established hierarchy and medical authority over clinical decision-making. Data is presented that demonstrates the construction of a new division of labour in which consultants maintain involvement in cases considered high in biomedical complexity and/or risk, and therefore their position of seniority in the system. It is proposed that the maintenance of this authority is the result, not of maintenance work on the part of consultants, but

the perception of external pressure experienced by all professionals within this system which drove adherence to the traditional hierarchy, the evidence for which is presented in chapter six.

Team Level Activity

Across all four cases participants described the activity of consultant psychiatrists, in collaboration with team leaders, to enable and encourage the development of new roles for consultant psychiatrists and the mental health professionals who work alongside them. Motivated by a heavy workload and resource pressures, as well as the acknowledgement of the skills and capabilities of non-medical professionals, the individuals in these teams worked to create change through altering day to day team interactions and decision-making and implementing non-medic led clinics. The aim was to create a more limited consultant role distributing clinical work and responsibility across the clinical team to more fully utilise the skills of non-medical professionals, and in doing so meet demand and improve service provision. In turn this would make consultants more accessible for cases in which their specialist expertise was most required.

The consultants and team leaders working within the cases selected were generally supportive of the broad aims and principles associated with *New Ways of Working* (DoH, 2005) in terms of enabling the distribution of clinical work and responsibility across the team. The consultants and team leaders, worked with the aim of creating an environment in which non-medical members of the team took on additional clinical work and/or a more active and central role in clinical decision-making. Consultant psychiatrists envisaged a role for themselves in which they would not invariably become involved clinically with all cases and lead on all decision-making, recognising that where appropriate other professionals could take on elements of this activity.

Challenging Assumptions and Implementing Protocols

A core element of the activity taken by consultant psychiatrists and team leaders to achieve this goal was to challenge assumptions regarding the consultant's position and role within the team. The consultants recognised that in order to distribute responsibility across the clinical team their colleagues must be enabled and empowered to act with increasing autonomy and take on a leadership role where appropriate. In order to achieve this, consultants described taking action to undermine assumptions of their inherent leadership role and authority within their clinical teams.

Consultant psychiatrists modelled an alternative way of working in their day to day interactions with their colleagues. When appropriate, consultants made a conscious effort to abstain from making clinical decisions where other professionals were involved. In doing this they aimed to create the space for others to lead, subtly undermining assumptions of their inherent leadership role. An important context for such work was occasions involving multi-disciplinary professional decision-making:

…in relation to a patient whose care is being reviewed, in other words someone who is being managed by a care coordinator, has a moderately complex package of care with a number of other people involved in it and periodically a meeting is held to review that and in the course of that meeting I would very much defer to the people who are actually doing the work with that patient rather than critically reviewing what they are doing. (consultant psychiatrist, case one)

Work to challenge assumptions of the role of consultants in the decision-making process was also enacted during more informal and ad-hoc decision-making encounters with colleagues. Motivated by the high demand upon their time, in the excerpt below the consultant describes their activity to avoid making decisions when approached by their colleagues but rather to encourage and support others to do so. Again this enabled others to lead, developing their confidence and decision-making abilities in order to proceed with more limited consultant involvement in the future:

Consultant psychiatrist, case two: ..if people come up to you and say "What should we do?" and you say "Do B" you're an idiot because they know what to do next time they have got a problem….ask you. And if you are, as I am with my teams, around for just a few hours per week what are they supposed to do for the other 160-odd hours? So again I feel that one of the roles of the consultant if someone brings a problem is to discuss not the problem, but if you like the process by which they concluded it was a problem. Work on their problem-solving. And if you want to help somebody work on their own problem solving the solution is not to tell them the answer.

Interviewer: And that is what you would do…encourage people to try to make those decisions?

Consultant psychiatrist, case two: Yes. Wherever possible. And if I notice that actually this is nothing to do with my area of expertise to help steer the conversation towards the people who do have that expertise and leave it there.

Through engaging in this activity consultants acted to alter understandings of when consultant input to cases should be given. By limiting their own input they placed others in a position of extended responsibility, encouraging them to enact new practice in their day to day activities.

In addition to working on altering the norms around team interactions, in case two this was supported by the implementation of protocols to support the delegation of decision-making responsibility to non-medical staff. In collaboration with the rest of the team the manager developed protocols to aid nurses in making decisions on the unit, for example, approving admissions. These protocols provided nurses with a framework to guide decision-making, fostering a sense of confidence:

Say for example if I got a telephone call here there is sort of a set procedure that we have to follow and now I am aware of that. When I first came to this unit I didn't have a clue what questions I needed to ask when I got a telephone call from a nurse from one of the acute wards. It is sort of like a set erm….procedure that you follow and as long as you ask the nurse admitting that patient all of those questions you can't really go wrong. (nurse 5, case two)

Case three represented a particularly interesting context where service redevelopment created the opportunity to set up a new team, in which the development of reconfigured professional roles was an explicit goal embedded in the team ethos from the outset. From the initial development of this new service the consultant psychiatrists and team leader set out to promote a model of distributed responsibility in line with the principles outlined in *New Ways of Working for Psychiatrists* (DoH, 2005). The intention was to move away from a model of care provision where consultant psychiatrists were routinely involved with many service users through medical outpatient's clinics to one where clinical activity was shifted to other members of the team. In this new model consultant psychiatrists would see patients only when necessary, instead providing their medical expertise through their input to case discussions in multi-disciplinary team meetings:

> We wanted to make sure that we were focussing the consultant where they really needed to be rather than just trying to spread themselves too thinly and see everybody and actually not do that very well because there is only a finite number of consultants. But I think it is also, it is about recognising the expertise and experience of the CPNs [community psychiatric nurses] and the social workers in the team as well. (team leader, case three)

These changes involved developing increasing involvement of non-medical professionals in initial assessments as new clients entered the services as well as implementing several nurse-led clinics including a non-medical prescribing clinic.

In line with the activity described above, the consultant psychiatrists, team leader and other senior clinicians, worked to challenge staff assumptions and beliefs regarding the role of the consultant psychiatrists within this team. These individuals worked to drive the new approach by challenging the perceived need for direct clinical contact from medics. Where appropriate, staff members were encouraged to discuss patients in a multi-disciplinary forum rather than book them into the medical outpatient clinic.

Again the consultant psychiatrists worked to abstain from clinical work and decision-making where they felt it was appropriate, encouraging others to take on an extended role:

> …and they [consultant psychiatrists] have been very much, you know involved in the meetings sitting there saying "I think *you* could make

this decision" or "let's make it now as a group, I don't feel I need to see that person." (social worker one, case three)

In addition, in circumstances where staff acted to draw a consultant into clinical work and decision-making, the reasoning behind this behaviour was challenged. Through informal discussion and supervision, the team leader and senior clinicians worked with staff to explore their motivation for consultant involvement, and where a clear rationale was absent alternative sources of input and support were suggested and implemented:

> Team leader, case three: ….people saying "Well I want to book them into Dr X's outpatient clinic" and I would say "Well what for?" You know. "Well because they have not seen a Doctor yet." "But actually if they need to see a Doctor they have a GP. What is the purpose of seeing a consultant psychiatrist?" So I've had to really drill down and find out what that person is worried about and err….get them to talk to the consultant and find out actually if that can be provided in a different way, with some supervision or, you know, just a general discussion about that person.

> Interviewer: Yeah, and that is something that you would challenge just by informal discussion again is it?

> Team leader, case three: And through supervision I suppose and seniors doing that in supervision as well. Really sort of reinforcing the idea that people don't get seen by consultants unless they really need to.

Removing Formal Associations and Explaining and Justifying Change

The consultants and managers involved in the development of team three also made a more systemic challenge to traditional roles by taking the decision not to routinely allocate a named consultant psychiatrist to each patient referred to the team. New patients were allocated to one of the other team members for initial assessment and would not become associated with a specific consultant psychiatrist unless there was a clear need for their involvement. In doing this, these individuals worked to remove the formal association between the team's consultants and individual patients and a mark of their authority over, and responsibility for, overall team functioning and patient care. The allocation of a consultant psychiatrist to each patient was standard practice in all of the former CMHTs that this service had replaced, as well as in most other teams in the organisation, and therefore represents a significant diversion from prevailing arrangements:

> I think that was quite a big thing for a lot of people because.….anyone who has worked in a CMHT, for ages, always, it has always been, whatever happens you have a consultant. You come in the team, you allocate a consultant by name. That was kind of the first thing that happened. And if you were a social worker, you know, you were always, any care- any profession, as a Care Coordinator you always had a, a consultant, a named consultant as a fall-back. (social worker one, case three)

The removal of the allocated named consultant psychiatrist system caused "anxiety" amongst many stakeholders, which triggered the need for those involved in creating this change to explain and justify it. Both the team leader and key managers involved engaged in activity to support the enactment of reconfigured roles by quelling anxiety through explaining and justifying the new system to patients, professionals, and those in positions of authority e.g., senior managers and the Coroner:

> Team leader, case three: -but at senior level, although in the team that's very much what we wanted to do, at senior level people said "Oh yes that is an absolutely great idea". But periodically senior managers would look fairly panicked when I would say "Well obviously they don't have a consultant because they have never needed to see one" and look very frightened and say "What do you mean they haven't got a consultant?" and "Well we have talked about this, they don't need one and that is why they have not been allocated one."

> Interviewer: Yeah, and when you say senior management, you are talking service manager and higher.

> Team leader, case three: Yeah. So it is sort of, my job really is containing the anxiety for people being referred, the GPs, the team and then my managers as well.

This activity was also carried out by more senior management associated with this section on the services:

> I go to Coroner's Court quite frequently urm…I always try and go along with staff to support staff. Erm…doctors are not always exclusively called to Coroner's. I have been to many Coroners court cases where we have just had our clinician staff and a doctor has not been called. (manager 2)

> Manager 2: ….the Coroner may well ask why this person didn't see a doctor and sometimes they do but you have to explain what the system is. We have had to do that.

> Interviewer: Yeah, and is that accepted?

> Manager 2: Yeah, we had to explain what the system is.

The data presented in this section illustrates activities carried out at the level of the clinical team to enable and support the development of new professional roles. Inherent in the above quotes and discussion is the support of the consultant psychiatrists interviewed. Far from engaging in resistance and defensive claims regarding their superior expertise and decision-making abilities, consultants in this case were supportive of change. These individuals engaged in activity to undermine assumptions of their inherent responsibility and authority in order to encourage others to take on increasingly dominant roles in the functioning of the team and therefore create change in practice.

Management Level Activity

The activity of consultant psychiatrists and team leaders to reconfigure professional roles within the individual clinical teams investigated occurred within the context of concurrent management level activity to create change. This section of the chapter outlines themes developed from interviews with four managers who ranged in seniority from middle management to executive level within the organisation.

These actors were keen to promote a change in the contribution that consultant psychiatrists made to community services in line with the suggestions outlined in the *New Ways of Working for Psychiatrists* document (DoH, 2005). Driven by unmanageable demand and concerns over cost-savings and efficiency, managers were particularly focussed on reducing the direct clinical input of consultants in outpatient clinics, favouring a model in which their skills and expertise were used in clinical appointments only when necessary and via consultation with other professionals in the clinical team. In order to avoid any potential resistance from consultants and other professionals, managers enacted a strategy of gradual change, identifying individuals and contexts particularly receptive and open to change to create pockets of innovative practice as pre-cursors to service-wide change. This strategy was facilitated by a number of activities to support change: collating supportive evidence, utilising outside examples of successful change and alignment with legitimising values and norms.

Managers were particularly focussed on altering the input of consultant psychiatrists in community mental health teams. They felt that consultants were overly involved in direct clinical contact with a large number of patients, via the provision of routine outpatient clinic appointments. Managers identified a number of problems with this model of service delivery. Firstly, this was seen as inefficient use of an extremely expensive resource. Many of these cases were not medically complex and therefore could be managed more economically by other mental health workers. Secondly, the large caseloads held by consultants created problems in accessing their expertise where it was really needed e.g., for emergencies and consultation on complex cases. Thirdly, the medical outpatient model was seen as an ineffective way to provide care for many patients. Managers had identified a large number of relatively stable long-term patients who were monitored exclusively within medical outpatient clinics and therefore received only medical, rather than multi-disciplinary input to their care. Managers questioned the value of this input and associated it with creating dependency and long-term, unnecessary retention of clients within the service. These clinics were not viewed by managers as consistent with the recovery agenda with which they were keen to align.

In a context where managers throughout the trust were under increasing pressure to make significant savings in the delivery of services, changing the inefficient and ineffective practices of consultant psychiatrists was seen as an area of priority. In the words of one manager: "we have to find a way in which

we can use this resource better….and it is not exempt from proper scrutiny."
(manager three)

Managers aimed to reduce the routine clinical input of consultant psychiatrists, limiting their involvement to complex cases. They intended to work towards an increasingly multi-disciplinary approach to patient care, where the consultants would work as a component of an integrated team focussed on eventual discharge of patients, only becoming involved where necessary. Managers took two approaches to reducing the number of patients managed by consultants in medical outpatient clinics: the development of nurse-led clinics and an amended model of service provision. Both approaches involved engaging with particularly enthusiastic consultant psychiatrists and other professionals to facilitate successful change.

Managers described the potential function of two forms of nurse-led clinics. The first functioned as a nurse-led alternative to a medical outpatient clinic. Rather than seeing a consultant or junior medic, patients who have their long-term care managed in medical outpatient clinics would see a nurse for this monitoring instead. Non-medical prescribers were seen as particularly well positioned to take on this role. Not only would this release consultant time to consult and deal with more complex medical cases, but it would also introduce a view of the client that was not entirely medically focussed, thus promoting more holistic, recovery focussed care.

The function of the second type of clinic was as an addition to medical outpatient clinic appointments designed to provide clients with targeted, time-limited packages of support. These clinics could deliver specific interventions such as cognitive behavioural therapy or more generalised psychosocial support in the form of "recovery" or "move-on" clinics. Managers believed these clinics would introduce a more holistic view of cases that would benefit the clients and increase the potential for safe discharge from services:

> Doctors are very medically focussed, so more social aspects for example, things like education and employment tend not to be as emphasised [yeah] whereas someone from a nursing background would probably, not only be able to do the non-medical prescribing, but also be interested in those areas. [right, yeah] We have been developing recovery clinics …so we have got nurses who are taking people out of outpatients and actually doing a whole review of, you know, "Where are you at? What are your goals? What might you need in terms of getting back onto a college course? or do you want to work? What might your options be? urm…have you got an advanced statement?" [yeah] You know, trying to actually give people some tools and some skills and contacts that should hopefully move them out of the service. (manager one)

Manager two was also instrumental in implementing the changes described in case three, where they had taken advantage of service redevelopment to establish new ways of working in which professionals enacted reconfigured roles. This team was explicitly developed to function in a way that avoided the

retention of many clients on medical outpatient caseloads; a model that this manager intended to implement across the service more widely:

> One of the things that we have done in that team, and we are trying to roll it out in other teams, is to try and actually get away from these traditional ways of working for consultant psychiatrists. For the X team [Case three] what we have done is we have used the consultants in a consultant role….so the consultants don't have massive caseloads of clients that they only see themselves. They will see clients for medical review if that's appropriate but the consultant provides the specialist input and supervision to the team, as opposed to seeing the client. (manager two)

Within this new way of working service users could potentially receive specialist mental health input to their care from a non-medical professional without direct psychiatric input. As described in the previous section, this model of service delivery was reinforced from set-up by taking the decision not to routinely allocate a named consultant psychiatrist to each patient referred to the team:

> …medically they might not need to see a consultant, you know the GP is still providing medication, because a lot of people that come to that service, the GPs are still prescribing medication, they want sort of specialist mental health advice, so they will see a CPN, they will see a social worker, they might have an occupational therapy assessment erm…and you know that can be the full assessment. Er…so allocating to a medic is not always necessary. (manager two)

Through their involvement with case three this manager supported the activities of members of this team to enable change. This included the action to remove the formal association between the team's consultants and individual patients, and justifying and explaining change to authority figures, in order to enable the enactment of reconfigured roles.

The changes outlined above were in the early stages of development and yet to be implemented on a service wide basis. The managers had identified and engaged consultants and other professionals who were particularly enthusiastic about change and worked with them to create areas of innovative practice, as well as utilising the opportunity provided by service redevelopment. From here they were engaged in activity to consolidate and expand this practice across the service. The initial set-up of new areas of practice as well as the intention to implement change across the services more widely was supported by the ongoing engagement of managers in three specific facilitative activities.

Collating Evidence to Support Change

The collation of evidence through monitoring and auditing to support the proposed changes was a central strategy in the creation of change. At every stage in the process, managers were collecting evidence to support their decisions. This included an audit of the activity within medical outpatient

clinics and evaluations of various newly developed nurse-led clinics. The information gathered was used to strengthen bids to commissioners for monies to develop nurse-led clinics, as well as a means to convince various management and staff groups within the trust of the necessity and efficacy of the new model of working.

> At the end of 2010 I commissioned somebody to just do a 3 month review erm….of some of the medical outpatients, so I got this person to go and sit in some of the medical outpatient clinics with the doctors [a nurse?] yeah a nurse, to see what happens, to see what goes on in medical outpatients. (manager 2)

Utilising Examples of Successful Change in Similar Organisations

Managers developed links with another mental health trust (Trust X) where the role of the consultant had been drastically changed in the direction desired by themselves. This link was utilised in a number of ways. Firstly, they talked to individuals within that trust about how they run their service, drawing upon this model to influence their own ideas for service development. Secondly, they arranged for staff to visit this trust and for sessions where staff from Trust X could come to deliver talks to clinical teams about their service. Overall Trust X was used as an example to demonstrate that their suggested way of working could be implemented successfully within a similar organisation.

> Manager two: And there is national developments as well because we have looked at other people. There are other places around the country that are doing a similar thing.
>
> Interviewer: Yeah, do you model on other-
>
> Manager two: -well we- when- the project that I commissioned I asked that person to go and talk to other people so there's …we went, I went on a visit with some of my staff to Trust X [I have heard about this before] yeah so there are different places around the country that are doing very similar things. I mean X actually, we went to visit, they just stopped their clinics, medical outpatients, overnight [yeah] and just put them all into nurse-led clinics which was fairly radical I thought.

In line with the previous activity of evidence collation, this trust was also used as a source of data to support the efficacy of the proposed model of working:

> Manager one: The feedback from the majority of people was that they much preferred the nurse-led clinic and some of them would still continue to go and this is something like two years after the change. I think something like they discharged about 30% so not all of them were discharged but actually that 30% would probably not have been discharged if they had remained in outpatients. But of the 70%, they were being seen less often and were saying/reporting that they preferred the kind of support that they were getting because it was broader, it wasn't just focussing on tablets.

Interviewer: Yeah

Manager one: So really I think that is a lot of food for thought.

Alignment with the Recovery Agenda

Rather than speaking solely in terms of efficiency and cost savings, managers aligned the changes they were making with recovery agenda. This represents a widely acknowledged current ideology within mental healthcare popular with many clinicians, service users and commissioners, providing their ideas for change with a legitimacy and credibility that efficiency alone would not.

> …it is also about saving money because we have to-we know we have got to find money [yeah a huge amount] (laughs) so part of that is about erm ….like I have said before we don't want people in the services who don't need to be there, so we have to think about…..what we are doing with who [yeah] and really think about recovery as well. Actually because when those people entered the service, the whole ethos was completely different and people were told, you will be on medication for life, you will be seeing psychiatric services for life, you will never work and actually, now, the message is very different and the evidence is very different that in fact you can. So those things so it is about, how, how do we change that for people so they can start having a bit of hope [yeah] for themselves, and that necessarily means that as professionals we have to work with people in different ways. (manager one)

Outcomes

The activities carried out by the clinicians and managers described above had been successful in generating new practices and roles for the mental health professionals working in the clinical teams investigated. Increasing numbers of non-medic led clinics and activities had been developed, shifting some of the clinical work previously carried out by consultants and their junior doctors to other professional groups. Specifically, the clinicians involved in case one were in the process of developing nurse-led clinics in order to relieve pressure on the medical outpatient clinics. As described in case three non-medical professionals were increasingly involved in clinical work through initial assessments and various nurse-led clinics including a "recovery" and a non-medical prescribing clinic. A non-medical prescribing clinic was also running in case four.

In addition there had been changes in the manner in which clinicians related to and viewed consultants in their teams that enabled an extended role for non-medical professionals in the clinical decision-making process. Interviews with clinicians across all of the clinical teams involved in the study produced descriptions of the involvement and leadership of non-medical staff in clinical decision-making:

> I mean this is a very nursing-led team so in terms of discharges, admissions, that is completely a nurse's decision here whereas in

[previous role] that was all a consultant's decision. Our consultant has no say over that whatsoever. Erm… Things are obviously fed back to the consultant and they are given information about clients that we have recently admitted but the consultant doesn't say "No that person is not appropriate er… we need to discharge that person". That is all of the nurses that make that decision. (nurse five, case two)

Nurse one, case one: Personally I have recently had experience with, I won't say who, a consultant who was asked to see somebody in outpatients and…I sort of made some comments about, I didn't think-about the way it was going and erm…she is quite a complex lady and it was lovely because the next thing they asked me if I would mind going and sitting in on the appointments with them for my expertise and opinion, and I was thinking I am not the expert you are. But it was nice to have that recognition. I think consultants are much more willing to recognise the expertise in teams now and that some clinicians maybe do have more awareness than the consultants might have about certain issues.

Interviewer: Yeah, and that is something that has changed since [definitely] …since you have worked in this team do you think?
Nurse one, case one: Yeah, definitely.

Consultants reported that this impacted upon their roles enabling them to reduce the amount of direct clinical work and routine decision-making in which they were involved.

However, with the exception of case four, the degree of role change enacted was largely limited to the delegation of more routine clinical work and decision-making from consultant psychiatrists to their non-medical colleagues. New roles were enacted in a manner that maintained medical authority over clinical decision-making, particularly decision-making regarded as more complex in nature. Within the new division of labour consultants retained involvement in the work viewed as most complex, both in terms of biomedical complexity as well as any work viewed as high in risk. This understanding of the role of the consultant was articulated by both consultants and non-medical professionals:

The medical side mainly we decide if it needs to see a psychiatrist it is medication, you know complex medical problem, uncertainty of the diagnosis. These are things you should you know see. Some are actually very high risk and then the team feels a bit uncomfortable and want to have a consultant opinion and you know to contain the risk. These are the main things they should go to, to me. (Consultant psychiatrist, case three)

Interviewer: OK. And the people you would refer to a consultant. Why would you be referring?

Nurse one, case one: Erm….It would be either due to medication problems, either withdraw- wanting a particular medication or wanting to come off a particular medication. Erm……maybe people have tried various medications that haven't been effective. So, treatment resistance. A combination of medication problems or it could be to do with risk. Behaviours have increased and it has become particularly risky so we want someone to just kind of share that risk with and a bit of support.

A dominant theme identified during the analysis process was the understanding that a key element of the role of the consultant psychiatrist was to manage risk. Many professionals in this setting, including consultant psychiatrists and non-medical clinicians stated that consultants should become involved in cases where risk management was a significant issue, and this risk was not restricted to medically related issues:

Consultant psychiatrist, case two: Often stuff around making decisions in risky situations, the consultant would be involved and it probably would be unreasonable to say "no you go away and you sort that out".

Interviewer: Whether it is medically related or not?

Consultant psychiatrist, case two: Any sort of risk….

By reconstructing the division of labour in this way the professionals involved acted to enable new practice whilst maintaining the core role boundaries and relative positions of the various professional groups within the established interprofessional hierarchy. Work could be delegated to non-medical clinicians but where this work became biomedically complex or risky it would fall back within the jurisdiction of the psychiatrist. This then enabled non-medical professionals to enact extended roles, whilst ensuring that consultants retained involvement in the most complex work and therefore their position of authority at the apex of the interprofessional hierarchy. Role change was largely mutually advantageous and non-threatening.

Interestingly the justification for the need for consultant involvement in the management of risk was not based on claims around expertise in risk management. These were notably absent from consultants working on the frontline in areas where change was occurring. Rather, the need for medical coverage over risk was based on understandings around authority and expectation:

…it is around the fact that, you know, the buck stops with the consultant, and again, me yeah, its structural. It is not that you ask the consultant because they are always right or we are brilliant or they are geniuses or they are just so incredibly, you know, good at their job that they never make a mistake. It is that actually, the point is, the consultant can make the decision because they are the *only* person who isn't *endlessly* then looking as it were up, further uphill thinking wow I better go and ask another expert. (consultant psychiatrist, case two)

…you need someone to come along and say "Right. Let's do B." Because you know that person will actually be able to stand up in the Coroners Court and give a good account of why they did B. (consultant psychiatrists, case two)

… in cases where anxieties are raised or where the service has entered into a long term commitment to support somebody who has complex or difficult needs then there is an expectation that a psychiatrist will be involved there somewhere…..the consultant I think is sometimes, not uncommonly perhaps, used, if you like, as air cover when a risky situation is going on. And that to some extent is reflected in the way in which the consequences of a risky situation going wrong are perceived ur….and that, as it were, runs all the way through to the Coroners Court where there is, if you like, still a routine expectation on behalf of the Coroner and their public that the doctor is somehow answerable or is the answerable party. (consultant psychiatrist, case one)

Although this reconstruction could be seen as activity on the part of the consultant psychiatrists to maintain their privileged position in the interprofessional hierarchy, and it undoubtedly works in their interest in this respect, it is argued that the dominant influence in creating this division of labour was not in fact the micro-level work of the consultants. The overriding constraints upon change appeared to stem from higher-level pressures and expectations acting upon all of the professionals within this system, particularly those emanating from dominant templates dictating role expectations and the risk management pressures under which these professionals work. Both medical and non-medical professionals perceived an expectation and pressure to demonstrate consultant involvement in cases in which increased or significant risk had been identified.

To summarise, this chapter illustrates the activity required to enable the enactment of new professional roles in which elements of the clinical activity and responsibility previously held by consultant psychiatrists is distributed across the various non-medical members of the clinical team. Consultants, team leaders and managers engaged in activity aimed at challenging norms and expectations around the traditional role of consultants in this setting to enable and embed new practice that involved extended roles for non-medical professionals. The creation of change required intentional and sustained effort on the part of the key actors involved and had resulted in the initiation of new practice in the various clinical settings studied.

New practice emerged in which non-medical professionals were enabled to take on extended roles involving elements of the clinical work and responsibility previously within the remit of consultant psychiatrists. Within the new division of labour work was allocated according to the level of biomedical complexity and risk it presented with consultant psychiatrists retaining involvement in work perceived as high on either dimension. As a result, the traditional hierarchy and distinction between medical and non-medical professionals in terms of authority and decision-making responsibility

was maintained. Crucially, the dominant influence constraining the degree of change was not the resistance of consultants, which appeared unnecessary, but the impact of powerful pressures acting within the organisational environment.

The following chapter more fully describes and presents the manner in which reconfigured roles were enacted, highlighting the influence of institutional pressures around interprofessional hierarchy and the management of risk in constraining the degree of change. The chapter will illustrate how the risk climate in which these professionals work drove the continued involvement of the consultant psychiatrists in decision-making.

5 Data: Constraining and Enabling Influences

This chapter illustrates analytical themes concerning the influences that constrained the degree to which professional roles in this context were reconfigured. The first section of the chapter presents data that demonstrates how dominant templates concerning medical authority and seniority within the interprofessional hierarchy, along with organisational representations of this authority, interact with concerns regarding accountability for the management of risk to drive the continued involvement of consultants in decision-making within everyday practice. The chapter then moves on to present data that demonstrates the effect of these influences within specific role reconfiguration attempts, including the manner in which nurse-led clinics were set up and the development of new ways of working within a redeveloped team (case three).

The latter part of the chapter presents data from an exceptional case (case four) where the effect of these constraining influences was to a large degree mitigated. Data is presented that demonstrates the enactment of extended roles by non-medical professionals who were enabled to take on significant decision-making responsibility including the management of risk. The characteristics of this case, particularly in relation to their influence upon the impact of interprofessional hierarchy and responsibility for the management of risk are outlined and discussed.

Constraining Influences: Interprofessional Hierarchy, Accountability and Risk

Despite the activities to distribute clinical activity and elements of decision-making responsibility across the teams, there were significant barriers that limited the extent of role change. There remained an understanding that consultant psychiatrists played a crucial role in the clinical decision-making process, particularly in complex or high risk cases. Whilst being willing to make "run of the mill" (nurse 4, case two) decisions autonomously and take an active role in contributing to multi-disciplinary decision-making, many team members were not comfortable to proceed without consultant input in decisions where increased risk was a particular concern. Although non-medical professionals were willing to manage a certain level of risk, and saw this as an integral part of their role, the cut-off point for which varied amongst individuals, significant or increased risk was viewed as an issue for the consultant. Participants articulated the need to involve the consultant in these decisions citing several inter-linked factors relating to their understanding of the roles and responsibilities of the consultant psychiatrist, each of which drove the continued involvement of consultants in decision-making.

The interviews revealed numerous accounts of non-medical professionals working to involve consultant psychiatrists when risk management became a significant issue in decision-making. As one consultant put it: "You can sort of

delegate this and you can ask people to do that, but the first sign of trouble, it all comes back to you."(consultant psychiatrist , case two) This typically involved action on the part of non-medical professionals to involve the consultant in multi-disciplinary decision-making in which responsibility was then jointly held, or "shifting" responsibility back to the consultant as described by the nurse in the following excerpt:

> Nurse 5, case two: We got a telephone call from one of the acute wards. We had a client... [details about client removed]..they had changed their name which meant that doing any CRB [Criminal Records Bureau check] made it very difficult to find out what their previous criminal history was so erm….i initially thought OK I need to then run this through with my ward manager. My ward manager then thought OK probably I do need to run this through consultant psychiatrist X and then it was ran through them and then they made the decision for the client to come.

> Interviewer: And why was that?

> Nurse 5, case two: I think that was because nobody really wanted to make that decision if I am really honest. I wouldn't have wanted to have said "Yeah that's fine for them to come" because I knew nothing about their history, before erm…I think it was about 2000. We knew nothing about anything that had happened and we knew that the client was very very risky prior to that but didn't know exactly what- how they were risky and I didn't want to make that decision as a band 5 so I then said Ok I will speak to my manager about it sort of and then shifted the responsibility, and they still didn't want to make that decision so then they shifted it to the consultant.

The motivation to gain consultant input in such cases was linked to a number of related influences, not least of which was a desire to provide quality multidisciplinary care for the patients, incorporating multiple professional perspectives. In terms of organisational and institutional factors, the analysis produced several influences of particular relevance to the role of the consultant and risk management. Firstly, consultant psychiatrists outrank all other members of staff in terms of "banding" or grading and salary. As highlighted in the above quote the nurse's position as a, relatively junior, "band 5" member of staff positioned them as subordinate to other members of the team, including the consultant psychiatrist. This justified the escalation of difficult decision-making upwards through progressive higher positions in the hierarchy, at the apex of which sits the consultant psychiatrist.

This authority and seniority was reinforced by the consultant's position as the organisationally defined "named consultant" or, in more limited cases, the legally defined "Responsible Medical Officer" or "RMO" in relation to individual patients. Interestingly, the term RMO was commonly used by participants not in its official legal sense in connection with patients detained under the *Mental Health Act 2007*, but in a more general sense to refer to the consultant who had been allocated to a patient as an alternative to the term "named consultant". In two of the teams studied these titles served to create a

formal link between a consultant and all patients on the team caseloads further justifying and driving their involvement in all major decision-making.

An additional and highly prominent theme relevant to the enactment of role reconfiguration was discussion regarding involvement in, and expectations around, investigations following negative incidents. Involvement in such investigations and the potential outcomes and consequences were clearly a central concern for the participants interviewed. Participants were highly aware that in the event of a negative incident the decision-making by the professionals involved in the case leading up to the incident would be subject to evaluation and potential critique. The investigations that participants made reference to were both internal and external to the organisation. Participants described the Serious Untoward Incident (SUI) process operated by the organisation in which designated professionals and managers explored the professional involvement and case management preceding negative incidents, and the investigations carried out by the Coroner in the event of a death.

Participants described how their awareness of reactions and processes following negative incidents had an influence upon their clinical practice, engendering careful consideration of how their decisions would be viewed by authority figures to whom they are accountable should they ever be investigated or audited. This created a desire to discuss decisions with colleagues, to gain different perspectives and input and to share the responsibility for risk management. For many professionals the consultant psychiatrists played a particularly important role in this regard and issues of accountability and negative incidents were closely associated with the involvement of consultant psychiatrists in decision-making around risk. Participants described an understanding that, in the event of a negative incident, those conducting investigations would expect consultant involvement in case management, particularly around risk, and that decision-making in which consultants had been involved would be more readily accepted. The identification of elevated risk levels, i.e., the recognition of an increased probability of a negative future event, therefore served to prompt the involvement of consultants in case management and decision-making.

By involving a consultant psychiatrist in risk management, professionals were acting in a manner that they felt would be viewed as satisfactory and acceptable to the authority figures who would become involved in investigations should a negative incident occur. This understanding was developed through direct experience, their colleagues' accounts of such experiences and various forms of formal communication from the organisation such as "lesson learned" documents following negative incidents:

> Nurse one, case one: "I have some risky people on my caseload and yes you do always think that, that is a question you will be asked: "Well if you were that concerned why didn't you discuss it with the consultant?
>
> Interviewer: And who would you be asked by?
>
> Nurse one, case one: Erm...if there was- if something happened and there was an internal inquiry. Whoever was investigating that. Worst

case scenario, if it went the worst way it could then you would be asked in Coroner's Court.

Interviewer: Yeah.

Nurse one, case one: You know, if you got to the that, you were working with someone and you got to the point where they were that risky that they were posing a risk to themselves you really do need to be having consultant involvement with that person, to sort of jointly manage that risk really.

Interviewer: Yeah, yeah. and...you said you hadn't had direct experience but you know you would be asked those questions. How do you know that?

Nurse one, case one: Because of other people that have been through. We have, i don't know if you have heard, we have things called lessons learned and things like that. So every time anything big does happen. Any time there is either an investigation, an internal inquiry or something goes to Coroner's Court there is always lessons learned that come out so...constantly as a trust we are always learning from things that have gone on and that is why you know those things, and we do erm... Coroner's Court training as well. [Do you?] yeah. If you ever get a chance to do it, do it. You will never write notes in the same way again. [really?] It really makes you think about what you write in your running records for people. [yeah] but it is those kinds of questions that if anything happened you will be asked: "Why didn't you feel that it was important to discuss it with your team leader or your consultant?" because there is still that perception that the consultant has more expertise and knowledge so....

By involving a consultant psychiatrist clinicians felt that they would be "backed-up" and their decision-making would be easier to defend. Without involving the consultant the non-medical professional left themselves open to potential criticism.

If something went wrong, it would be asked of me, where was the multi-disciplinary decision-making, that assessed their risk to say that it was OK for them to work in the public. Say they attacked somebody. Because of that, I suppose that is my background, it is about covering your back and it is I don't like to make that decision on my own. I might be 90% confident that it is OK and I am but I want that decision to be discussed at a multi-disciplinary team meeting, including the consultant who is their RMO, and written in the notes discussed, everyone in agreement, or these things discussed, and then I am backed up. (non-medic one, case two)

A similar understanding was also articulated by consultants themselves, who felt that the management of risk was a responsibility that they were expected to fulfil. Consultants argued that their continued involvement in major decision-making around cases was necessitated by their position of authority and

responsibility, reflected most clearly in their involvement in investigations following serious negative incidents:

> If you come to this trust you will hear distributed leadership talked about a lot, because in a big trust like ours, you have got to have distributed leadership in order to achieve your goals…erm……and the anxiety of my consultant colleagues has always been, and is, if the s**t hits the fan it is me who ends up in the Coroner's Court. And the reality is that it is a bit like that still. (consultant with senior management responsibility)

The data described and presented above illustrates how a number of inter-linked factors concerning the consultant's authority create an organisational environment that drives their continued involvement in complex decision-making, particularly around risk. Organisational and macrolevel representations of consultant authority and responsibility reinforce dominant understandings of medical seniority. The impact of these influences is exacerbated by professional concern with accountability to internal and external authorities who convey an expectation of consultant involvement in decision-making, particularly where elevated risk has been identified. Both medical and non-medical professionals perceived pressure to demonstrate consultant involvement in risk management, limiting the degree to which responsibility could be distributed and roles reconfigured. The constraining influence of these pressures on role reconfiguration was evident in the degree of change created in day to day decision-making as described above as well as in the manner in which specific role change attempts were enacted.

An example of the desire to maintain medical authority over case management is provided in the manner in which the planned development of nurse-led clinics in case one was envisioned. Although the aim of this development was to transfer clients from a consultant to a nurse-led clinic it was anticipated that all clients would remain "open" to the medical outpatient clinic and therefore continue to fall under the jurisdiction of the consultant psychiatrist; an arrangement that conveyed a sense of "safety" to the team leader involved.

> Team leader, case one: I think it's important that when we are actually doing that clinic there is a medical responsibility still [OK]. Yeah? Urm….
>
> Interviewer: Why is that?
>
> Team leader, case one: Well because its urm…….i think it gives, it gives us I suppose a, a safety net.

This safety net was for the benefit of patients as well as the professionals involved, and all staff members interviewed including the consultant, team leader and senior nurse, were in agreement about the need for this. The link with outpatients would help provide stability and contain the anticipated anxiety of the patients, as well as allowing a quick link back to the consultant should any deterioration occur:

Interviewer: Would these people [those being seen in new nurse-led clinics] be discharged from [medical] outpatient clinics, will they be like coming back to the team?

Nurse one, team one: Not necessarily. No if they are open to outpatients they would remain open and erm outpatients, they would still have medical responsibility for those patients, but they would be seen in the clinic.

Interviewer: Why is that?

Nurse one, team one: I guess, for the simple fact that if you put yourself in the patient's chair for a minute, you have been held in outpatients for five, ten years sometimes longer and that is all you have had. You have not been seen by a care coordinator, you have just seen your consultant psychiatrist every six months. To then be told that by the way you are just going to see a nurse now every couple of months, you don't need a consultant, for a lot of people it could cause them to just completely relapse and fall apart, so what we have said is that they will be seen by the nurse-led clinics but still remain open and responsible to outpateints, but they wouldn't necessarily be seen in outpatients. And then from the patients point of view they know that they are still under outpatients, it is just a new way of working but hopefully we will be able to discharge them out and also if there was any relapse then they would be able to be seen quickly to deal with it rather than having to be referred back in again.

Interviewer: And where did that suggestion come from, of running it that way?

Nurse one, team one: Erm….a combination, from ourselves, from the consultants and from the service manager.

Interviewer: So everyone thought that was the safest way to do it.

Nurse one, team one: Yeah, it is about managing risk.

Pressure to maintain consultant involvement in decision-making was also evident and highly influential in constraining the changes developed in case three. As described in the previous chapter the notion of distributed responsibility, particularly the removal of the allocated named consultant psychiatrist system caused "anxiety" amongst those involved in this change from the clinicians working on the frontline to senior managers. As described above this anxiety was linked to concerns regarding accountability for decision-making, particularly in the event of a negative incident. Interviewees articulated a belief that in the event of a death those conducting investigations, including the Coroner, would seek and value the opinion of a consultant psychiatrist. Decision-making that had not included a consultant would be questioned. This belief was articulated by the consultant psychiatrist and non-medical team members alike:

Consultant psychiatrist, case three: …..people are really anxious about say if something bad happens to one of the patients you know…and then "why you haven't discussed with a medic?"

Interviewer: And who would ask them that? Who would say "Why haven't you discussed this with a medic?"?

Consultant psychiatrist, case three: So for example if you have a suicide or whatever or there is a what we call a Serious Untoward Incident, then you get an audit and people would say "right …" …but I think people have that mind-set and they will ask why or the Coroners will ask why it hasn't been discussed.

Although the consultant psychiatrists were not routinely allocated to all patients and may never come into contact with many individuals receiving input from the team, there was still a feeling that they had to be involved in decision-making in some way and that there needed to be evidence of such input. In order to achieve this, the team manager, consultants and senior members of staff drove involvement in multi-disciplinary team meetings (MDTs), which formed a crucial part of the way this model functioned. Multi-disciplinary team meetings began as a weekly occurrence but increased in frequency until they were happening daily. These meetings provided a forum for the discussion of every new referral, assessment and discharge, as well as for discussing any issues of concern in on-going cases: "All decisions should come through that meeting" (social worker one, team three). This meant that consultant psychiatrists remained involved and jointly accountable for all major decision-making.

Social worker two, case three: They [consultant psychiatrists] have the chance to hear about each case at the initial referral stage, then every time there is a new development the worker can bring it back to that meeting. The doctors do it too. They bring it back with people.

Interviewer: Yeah. And why is it so important that erm…there is psychiatric input for all cases?

Social worker two, case three: I think it's mainly to do with the hierarchy of responsibility.

Interviewer: Hierarchy. Can you tell me more about that?

Social worker two, case three: Well…although in our team I'd say that it is more linear than anywhere else that I have worked.

Interviewer: Really? Yeah.

Social worker two, case three: There is still, I think, although I am not sort of quoting policy here, but I think there is a level of responsibility. So if, for example, a case was referred in and myself as a social worker looked at that referral and decided that it would be appropriately held in a nurse-led clinic, went to the nurse-led clinic and then actually there was a problem, there was an incident, maybe the person killed themselves or there was, you know, some problem with it.

When…when that was investigated there would be a question asked of you know, "well what was the doctor's input with this case?" So that's how we ensure that everybody gets an appropriate level of psychiatrist input as well.

All meetings were recorded on a specifically developed pro forma to provide clear evidence of consultant involvement and accountability:

We developed a pro forma for people to complete so, you know, so it clearly says, this is the date of the meeting, this is who was present, this is the client being discussed, these are the risks, this was their FACS [Fair Access to Care Services] eligibility and their social care needs, this is their mental health needs, this is your care plan kind of thing, you know, pops out at the end. And you stick that in their notes and it is very clear then that from an accountability point of view that although a doctor has not seen them, actually they have been involved in the decision-making. (team leader, case three)

The use of the MDT meeting model and pro forma served to reduce anxiety regarding accountability for decision-making and shift at least part of the accountability for decision-making back to the consultant psychiatrists. One form of medical authority was replaced by another. Again the involvement of consultant psychiatrists in the decision-making process was understood as providing a form of professional "safety"; a message that was conveyed by the consultants, team leaders and senior staff members in the team.

….it just took a little bit of adapting to and we just needed to communicate really clearly that for staff safety and for the medic's own peace of mind and their sort of professional responsibility and accountability we need to be discussing all the assessments that happen in the team. (social worker two, case three)

The development of the specific changes to practice developed in cases one and three further illustrate the manner in which pressure to demonstrate consultant involvement in decision-making limited the extent to which professional roles were reconfigured. Whilst there were planned and actual changes in clinical practice that extended the roles of non-medical professionals these were enacted in a manner that maintained medical authority over decision-making. The involvement of consultants in decision-making provided a form of safety for professionals in the event of an investigation following a negative incident.

Again, the involvement of consultant psychiatrists in supporting the development of new practice in a manner that maintains their involvement in, and authority over, complex decision-making could be viewed, not as a reaction to pressures but as activity on their part to protect their privileged position within mental health services. The interpretation made in this case is that this behaviour represents predominantly the former. The view that authority figures expect consultant involvement in decision-making was widely held by non-medical professionals and consultants alike, with both groups acting to meet this expectation. At the time of the investigation, whilst

there was activity to create change in practice there appeared to be little pressure to move away from general medical authority.

In addition, interviews with senior managers revealed an expectation for consultants to become involved in, and take responsibility for, complex issues and serious incidents, although this message was complex and mixed. For some managers the message was clear, as evident in the following example:

> Interviewer: …One of the key things I was looking at that people have talked about a lot, about the role of the consultant is their involvement in managing risk and erm… how they seem to be looked at when things like SUIs happen.

> Senior executive: Absolutely. Yeah that is the call.

> Interviewer: Is that the case?

> Senior executive: Yes. When it gets tough erm….why did they die? Why did they commit suicide? Why did they self-harm?

> Interviewer: Would the trust be looking at the consultant to answer those sorts to questions?

> Senior executive: You would want the team but it would be the named consultant who is the RMO-

> Interviewer: -ultimately responsible?

> Senior executive: -usually, usually, so erm…they are accountable for, for that. That's that professional accountability is a lot stronger as a doctor than it is as a nurse …

For another senior manager the issue was less clear cut. From their perspective, whilst the organisation did not view the consultant associated with a team as formally responsible and accountable for the overall management of the care of patients within that team, they did acknowledge unwritten and informal expectations and pressure. This manager illuminated the point with the use of an incredibly sad and serious incident that occurred in relation to a patient in contact with the trust:

> Manager three: ...a long term patient supported by a community team erm..became very unwell, not noticed by the team erm…although allowed for by the team….erm…was very delusional, murdered a family member [details removed]…erm…the team were, went through the SUI process and the RCA and an independent inquiry and everything else and individual members in the team were…erm..held to account and there were certain things that were expected to have been done. Erm….the consultant took, took personal accountability and felt that what was being said was erm…aimed specifically at them as the leader of the team. That wasn't necessarily the case, although the consultant and other members of the team had questions asked of their

judgment and…The inquest is going to be held and there is an expectation that the consultant will be asked to the inquest, as will other members of the team, so the consultant isn't necessarily being seen as the responsible person but is being seen as perhaps a spokesperson, perhaps by default the leader of that team. Erm… but organisationally we haven't held anybody to account for that incident. We have done an investigation, and we are content that the investigation identifies weak practice across the board erm….without identifying specifically, it was that person's fault, so we have constructed an action plan to help support the team. So we don't ….the organisation doesn't like to blame er..it likes to hold people to account and then find ways of addressing skills deficit or erm..errors.

Interviewer: Yeah, so there is nothing specific or inherent about these procedures that erm…points to a consultant..they would be part of..

Manager three: -I don't know whether consultants would feel that. I, I would suspect that consultants feel that erm…you know that the point of the triangle is on their head. Erm…but that is different to the way that the organisation feels it behaves.

Enabling influences: An Exceptional Case

Case four provides an example of a team in which roles diverge from those traditionally undertaken; responsibility for clinical decision-making is distributed across the clinical team. Interviewees' accounts reveal relatively little in terms of activity to create a model of distributed responsibility, more influential in this case were the contextual factors relating to the team's function and client group. The limiting factors outlined in the previous cases do not appear to exert such a constraining influence on role reconfiguration under these circumstances, at least amongst the non-medical team members interviewed. Interestingly, the constraining influences continued to impact upon the views and actions of the consultant psychiatrist who worked to oversee the activities of the team.

Reconfigured Roles

The participants working in this case described the enactment of roles that differed significantly from those associated with the dominant template of medical dominance and those described by professionals working within the other cases investigated. Non-medical professionals were enabled to carry out extended roles including clinical activity and decision-making without deference to the consultant psychiatrist. This case is made particularly interesting by the fact that the presentation of risk is a criterion for referral to this team and is therefore an ever-present issue, dealt with by all team members.

The nurses interviewed within this case clearly and explicitly stated that the identification of elevated risk was not, in itself, a factor that necessitated the need to gain consultant authority over decision-making. Rather than seeking

consultant involvement in decision-making surrounding risk the nurses in this case were confident to make decisions themselves:

> Nurse six, case four: I can't think of a case actually where I would want them [consultant psychiatrist, case four] to make a decision that I wasn't happy to make myself, or that I wasn't sure about, I can't think-
>
> Interviewer: -because it seems a bit risky.
>
> Nurse six, case four: Yeah. We are all very risk aware really. Because, because risk is, risk is why people are referred to us by and large and we are kind of comfortable with risk.

In contrast to the professionals interviewed in association with cases one to three, the nurses in this team did not view involving a consultant psychiatrist in the management of risk as providing a form of professional safety. This was associated with an understanding that the assessment and management of risk was a role that legitimately fell within the nurse's area of professional jurisdiction within this team.

> Nurse seven, case four: I don't think it really gets you out of jail saying "I told a Doctor about it." so….
>
> Interviewer: It doesn't?
>
> Nurse seven, case four: I don't think so. No.
>
> Interviewer: No.
>
> Nurse seven, case four: No, because it is just a matter of, you know… If you were part of a chain of co- er….information and you fail to do your bit in the chain of information exchange and…then sure, you know, if that was all your role was. But our role is to observe, to make observations and, and erm….to formulate an impression of this presentation and use it to measure and assess risk.

The nurses interviewed did not see the consultant psychiatrist as carrying an enhanced position of accountability or responsibility for the patients associated with the team. They viewed accountability and responsibility for decision-making as being shared across the practitioners who had been involved in a particular case which, in many cases, does not include the consultant psychiatrist. Whilst recognising the psychiatrist's expertise, staff viewed the consultant's accountability as extending only as far as the consultant's own individual decisions and involvement, as with any other member of the clinical team:

> Nurse seven, case four: They [consultant psychiatrists] are accountable for their own role.
>
> Interviewer: Their own role. Yeah. Erm…and, yeah. So they would only be accountable for when they did become involved in a case.

Nurse seven, case four: Yeah.

Interviewer: So the way you would see ultimate- who is ultimately accountable for the people under this team? Who would that be or…?

Nurse seven, case four: Err…well it is the practitioners who have had contact.

This understanding of accountability was reflected in staff views on proceedings in the event of a negative incident i.e., the trust's Serious Untoward Incident [SUI] process and Coroner's Court hearings, of which the two nurses interviewed had had experience. In contrast to nurses in the other teams analysed, nurses in this team did not perceive an expectation of consultant involvement during these processes.

Nurse six, case four: I don't know if nominally they [the consultant psychiatrist] has got some responsibility on, on…you know in the system sort of officially but certainly on a, a- in terms of the team I don't think he's ….responsible for everyone, you know automatically.

Interviewer: No. No.

Nurse six, case four: I wouldn't have said so.

Interviewer: So who does hold that responsibility?

Nurse six, case four: I guess. I guess the…I guess the team and the people who do the, you know- for example these, these, these [detail removed] SUIs that we had, and we have got the Coroner's Court things coming up this year erm…only the people, er.... involved with those people have been called up. Not the whole team.

Interviewer: Yeah.

Nurse six, case four: If that illustrates the point maybe.

Like the professionals in the other teams, participants in this team were highly aware of the potential scrutiny their decision-making could undergo in the event of a negative incident:

They [a non-medical colleague from the team] said "When you make a decision. Think how, think how it would read in the papers." Which is a little bit kind of slightly kind of alarmist but there was, there was a lot of truth in that. So….i guess er, er….we do kind of just think about justifying our actions really, maybe a bit more in the light of whats- things that have happened. (Nurse six, team four)

This however, did not serve to constrain role reconfiguration and drive the continued involvement of the consultant psychiatrist in decision-making in the manner illustrated in the other cases.

The team emphasised that they would not hesitate to involve a consultant psychiatrist when medical input was necessary but, crucially in this team, this did not include the management of risk in a crisis situation. The psychiatrist's opinion was valued as one part of a multi-disciplinary team and contributed to decision-making process in multi-disciplinary meetings. However, the psychiatrist was not viewed as the ultimate authority figure concerning the management of risk. This understanding then allowed non-medical professionals within this case to carry out extended roles without being constrained by a perceived need for medical authority over the management of risk.

Enabling Influences: Client Group and Team Function

A major factor facilitating the development of a model of distributed responsibility in this case was the manner in which the problems of the client group served were categorised or constructed. Crucially, the presentation of many of the clients referred to the team was described as related to a situational, personal or emotional crisis rather than an underlying mental illness or "a genuine psychiatric crisis" (team leader, case four). Client issues were understood predominantly in psychosocial as opposed to medical terms; the clients were not suffering mental ill-health but reacting to difficult life events or circumstances.

> Team leader, case four: GPs refer and its not- a big proportion of it is not a mental health issue, it is a lot of social issues that impact on people's wellbeing.
>
> Interviewer: Yeah.
>
> Team leader, case four: But isn't strictly what we would call a mental health problem.

As evident in the following quote, the fact that the risky behaviour displayed by the individuals seen by this team are viewed as being triggered by the experience of an adverse life event meant that they did not require the attention of a consultant psychiatrist:

> We get a lot of broken-hearted people. People dumped by partners. People who take rash drunken, overdoses because they have been dumped by their boyfriend or girlfriend the previous night. That does not need a – that does not need a psychiatria- a psychiatirst's- a consultant's time. (nurse six, case four)

The team leader, who had worked within several teams, described the manner in which the level of medical influence within crisis teams differed from that within others:

Team leader, case four: Because I think in the beginning, like I said, it was quite a different way of working.

Interviewer: Yeah.

Team leader, case four: Anxiety provoking at times.

Interviewer: Yeah.

Team leader, case four: And I suppose traditionally when you worked in say an inpatient setting or even when I worked in a CMHT, you always had reviews with the doctor, or, do you know what I mean, so that's always what you did.

Interviewer: Yeah, they were involved somewhere.

Team leader, case four: Yes. So to come to CRHT I guess you wanted that er..you know that kind of reassurance because that was how you were used to working.

Interviewer: Yeah.

Team leader, case four: But I think as things developed that has become less and less.

Unlike many other teams, some crisis teams, including the one explored in case four, have had a psychologist embedded within the team. The team leader interviewed described the role of psychologists in the development of an alternative view of, and approach to, client issues:

Team leader, case four: …. I think because a lot of the people we see…it is more of a psychological erm…need that they have than a psychiatric one if that makes sense.

Interviewer: Yeah.

Team leader, case four: And I think as well the psychologists have helped the team of staff to think in a different way.

Interviewer: Really?

Team leader, case four: So you are not thinking necessarily always in the medical model.

Interviewer: Yeah.

Team leader, case four: You are thinking about holistically the person and lots of social things. It changes the way you think a little bit, working with psychologists.

Interestingly, an approach to client issues that is, to some extent, demedicalised was also identified as an enabling factor within cases two and three, although one that was less extreme and exerted less of an enabling impact than in case four. Whilst the medical elements of care were recognised, participants described an approach to client issues that departed to some extent from the medical model. In case two this was linked to the culture and history of the unit which was described as "person-centred" or "recovery-based" (Team leader, case two) rather than medically focussed. The professionals in case three also emphasised the importance of the "recovery" ethos within their team and an increasing focus on "psychosocial interventions" (occupational therapist, case three).

In addition to the demedicalised construction of the client group's problems, the functioning and remit of the team also facilitated the enactment of distributed responsibility. The aim of the team to provide short-term, fast-response support during a period of crisis influenced the ability of professionals to enact reconfigured professional roles in two important ways. Firstly, it necessitated the need for non-medical professionals to engage in autonomous decision-making. As this team is by definition a rapid response crisis team, the team members available at any given time are required to make clinical decisions regarding the cases they are presented with.

> …sometimes you'll, you know, if it is an evening visit and you are on your own and there is no one else around then you have to make that call. There is no consultant, you know, you haven't got anybody there in the office or anybody there with you, you know, next to you. So you have got to make that call and err..you know, it is a responsible job sometimes. (nurse six, case four)

This also served to motivate the consultant psychiatrist to work in a manner that encouraged the development of decision-making skills and autonomy in their non-medical colleagues:

> I am a psychiatrist who is not based with the team five days a week so it's a case of, you have to get your skill levels up for what happens over the weekend, what happens when I am not around. (consultant psychiatrist, case four)

Linked to this need for autonomous decision-making in a crisis, the qualified members of staff in the team are all of a senior grade (band six or above). This was viewed as a facilitating factor bringing the experience necessary to take on additional clinical decision-making responsibility:

> …all the qualified people are band six. I think- and I think that is because of the level of risk that people have to manage. And it is- I think it is felt that people have to be of that senior sort of experience. It would be no good really a newly qualified person coming to CRHT. Because- and especially the duty worker has to make decisions sometimes…quickly. And difficult decisions. At night time it is one person on their own. (team leader, case four)

Secondly, the team's specific and time-limited remit meant that their activity was not constrained or dictated by some of the requirements imposed upon the other teams within the organisation. The purpose of the team is to deal with the immediate period of crisis, after which clients with more complex mental health problems requiring longer term care would be referred on to other parts of the services. The care provided by this team is therefore delivered largely in the absence of the influences associated with more complex, longer term care i.e., the processes and requirements imposed by frameworks such as the Care Programme Approach (CPA). This is articulated in the following excerpt in which a nurse in the team compares their role to that of a nurse in an Assertive Outreach Team (a community team providing care to patients who require longer term more complex packages of care). Nurses within these teams are required to adhere to specific processes around decision-making involving multiple professionals:

> Nurse six, case four: …..if you speak to a CPN [community psychiatric nurse] say in the assertive outreach team about their caseload, they have probably had their caseload for years, with maybe slight changes, but more or less they have had him, him, her, her for five years and you know, and er…if they were going to discharge one of those at the CPA meeting the consultant would be there, the GP might be there, everyone involved might be there and they would plan discharge.

> Interviewer: Yeah.

> Nurse six, case four: So it is really different. We would have somebody, I could assess somebody today, somebody who for example, erm… we, we get a lot of sort of thing, they have been dumped by their partner. They have taken an overdose. Is seen by A and E [Accident and Emergency] or GP. GP refers to us. This person has tried to kill themselves, you need to see them. So I might assess this person erm…and then a week later they say "Oh what an idiot I was, I had had too much to drink, I took an overdose, won't do it again." and er…and then I will sort of say "alright then, OK." and I will discharge them. It is completely different way of, of, it's not. They are not under CPA. There isn't a CPA process like there would be for the other teams.

Work to Create a New Role

When the consultant psychiatrist began working with this team they took the decision not to see any patients in a medical outpatient's clinic. In line with the proposals outline in the *New Ways of Working for Psychiatrists* (DoH, 2005) document, this consultant worked to set up a role where they had limited direct clinical contact with patients and instead provided medical expertise via MDT meetings and community visits only when necessary:

> Although I am working as a member of the team, I didn't want to be used as another CPN, one other person for the purposes of assessments.

It was a case of being a benefit for MDT discussions. (consultant psychiatrist, case four)

The consultant encouraged a democratic, multi-disciplinary approach to decision-making within MDT meetings. This was readily accepted and fitted well with the existing approach to decision-making within this particular team:

They like to be asked questions and sort of challenged about what they are doing and they likes to involve. They are not dictatorial. They are not prescriptive. They are not a my way or the highway kind of person. They are very much, kind of team…minded. Erm…er…yeah, you know,.er…they, they just kind of, they are just part of the team and everyone chips in with a kind of a thought and an idea and erm…and yeah. So they work that way of, that way of, that way of decision-making I guess and that way of sort of working. It was already happening but they came in and thankfully they fitted in with that. (nurse six, case four)

There was little discussion within the interviews of any other activity to generate a model of distributed responsibility. Whilst there was acknowledgment that the nursing role in this team carries a greater degree of decision-making responsibility than the same role in other teams, this was not viewed as something that required any particular encouragement. In this case the most influential factors in creating these professional roles were the contextual factors relating to the team itself.

The Consultant Psychiatrist's Views and Actions

Interestingly, despite the team members' views on accountability and risk management the views of the consultant psychiatrist in this team remained consistent with those commonly articulated in the other cases. The consultant within this team felt that they held a position of particular responsibility within the team over and above the other members.

… I end up being the person with whom the buck stops. (Consultant psychiatrist, team four)

This consultant also recognised an increasing concern with accountability within the services:

I think there is this culture of ur….being defensive. There is a greater awareness of you know what if your name gets dragged through the Coroner's Court and you know do you want to be taking that decision, you know. (Consultant psychiatrist, team four)

The consultant working within case four stated that some team members felt comfortable to "contain risk" without the consultant's support, merely informing them of the decisions they had taken at a later time. However, this consultant did also describe experience of working with other staff members who preferred consultant input around their decision-making. As in the

previous cases this was associated with reaction to experiences in investigations following negative incidents.

> Some individuals always like to run things by you, so that they feel at ease that I have run it by the consultant or the doctor. Others might be happy with what they have done, feel more confident and you know, so long as they have done their best in terms of their clinical decision-making and documented everything, that's fine. They might just then go ahead and let you know in two days' time or three days' time "this is what I have done" and they can contain the risk much better. So it all depends on, it is down to what kind of individual you are and how anxious you are and you know what kind of experiences you have had in the past, because if you have had a couple of SUI's you very quickly turn into somebody who is quite anxious and who would like to come and get everything checked. (consultant psychiatrist, team four)

Although this consultant did not agree with it, they described a perception that the Coroner continued to expect consultant involvement in decision-making on account of their senior position in the team in terms of salary and grade:

> … if something goes wrong and you go to the Coroner's Court, for something like a SUI, he will say "Well what did you do?" and they [non-medical team members] will say "I did this, this and this." "Well why didn't you ask the consultant?" So it is not just individuals but people looking at things from outside who also raise the same point that you had somebody who is supposedly more senior. (consultant psychiatrist, team four)

Despite having worked to limit their routine clinical contact this consultant continued to view involvement with cases involving complex medical issues as well as those presenting sustained risk as a key part of their role. In addition the consultant felt the need to maintain an overview of all clients on the team caseload which they ensured through increasing the frequency of MDT meetings:

> Interviewer: Which people would you be actually going out and seeing with case four now then?
>
> Consultant psychiatrist, team four: Ur…anybody who er needs some clarity on the diagnosis. If there are issues of prescribing medication or alternation of medication that is something else that I get involved with. If there are physical health problems and issues that might further complicate somebody's picture. I might get involved there. Anybody else with a sufficient level of complexity, or er a high enough level of risk I would still get involved. Er…people who need to have risk strategy meetings or high volume servcice user meetings, that kind of individual as well, I would get involved in.
>
> I really want to have an overview of everybody on the caseload… (consultant psychiatrist, team four)

…there was a need for an opportunity where everyone in the team could get together and we could discuss people so that every member knew what was happening [with everyone] with everyone, absolutely. And I thought that was quite central in terms of having to manage risks and having an oversight of, there might be thirty people on the board [the team's caseload], I would not have been able to see all thirty so that was the time to – this MDT time was made more prominent and we brought in some MDT documentation and we were able to have a discussion of individuals er based on their mental health, physical health, social issues and risks.. (consultant psychiatrist, team four)

The differing views of the non-medical team members and the consultant could be attributed to the fact that consultants, unlike most non-medical staff, work across different types of teams and are therefore exposed to the expectations of the consultant role in the organisation more widely.

Conclusion

It appears that this team operated according to a principle of distributed responsibility in which non-medical staff members take the lead in clinical decision-making when appropriate, even in high-risk cases. Although the consultant continued to feel a heightened sense of responsibility and accountability for the overall activity of the team, this view of their role was not shared by the other interviewees. Consequently, unlike the non-medical professionals in the other cases, these interviewees did not feel pressure to use the consultant psychiatrist to "back up" or approve their decisions.

This particular type of team represents a small, atypical section of mental health services, providing very short-term input to individuals experiencing a mental health related crisis. In many cases the issues experienced by the clients were not viewed as consequences of diagnosable mental illness but acute situational crises. This case suggests that this particular team function and client group facilitate a model of distributed responsibility alleviating some of the limiting influence of understandings and expectations of the role of the consultant psychiatrist, at least amongst non-medical staff who felt able to enact extended role.

6 Discussion

The aim of this chapter is to draw together the key analytical themes presented in the previous two chapters, providing a theoretical interpretation of the data and situating it within the key frameworks and existing literature. The discussion describes a case of largely consensual role renegotiation in which a senior professional group support drives toward change involving the transfer of work previously within their jurisdiction to subordinate workers. Drawing upon the concept of institutional work the chapter describes how senior professionals, in collaboration with managers, work to enable new practice involving the delegation of their work in an established system. Crucially, under the institutional pressures within this field, the professionals enacted change in a manner that maintained established role boundaries, ensuring medical authority over key decision-making. The discussion highlights that the reconfiguration of professional roles was interpreted not only as the transfer of clinical activity and expertise across professional boundaries but the concurrent transfer of accountability for the management of risk, a responsibility that triggered concern with *professional* risk and adherence to the safety of the established and readily accepted hierarchy.

The chapter is divided in to three main sections. The first section describes institutional work to create a new role for consultant psychiatrists. The conceptualisation of various forms of agency draws on Lawrence and Suddaby's (2006) taxonomy of "institutional work" i.e.,"the purposive action of individuals and organisations aimed at creating, maintaining and disrupting institutions" (Lawrence and Suddaby 2006, pp 215). The institutional work evident is framed in terms of Zietsma and Lawrence's (2010) distinction between boundary work and practice work i.e., "the work of actors to create, maintain, and disrupt the practices that are considered legitimate within a field (Practice work) and the boundaries between sets of individuals and groups (boundary work)" (Zietsma and Lawrence 2010, pp. 189). Practices are defined as "shared routines of behaviour" (Whittington 2006, pp.619) and boundaries as "the distinctions among people and groups" (Zietsma and Lawrence 2010, pp. 190). In this case the focus of the analysis is on changes to the *practices* of consultant psychiatrists and other mental health professionals associated with the development of a new consulting focussed role for psychiatrists and the interprofessional role *boundary* between consultants and associated mental health professionals, particularly in terms of authority over clinical decision-making.

Evident in varying degrees in each of the four cases, as well as at management level, practice work represented the dominant category of institutional work identified within this context. The analysis revealed the concurrent activity of team leaders and consultant psychiatrists to create novel practice within their individual clinical teams and trust managers to enable and legitimise these isolated examples of new practice in order to create service-wide change. This section describes how these actors worked to move away from traditional practices to create a new role for the consultant psychiatrist and associated

professionals involving the transfer of elements of clinical work and decision-making responsibility from the consultant to the wider clinical team. Attempts at boundary work aimed at redefining the bounds of consultant responsibility and authority are also described.

Section two describes the organisational and institutional level influences that interacted with the institutional work evident to inform and constrain the reconstruction of roles in a manner that maintained core interprofessional role boundaries. This section highlights an absence of the professional competition and legitimacy claims commonly described in the literature and a notable concern with accountability for the management of risk. This finding is situated within literature that describes an increasing focus on professional accountability (e.g., Evetts 2009, Liljegren 2012) and risk management (e.g., Power 2004, Bianic 2011) within contemporary organisations to suggest that as well as the transfer of clinical activity, knowledge and expertise the reconfiguration of professional roles represents the transfer of accountability for the management of risk: a more complex commodity with potential secondary risks for the professionals themselves (Power 2004). The discussion describes how the interprofessional hierarchy, organisational structures and processes, and reactions to negative incidents, created pressure toward the maintenance of medical authority over decision-making, particularly around risk, which represented a source of professional safety.

The third and final section of the chapter examines an exceptional case in which more significant institutional change (i.e., that involving both change in institutionalised practice and boundaries) was evident in a particular sub-context of the organisation. In this case non-medical professionals enacted extended roles, leading on clinical decision-making, including that involving significant risk, often in the absence of consultant approval and authority over that decision-making. Whilst this case continues to illustrate the association of clinical activity with risk management and concern with being held to account for clinical decision-making around risk, the pressures toward maintaining established role boundaries in the face of such concern appeared mitigated. It is proposed that location of these professionals in an organisational sub-context in which client issues were constructed through a largely demedicalised cultural-cognitive framework weakened the influence of expectations and safety associated with the model of medical professionalism (Battilana 2011) allowing non-medical professionals to legitimately take authority over decision-making.

Institutional Work to Create New Professional Roles

In the case study organisation practice work was evident at the team level and within managerial strategy. In three of the cases investigated enthusiastic consultant psychiatrists and team leaders, with the support of management, engaged in activity to drive role reconfiguration within their clinical teams. Motivated by an unmanageable workload, resource pressures, and an acknowledgement of the need for change, these actors worked to shift elements of clinical work and decision-making from consultant psychiatrists to the wider clinical team. In an effort to support new practice within these teams, as well

as encourage its implementation across the service more widely, managers engaged in practice work to legitimise the new role for consultant psychiatrists.

Practice Work within Clinical Teams

Motivated by a heavy workload consultants laboured to create changes in practice that allowed them to delegate routine clinical work and decision-making, limiting their direct involvement to those cases and situations that warranted their specialist expertise. This work was aimed at changing practice in terms of when and how to involve consultants through altering the way in which other mental health professionals related to, and worked with them. Changes in practice included the development of non-medic led clinics and assessments, the provision of consultant input through team meetings rather than direct clinical contact and the transfer of more routine decision-making to non-medical colleagues. The creation of new practice required significant and conscious effort on the part of the consultants and team leaders who engaged in two forms of institutional work to encourage change: "changing normative associations" through challenging the expectations of their colleagues and "embedding and routinizing" through the development of processes that supported new practices (Lawrence and Suddaby 2006).

"Changing normative associations" involves "re-making the connections between sets of practices and the moral and cultural foundations for those practices." (Lawrence and Suddaby 2006, pp. 224). In this case this involved the activity of consultant psychiatrists and team leaders to alter staff conceptions regarding when consultant involvement became necessary. In all cases consultants modelled an alternative way of working in their day to day practices. When appropriate, consultants made a conscious effort to abstain from making clinical decisions and engaging in clinical contact where other professionals were involved. Through limiting their own input in multi-disciplinary settings and actively drawing others into case discussions they created the opportunity for other members of the team to lead. In case two during occasions when staff attempted to enact old practice in the form of booking patients into consultant clinics, the reasoning behind this behaviour was challenged. Through informal discussion and supervision, consultants, team leaders and other senior clinicians worked with staff to explore their motivation for consultant involvement and where a clear rationale was absent alternative sources of input and support were suggested and implemented.

To use Reay et al.'s (2013) terms, an important function of the institutional work carried out by consultant psychiatrists and team managers to enable new practice was the "de-habitualization" of pre-existing, established practices. Through encouraging and enacting new practice, consultants and team leaders enabled non-medical professionals to perform reconfigured roles in which they took on elements of clinical work and decision-making previously carried out by consultants, and in doing so break habitualized practice and develop their own experience and understandings of the new practice. This demonstrates the potential role of senior professionals in this process in addition to that of managers described by Reay et al. (2013).

In case two this institutional work was reinforced by the activity of the team leader and consultant to implement protocols and procedures to support the delegation of decision-making responsibility to non-medical staff. The activity of embedding and routinizing "involves actively infusing the normative foundations of an institution into the participants' day-to-day routines and organizational practices" (Lawrence and Suddaby 2006, pp. 233). The development of particular protocols around decision-making e.g., accepting new admissions to the unit, served to legitimise and support nurses in their decision-making role.

By engaging in these forms of institutional work these actors encouraged and enabled the development of new practice within their clinical teams. Through activity to challenge assumptions regarding when and how consultant input was provided, and to encourage and model the enactment alternative ways of working the consultants and team leaders had begun to develop and establish new practices involving extended roles and responsibilities for non-medical staff.

Management Level Practice Work

The action of managers was based on a common dissatisfaction with the traditional role taken by consultant psychiatrists within community mental health services. Specifically the practice of delivering a large volume of routine medical outpatient clinics was viewed as outdated, inefficient and ineffective. Driven by increasing pressure to deliver services more economically, and supported by suggestions outlined in the *New Ways of Working for Psychiatrists* (DoH 2005) document, these actors engaged in practice work to legitimise a new role for consultants within their services increasingly focussed on consulting with the multi-disciplinary team rather than engaging in extensive direct clinical contact and corresponding extension of non-medical roles.

The work of managers in this case resembles that described by Reay et al. (2006) in their description of the activities of nurses and their managers during the introduction of the Nurse Practitioner role to the Canadian healthcare system. Like the managers in the Canadian system the managers in this setting engaged in a number of strategic micro-level activities to initiate and begin to legitimise a new way of working i.e., to move from "isolated incidents of a new practice to wide-spread acceptance.." (Reay, Golden-Biddle et al. 2006, pp. 979).

In the case presented here managers had identified opportunities to develop areas of novel practice (e.g., nurse-led clinics and consulting focussed psychiatrist roles) in isolated areas of the trust. In order to do this, managers had deliberately identified and engaged with particularly enthusiastic staff and utilised service reconfiguration to implement and establish new practice. In this way, managers were "cultivating opportunities for change" by seeking out and using circumstances particularly receptive to change. (Reay et al. 2006, pp. 985)

Managers in this setting also worked to "prove the value" of the new way of working (Reay et al. 2006, pp.988). In contrast to the actors in the Canadian case who achieved this primarily through carefully cultivating working relationships and demonstrating the value of the new role on the ground through interaction with their colleagues, the central strategy used by managers in this case was the collation of evidence to support the need to change the old practice and to demonstrate the efficacy of the new practice. This was achieved through "auditing and monitoring" of traditional practice and the innovation sites (Lawrence and Suddaby 2006, pp. 231). These activities, previously conceptualised as "policing" activities associated with institutional maintenance (Lawrence and Suddaby 2006), allowed managers to generate data to support their arguments for change and to secure resources and support from key stakeholders.

This activity was supported by two forms of concurrent cultural work (Perkmann and Spicer 2008). Firstly, the managers had begun "constructing normative networks" i.e., "the interorganizational connections through which practices become normatively sanctioned" (Lawrence and Suddaby 2006, pp. 224-225). By making links with another similar organisation who had successfully implemented the new practices the managers began to provide their ideas with some level of normative legitimacy. In addition this organisation was used to obtain further data in support of the new practice to augment that gained through auditing and monitoring in their own organisation.

Finally managers closely tied the whole change process to the concept of "recovery" in mental health, an ideology currently increasingly influential within mental health services and one associated with challenging the traditional medicalised approach to mental health issues (Middleton 2007, Schrank and Slade 2007, Pilgrim and Rogers 2009). They argued that providing an increasingly multi-disciplinary, psychosocial approach to care would promote notions of independence, recovery and the hope of eventual discharge from services improving patient care whilst also reducing pressure on services. This demonstrates the "cultural work" of managers in "promoting discourses that associate practices with widely accepted norms and values" (Perkman and Spicer 2008, pp. 829). In Lawrence and Suddaby's (2006) terms this institutional work could be categorised as a form of "theorizing". Reminiscent of the micro-level work around meaning identified by Zilber (2002) and particularly the "micro-level theorizing" described by Reay et al. (2013, pp.976-7) in the Canadian healthcare system, the managers in this setting framed the new practice in such a way as to enhance its legitimacy within this context and increase its appeal to key actors within the field.

Managers in this case engaged in institutional work to initiate and legitimise new practice across the case study service. Like the managers described by Reay et al. (2006) these actors identified and utilised opportunities to implement new practice as well working to "prove the value" of the new way of working, in this case by collating supportive data through "auditing and monitoring" activities (Lawrence and Suddaby 2006, pp.231). These activities were supported by "constructing normative networks" and "theorizing" work around the concept of "recovery" (Lawrence and Suddaby 2006, Reay et al.,

2013). By engaging in these forms of institutional work managers enabled the implementation of new forms of practice within the clinical teams studied and were involved in ongoing work to diffuse these practices across the service more widely.

Boundary Work

Case three represents a situation in which attempts at more significant institutional change were made through the combination of the practice work described above with elements of boundary work (Zietsma and Lawrence 2010). The actors involved in generating change in this case recognised that the extent of role reconfiguration would be limited unless efforts to establish new practices were combined with efforts to alter interprofessional role boundaries concerning authority and responsibility for clinical decision-making. Therefore these actors did not merely engage in activity to change practice that shifts clinical work from consultants to other professionals, but also to address the underlying issue of ultimate accountability and responsibility for that work.

In an effort to create the conditions that would enable a new role for consultant psychiatrists and the professionals working with them the actors in this case engaged in what Lawrence and Suddaby (2006) describe as "overtly political work" targeted at redefining professional role boundaries in terms of ultimate responsibility and accountability for patient care. Specifically this work took the form of "defining" which refers to "the construction of rule systems that confer status or identity, define boundaries of membership or create status hierarchies within a field" (Lawrence and Suddaby 2006, pp. 222) and "advocacy" which involves "the mobilization of political and regulatory support through direct and deliberate techniques of social suasion" (Lawrence and Suddaby 2006, pp. 221)

In this case, consultants and managers acted to enable the creation of new role boundaries by removing a symbolic representation of consultant authority and responsibility for patient care embedded within established organisational functioning: the allocation of a named consultant psychiatrist to all patients. In place of this system, patients would be allocated to the most appropriate mental health professional and responsibility for care shared across the clinical team. New patients would not become associated with a specific consultant unless there was a clear need for their involvement. The allocation of a specific consultant psychiatrist to every patient was standard practice in most other teams in the organisation and therefore this change represented a significant diversion from prevailing arrangements. By allocating cases to the team rather than a named consultant psychiatrist these individuals acted to "*define*" or redefine the boundaries of responsibility and the role and position of the consultant within the clinical team (Lawrence and Suddaby 2006).

This change caused "anxiety" amongst many practitioners in the team as well as some senior managers. The team leader and managers involved in making this change were required to quell some of this angst by providing justifications and explanations for the absence of blanket medical authority over case management. This occurred within the organisation as well as

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outside. Managers and team leaders supported staff during appearances in the Coroners Court, where again, explanations and justifications for the absence of consultant authority were required. By engaging in this "*advocacy*" work these individuals acted to legitimise new professional role boundaries that placed non-medical clinicians in a position of authority over clinical decision-making (Lawrence and Suddaby 2006).

Crucially, the various forms of institutional work described above, whilst achieving changes to institutionalised practices, did not impact upon the core interprofessional role boundaries and hierarchy. Rather than the distribution of responsibility proposed in *New Ways of Working for psychiatrists* (DoH 2005), with the exception of case 4 (discussed later), the cases illustrate change in practice that involved merely the delegation of routine work. Consultant psychiatrists continued to hold a position of seniority, authority and responsibility within their clinical teams retaining an oversight of the team's activity and involvement in non-routine decision-making through multi-disciplinary meetings or clinical contact. Even in case 3 where practice work and elements of boundary work were evident, a combination potentially associated with movement through the cycle of overall institutional change (Zeitsma and Lawrence 2010), the activity proved insufficient to impact upon the underlying foundations of the boundary. The team quickly implemented daily multi-disciplinary team meetings in which all cases were discussed, and where the input of a consultant psychiatrist was provided and documented, with transfer to medical clinics if deemed necessary. One form of medical authority over clinical decision-making was simply replaced by another. Medical authority and seniority remained.

Constraining Influences: Accountability, Risk Management and the Interprofessional Hierarchy

Interestingly the limited scope of change in this case was not a result of the activity of consultant psychiatrists to defend professional territory and therefore their power and position. As we have seen the consultants were supportive of change taking an active role in supporting the development of extended roles for their non-medical colleagues. Rather, the maintenance of established interprofessional boundaries was informed by a number of inter-linked organisational and institutional level influences that created notable concern from all groups of professionals, as well as some management colleagues, with accountability for the management of risk. The findings demonstrate that the transfer of clinical activity in this case was associated with the concurrent transfer of accountability for the management of risk around that activity, a responsibility with perceived *professional* risks for the clinicians involved. The following section describes the manner in which the role of the consultant was reconstructed to enable change in practice whilst maintaining institutionalised role boundaries and medical authority, highlighting the influences that informed this reconstruction.

Firstly, the continued involvement of consultant psychiatrists in decision-making was justified in part by their medical knowledge. As the only doctors within this multi-disciplinary system, psychiatrists had an exclusive claim to expertise surrounding the medical aspects of care and therefore a well secured

jurisdiction. The consultant's role in diagnosis and the prescription of medication ensured that they had a key role in the development and reviewing of treatment plans for the vast majority of patients within secondary mental health services. Despite the introduction of non-medical prescribers the consultant's superior expertise around these practices was so uncritically accepted that it was rarely even articulated or debated. The continued importance of the medical aspects of care in mental health services and the psychiatrist's jurisdiction over the associated practices played a large part in securing the boundaries of their role.

Whilst the security of this jurisdiction ensures the psychiatrist an important role within mental health services it does not follow that it should confer such extensive involvement within team functioning, particularly in a context where the value of psychosocial input to care is becoming increasingly recognised. Theoretically the involvement of consultants could be limited to those cases or occasions where complex medical knowledge is required. However, as evident in cases one, two and three this was not what occurred in practice. Such a reconstruction was not informed by understandings of, and claims to, medical or any other form of expertise but who would and should be held accountable for decision-making, particularly surrounding the management of risk. When negotiating new professional roles, accountability for the management of risk was a central concern and a key feature that informed the enactment of change.

Interviews with clinicians revealed an understanding that the consultant's area of jurisdiction and responsibility extended beyond that dictated by their specialist medical knowledge to include a unique role in risk management. A clear and consistent argument from practitioners was the need for consultant input in cases high in risk, medical or otherwise. Where consultants felt it would be acceptable to refrain from involvement in routine clinical decision-making, they felt that this would be inappropriate under these circumstances. Whilst they challenged norms and assumptions regarding the need for their involvement in routine work, their involvement in complex and risky work went unchallenged. Similarly, whilst non-medical professionals were happy to work more autonomously and take on some aspects of clinical work previously carried out by consultants, there were clear limits to this. If a case became difficult to manage, particularly in terms of risk, many team members were not comfortable to make decisions without consultant input which they worked to obtain. Both consultant psychiatrists and non-medics acted to maintain the institutionalised role boundary between their professions by enacting new practice in a manner that maintained medical authority over key decision-making, particularly that surrounding risk management.

This finding sits in contrast to the dominant theme within literature that explores the enactment of professional role reconfiguration attempts in healthcare which privileges the strategic activity of professional groups to establish, maintain and extend their jurisdiction (Allen 2000, Norris 2001, Timmons and Tanner 2004, Sanders and Harrison 2008, Currie, Finn et al. 2009, Martin, Currie et al. 2009, Salhani and Coulter 2009, Bach, Kessler et al. 2012, McIntyre, Francis et al. 2012, King, Nancarrow et al. 2015). Subordinate groups who stand to enhance their position through encroaching on new territory work to legitimise and extend their jurisdiction whilst more senior

groups, to whom change represents a potential threat, seek to maintain control over their area of work and expertise. A central theme concerns "the use of discourse to discredit the competitor profession" (King, Nancarrow et al. 2015, pp.5). This literature is commonly informed by traditional conceptualisations of the professions as groups, who by virtue of their claims to esoteric knowledge and expertise, along with their service orientation, ethics and capacity to autonomously self-regulate, obtain power and status through securing control and monopoly over particular areas of work (Freidson 1970b, Johnson 1972, Larson 1977, Freidson 1988). The opportunity to extend or maintain jurisdiction, through claims to skills or expertise, competence and/or approach to clinical work (Sanders and Harrison 2008, King, Nancarrow et al. 2015) and other forms of institutional work (e.g., Currie, Lockett et al. 2012), is associated with the opportunity to extend or maintain status and power.

However, within the contemporary organisational context the defining features of professionalism and the function of professional expertise have evolved with implications for professional interpretation and enactment of role reconfiguration attempts. Under the pressures of neoliberal approaches to the management of healthcare and other public services, professionals now work in an organisational context within which they are held to account for their decision-making and the self-regulation and autonomy that once defined the professional institution has been replaced with a managerially informed concern for professional accountability (Evetts 2002, Scott 2008a, Evetts 2009, Liljegren 2012). As vividly illustrated in this study, professionals are highly aware that they will be held to account for the consequences of the clinical decisions that they make and the issue of who will become accountable should a decision come under scrutiny is a paramount concern.

The particular focus on accountability for the management of risk also reflects the pervasive focus on risk within modern organisations and the involvement of professionals in its management as they carry out their work (Kemshall 2000, McLaughlin 2001, Power 2004, Fine 2005, Horlick-Jones 2005, Lankshear, Ettorre et al. 2005, McDonald, Waring et al. 2005, Bianic 2011). Professional work now almost inevitably involves the management of risk within organisations and the professionals in this case were no exception; the process of assessing and managing risk formed an integral part of their work. This is a regular activity that state policy, through the processes outlined in the Care Programme Approach (Department of Health 1990, Department of Health 1995, Department of Health 1999, Department of Health 2008), has dictated in relation to patients with more comprehensive packages of care since the early 1990's (Godin 2004) and continues to inform practice today.

In this context the transfer of clinical activity between professional groups was associated with the transfer of responsibility for managing the risks connected to that activity. The findings from this study therefore suggest that the reconfiguration of professional roles within contemporary healthcare organisations represents more than the transfer of clinical activity; it also involves the potential for the concurrent transfer of accountability for the decision-making around such clinical activity including responsibility for the management of the risks that it presents. The professionals in this study took particular care in renegotiating this element of their roles.

Whilst the transfer of clinical work across professional boundaries is associated with the transfer of professional expertise, resource and power the transfer of responsibility for risk management in the contemporary organisational context also represents a potential risk for the individual professionals involved. As the literature suggests, the management of risk presents a particularly complex professional task which confers secondary risks to the professionals themselves should they be held accountable for its mismanagement (Kemshall 2000, Power 2004). The role of risk manager has become a potentially "anxiety-provoking" one to take for the individual practitioner (McLaughlin 2003 , pp.268). This reconceptualisation adds complexity to accounts of professional role reconfiguration that dominate the literature in this area and explains and predicts a different professional response and barriers to change.

Rather than professional competition over jurisdiction this study illustrates the careful renegotiation of responsibility for risk management to ensure the protection, not just of the patients, but of the professionals involved. In this case, this involved ensuring that responsibility for the management of any significant risk was placed, at least in part, with the consultant psychiatrist. This reflects accounts within the literature of the defensive and self-protective strategies evoked from professionals when functioning within an organisational context that they understand to be focussed on accountability and risk management (Annandale 1996, Power 2004, Bianic 2011). The particular manner in which professional roles were reconfigured in this case reflects the impact of several inter-linked pressures: the institutionalised interprofessional hierarchy; organisational structures; and organisational and societal processes, reactions and expectations following untoward events.

One of the major justifications for the necessity of consultant involvement in risk management provided by professionals was the expectation of their involvement from those charged with conducting investigations following a negative incident. This was reflected in reactions to negative incidents both organisationally through the Serious Untoward Incident (SUI) process and externally through Coroner's inquests. Both psychiatrists and non-medical professionals expressed the view that in the aftermath of an untoward incident decision-making that had not involved a consultant would be subject to questioning. The lack of consultant involvement would require justification and attract potential criticism.

The explicit connection that participants made between risk management and the investigation of decision-making following an untoward incident highlights the "forensic function" that risk plays in this setting (Douglas 1992). Professionals were highly aware of the scrutiny their decision-making would undergo should a negative incident occur and that this discussion would be framed in terms of the risks presented and the manner in which they were managed or mismanaged. SUI and Coroner's investigations represent a major concern for professionals working within mental health services often raising significant anxiety. The consequences of being held accountable for making the "wrong" decision or being implicated in bad practice can have serious negative consequence for professionals ranging from formal action to informal notions of shame or damage to reputation. The processes and outcomes of

these investigations can therefore have a powerful impact to those working within the organisation triggering concern with the "secondary risks" of professional practice, i.e., risks to the professionals themselves, and behaviour to protect against these (Power 2004). In this case conforming to the expectations of those conducting investigations could be viewed as a form of defensive or safety behaviour in which professionals engage to protect themselves from criticism.

An additional and related feature of the organisational field that limited the extent of change and prompted the continued involvement of consultants in risk management was the consultant's position as the patient's "RMO" or "Responsible Medical Officer", a responsibility commonly cited by participants as motivating consultant involvement in decision-making. In some cases this term was used to refer to the consultant psychiatrists' legal responsibilities as a patient's RMO as defined in the Mental Health Act (1983). Until 2007 consultant psychiatrists remained the only mental health professionals with the legal right to detain and enforce treatment under the Act. The 2007 amendments to the Mental Health Act saw the introduction of the Responsible Clinician role, which allows non-medical professionals to take on most of the responsibilities previously held by the Responsible Medical Officer. However, recommendations for initial detention under sections 2 or 3 of the Act remain a medical responsibility. In addition, at the time of data collection there was little interest from non-medical professionals in carrying out this role and there were no non-medics functioning as Responsible Clinicians in the service investigated. Detention and treatment of individuals under the Mental Health Act (1983) therefore continued to be the responsibility of consultant psychiatrists, however their legal responsibilities as RMO were only relevant in a small number of incidents as this case is located within community mental health services.

"The role of the RMO is only enshrined in law in the *Mental Health Act* (1983) referring to patients receiving compulsory treatment" yet the term is used, and associated with medical responsibility for patient care including risk management, across secondary mental health services more widely (Kennedy and Griffiths 2002, pp. 205). This generic function of the consultant psychiatrist as "RMO" in community mental health services has no formal link to the legal jurisdiction of the profession in relation to their responsibility for patients detained under the *Mental Health Act*. Rather it is a term, often used interchangeably by interviewees with the term "named consultant", to refer to the doctor with whom a patient becomes associated when they enter secondary mental health services.

The routine allocation of a named consultant or RMO on entry to the service was standard practice across the majority of community teams in the organisation studied. Therefore, in these teams a consultant psychiatrist had a formally documented association with every patient in the teams in which they worked. It was around the meaning of this title that the lines of accountability for clinical decision-making and the associated implication for distributing responsibility became problematic. For some the implication of this label was clear: the consultant held ultimate responsibility and accountability for overall patient care. For others, this was a less straight forward relationship involving

varying degrees of delegation or joint responsibility with professionals in other roles particularly "care co-ordinator". Regardless it commonly necessitated and justified the involvement of the consultant psychiatrist in all major decision-making, particularly surrounding the management of significant risk representing an important organisational level constraining influence upon role reconfiguration attempts.

The issues concerning the lines of accountability and responsibility for consultants working in multi-disciplinary and multi-agency settings have been identified in the professional literature (e.g., Kennedy and Griffiths 2002). The definitions and guidelines provided by the General Medical Council (GMC) in relation to medical responsibility become confused in these settings, an issue that is only exacerbated by suggestions of role reconfiguration and distribution of responsibility. In fact, this issue was recognised and explicitly identified as a potential barrier to the implementation of distributed responsibility in the *New Ways of Working* (DoH 2005) document:

> "A major stumbling block to NWW [*New Ways of Working*] has been the perception that the consultant psychiatrist carries clinical responsibility for all service users in secondary and tertiary care. Although this is not true, the advice given from the GMC, British Medical Association (BMA) and the College has used terminology that has led to ambiguity in interpretation." (DoH 2005, pp. 16)

In an effort to overcome this barrier the *New Ways of Working* document includes clarification from the GMC regarding its guidance to consultant psychiatrists around "accountability in multidisciplinary and multiagency mental health teams" (DoH 2005, pp. 16). This guidance clearly states that whilst "Doctors should do their best to ensure that the systems in which they are working provide a good standard of care to patients… Doctors are not accountable to the GMC for the decisions and actions of other clinicians" (DoH 2005, pp.16).

This clarification appears to have had limited impact in the case study organisation in terms of influencing perceptions concerning the boundaries of consultant responsibility and position. A contributing influence is the fact that the majority of service users continue to be allocated a named consultant psychiatrist and therefore they maintain some level of responsibility for these patients. The limited impact of these revisions also reflects the source of institutional pressure experienced by consultants and associated mental health practitioners. The concern of these professionals when considering the implications of distributed responsibility for clinical decision-making following a negative incident was not only the action of their governing bodies. Rather it was focussed on being held to account by other groups, most notably those conducting SUI and Coroner's investigations, but also their colleagues, their patients and their families, and the wider public. The accountability they were referring to had informal as well as formal consequences and was founded on moral as well as coercive pressures from a range of sources.

An overarching institutional influence in this case is the impact of the interprofessional hierarchy and the dominant template for role enactment associated with it. The medical profession hold an extremely well established jurisdiction over the provision of medical care representing the dominant group within the interprofessional hierarchy (Freidson 1970b, Abbott 1988, Freidson 1988). The institutionalised model of medical professionalism positions physicians as "key decision makers", holding "authority over all other NHS professionals.." (Batillana 2011, pp. 820). Within this model "nurses act as physicians' assistants" and "allied health professionals act as medical auxiliaries" (Batillana 2011 pp. 820). Thus, the allocation of professional roles imposes powerful normative rules upon role enactment. "These beliefs are not simply anticipations or predictions, but prescriptions—normative expectations—regarding how specified actors are supposed to behave. The expectations are held by other salient actors in the situation, and so are experienced by the focal actor as external pressures. Also, and to varying degrees, they become internalized by the actor." (Scott 2014, pp. 64) The role of doctor comes with expectations: they hold a position of authority, responsibility and leadership.

As consultant medical specialists working alongside non-medical professionals, consultant psychiatrists were recognised as the most senior professional group in the organisation. This was explicitly discussed by interviewees as a factor directly motivating the involvement of consultants in decision-making. The responsibility and authority of the consultant psychiatrist was also reflected and concurrently reinforced by the other constraining influences discussed i.e., their position as RMO and named consultant. The psychiatrists' role as the named consultant in this organisation appeared to be particularly influential in limiting the degree of change perceived as legitimate. As an organisationally defined role this is particularly interesting and could be interpreted as a means by which professionals are positioned and mandated to utilise their expertise and authority to manage risk on behalf of an organisation (Bianic 2011). Paradoxically, this arrangement appeared to undermine organisational drives toward the redistribution of responsibility from consultants to other members of the clinical team. These conflicting pressures were also evident at the policy level where support for the distribution of responsibility co-existed with a focus on risk management that created concern with individual professional accountability.

Reminiscent of the descriptions of safety behaviours described in the literature (Annandale 1996, Power 2004, Bianic 2011), clinicians in this study responded to practicing within an environment that created concern with accountability for the management of risk by utilising adherence to the interprofessional hierarchy as a safety mechanism. This climate interacted with the established interprofessional hierarchy, organisational structures and expectations and reactions following negative incidents to create pressure towards the maintenance of established boundaries. In this context, movement away from the safety of the traditional and readily accepted hierarchy represents a professional risk that clinicians may be unwilling to take. By enacting new practice in a manner that maintains these boundaries and reproduces the interprofessional hierarchy clinicians acted, in part, to protect themselves. This may be particularly important in NHS mental health services, which exist

within an institutional field subject to regulatory forces imposed by the state that dictate the explicit and repeated assessment of risk (Godin 2004). Consultant psychiatrists hold the authority and legitimacy to justify multifaceted, unclear decisions explicitly framed in terms of risk.

In addition to developing understandings of the influences relevant to professional role reconfiguration attempts in healthcare, the manner in which professionals interpreted and responded to change attempts in this study also has implications for theoretical conceptualisations of professionalism more broadly. This study builds on a limited body of literature that connects micro-level empirical work to emerging conceptualisations of professionalism that reflect the pressures of wider institutional and organisational context. Like the work of Correia (2016) and Liljegren (2012) this study demonstrates the impact of managerial and organisational concerns on the manner in which professionals construct and conduct their activities on the ground providing evidence for the emergence of an evolved form of *organisational* professionalism as proposed by scholars such as Evetts (2009). This study makes an addition to the literature by focussing specifically on the impact of changing conceptualisations of professional accountability on micro-level professional work.

This work also contributes to literature that highlights the increasing importance of risk management within professional work and reflects Bianic's (2011) proposals concerning the impact of requirements for risk management within organisations on contemporary professionalism. Like the professionals in Bianic's (2011) study one could conclude that the findings presented in this thesis suggest an expectation or requirement from the organisation, the state through policy, and beyond for mental health professionals and particularly consultant psychiatrists to manage risk and that this forms a central element of their role within the organisation. This study therefore provides tentative support for Bianic's (2011) suggestion of a judicial form of professional expertise in which professionals are mandated and required by an organisation to manage particular forms of risk.

An Exceptional Case: Demedicalisation and Institutional Change

The roles enacted in the crisis team discussed in case four provide an exception to the pattern displayed in the other cases; responsibility appeared to be truly distributed across the clinical team. Non-medical professionals felt confident to work more autonomously, even in situations high in risk, and this was not inhibited by the perceived consequences or expectations surrounding negative incidents. This case continues to reflect the association of clinical activity with accountability for the management of risk around that activity as evident in the wider organisation; however, this was not associated with adherence to established interprofessional boundaries and hierarchy. In this case, while still a valued source of medical expertise, the consultant did not represent such a central source of authority with which to justify and legitimise decision-making around risk.

One of the major factors distinguishing this team from the others studied is the extent to which the problems of the client group served were viewed as

psychosocial as opposed to medical in nature, or demedicalised. Case four is distinct in that a large number of their clients were viewed as having problems that emanated predominantly from their circumstances rather than an underlying mental illness. To use the words of the team leader, the team viewed a large proportion of their work as consisting of "social issues that impact on people's wellbeing" (team leader, case four) for example the break-up of a relationship. These individuals were not labelled or diagnosed as mentally ill and therefore were not deemed to require the attention of a consultant psychiatrist. What differentiates this team from the others is the manner in which the client's problems were constructed and interpreted. The presenting issues of the client held a different meaning to the professionals involved, and as Zilber (2002, pp. 247) put it "meaning matters".

Both the sociology of the professions and neoinstitutional theory literatures centralise the importance of meaning in professional and organisational activity respectively. As outlined in chapter two, Freidson (1988) and Abbott (1988) suggest that a profession's ability to construct and define the issues of their clients confers the foundation of their success and power. Abbott (1988, pp. 40) specifically highlights the "cultural machinery" or "cognitive structure" underpinning professional work, that is their "claims to classify a problem, to reason about it and to take action on it", as central to the security of professional jurisdiction. Thus the manner in which client issues are constructed determines what action is then taken upon them and by whom. Without the ability to construct client problems in their own exclusive terms professional jurisdiction is weakened.

In neoinstitutional theory terms, the construction of meaning around a problem or an area of activity relates to the cultural-cognitive foundations of an institution (Scott 2014). As outlined earlier in the thesis, this pillar refers to "the shared conceptions that constitute the nature of social reality and create the frames through which meaning is made" (Scott 2014, pp 67). The cultural-cognitive pillar of an institution underpins the institution, providing the foundations on which regulations and norms are based (Scott 2014). It then follows that the manner in which a particular problem or activity is understood or constructed, i.e., the institutional cultural-cognitive frame through which it is viewed, dictates the regulations and norms that it will be influence by; "meanings connect actors to action" (Zilber 2002, pp. 236).

Of particular relevance in this study is the manner in which the construction of client issues in terms of an alternative cultural-cognitive frame appeared to influence the impact of the normative pillar of the dominant (medical) institution within the organisation, specifically the enactment of roles. Within a context in which the problems of clients are constructed according to a demedicalised cultural-cognitive framework the norms regarding role enactment dictated by the model of medical professionalism (Battilana 2011) became less relevant and powerful thereby allowing non-medical professionals to legitimately lead in decision-making. The construction of client's problems, not in terms of the medical institution but in demedicalised or psychosocial terms loosened the constraints imposed by the medical hierarchy altering perceptions of who was legitimately able to lead on decision-making around

client care, enabling non-medical team members to enact extended roles involving leadership in decision-making. The demedicalised construction of client issues in this team impacted upon the power relations and the division of labour across the professionals within the team.

The influence of this construction appeared to be reflected at a more formal level within the organisation as evident in the shared caseload model operating within this team. The patients receiving care from this team were not associated specifically with the consultant by name but where under the responsibility of the team as a whole, of which the consultant was a part. The absence of this formal representation of medical responsibility may have further enabled and legitimised the extended role of non-medical professionals in this case.

Whilst professionals in this setting expressed concern regarding issues of accountability like those in other settings, this did not result in adherence to traditional interprofessional hierarchy and role boundaries. Unlike professionals in the other cases, non-medical professionals in this team did not perceive the involvement of a consultant as a necessary safety measure to legitimise their decision-making and protect themselves from potential criticism in the event of a negative incident. Rather they were confident that their own decision-making would be viewed as legitimate and adequate.

As described, an approach to, or view of, the clients' problems that was to some degree demedicalised by the team as a whole was identified as a factor facilitating the development of new practice, evident in cases one and three. Whilst these teams provided services to clients with diagnosable mental health conditions to which medical understandings and approaches were considered relevant, the prominence of psychosocial factors and interventions was an identifiable feature of the teams. Considering that the teams investigated were purposefully selected as they represented sites at which attempts to create new roles for consultant psychiatrists were evident, it may be the case that the development of a model of distributed responsibility was more likely to be attempted in teams where client problems were constructed in this manner.

Location in a team in which the construction of client issues had a significant psychosocial component appeared to legitimise alterations in practice in which consultant psychiatrists re-distributed work and non-medical professionals took a more prominent role. A view of client issues through a cultural-cognitive frame in which medical and psychosocial issues held significant legitimacy loosened the constraints imposed by the model of medical professionalism (Battilana 2011).Whilst this was not sufficient to overcome the boundary between medical and non-medical staff in terms of ultimate medical authority it did contribute to allowing actors to consider and begin to enact new practice in which non-medics took extended roles.

The distribution of responsibility to non-medical professionals in case four was also facilitated by a number of other factors, linked to the function of the team in providing immediate, short-term input in the event of a crisis. Although these factors are of less theoretical relevance they are nevertheless worth

discussion. The need to make quick decisions outside of the hours when consultants routinely work made gaining their input, and therefore working according to the norms associated with the model of medical professionalism (Battilana 2011), whilst still possible, less immediately accessible. In addition, the location of the team outside the influence of certain regulative influences, such as the processes dictated by CPA, allowed professionals in this team more freedom in terms of the processes and professional involvement around decision-making.

As illustrated in the data chapter the consultant psychiatrist associated with this team continued to hold the views, and perceive the constraints and expectations, described by participants within the wider organisation. The consultant also described a desire from some non-medical team members to involve them in decision-making around risk, particularly following experience of investigations, although this was not the case for the non-medical professionals interviewed. This differing perception could be explained by the fact that, unlike most non-medical professionals, consultants provide input to multiple clinical teams, including teams that perform different functions to the exceptional case outlined here. In theoretical terms they have greater exposure to the influences, expectations and constructions at work across the wider organisation (and institutional field).

7   Conclusions

This thesis began by highlighting and problematising an issue of significant contemporary relevance: the development of the healthcare workforce to meet the demands of modern society. Specifically, this work focusses on the micro-level enactment of policy attempts to reconfigure professional roles that challenge traditional professional practice and boundaries and encourage the development of a more flexible and adaptive workforce. The study set out with the aim of developing clearer practical and theoretical understandings of the activities and challenges associated with enactment of such change within contemporary healthcare organisations, addressing the specific research questions:

- How do individuals and/or groups work to change or maintain professional roles in the context of role reconfiguration attempts?
- What are the relevant challenges, barriers and enabling factors that inform this activity?

The thesis adopts an organisational neoinstitutional theory framework in order to conceptualise the institutional pressures that guide social activity within the field of healthcare as well as the various forms of agency intended to influence such pressures. As an institutional influence of enormous relevance in healthcare the thesis draws heavily on sociological theory on the professions, connecting this work with the developing neoinstitutional approach to the study of the professions. Specifically, the thesis highlights the focus on the importance of monopoly and jurisdictional control over particular areas of activity and expertise to professional power within this literature and the professional activity necessary to develop and maintain these arrangements. This theme is reflected in accounts of professional role reconfiguration attempts which privilege the strategic activity of professional groups to extend and maintain jurisdiction and associated professional power.

In line with the centrality of the organisation to the neoinstitutional approach to the study of the professions, and in answer to calls the more fully integrate the study of organisations and the professions, this thesis utilises literature concerning the nature of the contemporary organisational context and its impact on professionalism to reconsider prevailing understandings of professional role reconfiguration attempts. In particular, the thesis draws upon literature that describes a move away from professional autonomy and self-regulation toward managerially informed professional evaluation and accountability (Scott 2008a, Evetts 2009, Liljegren 2012), and the use of professional expertise in the management of risk (Annandale 1996, Power 2004, Bianic 2011): changes that exert a profound impact on the manner in which professional work is interpreted and enacted. It is proposed that despite their neglect in the workforce development literature these fundamental changes to contemporary professionalism are highly relevant to the enactment of professional role reconfiguration attempts that shift the boundaries of professional responsibility and the manner in which such change is theorised.

The thesis presents a case in which members of a senior professional group are complicit with policy and management drives toward the reconfiguration of professional roles involving the transfer of elements of clinical work and responsibility previously within their remint to other professional groups. It illustrates the activities by which this change was supported and enabled by the concurrent institutional work of medical professionals, senior non-medical professionals and managers. Through engagement in a number of forms of institutional work, including "changing normative associations", "embedding and routinizing", "auditing and monitoring", "constructing normative networks" and "theorizing", key actors in this setting worked to create new practice in which non-medical professionals carried out work previously within the remit of doctors (Lawrence and Suddaby 2006).

Despite achieving change in practice, the institutional work carried out did not impact upon the core boundaries between these professional groups in terms of authority and responsibility. Change in practice was carried out in a manner that maintained the institutionalised roles and hierarchy dictated by the model of medical professionalism (Battilana 2011) and medical authority over decision-making remained. Within the reconfigured division of labour in which non-medical professionals carried out elements of the clinical work previously within the remit of consultant psychiatrists, consultants continued to become involved in major decision-making around cases, particularly that which involved biomedical complexity and/or the management of elevated risk.

In contrast to the accounts of professional role reconfiguration that dominate the literature, this more limited reconfiguration of roles was not informed by medical resistance to change in the face of encroachment by subordinate groups. Rather the limiting influence in this case was professional and managerial concern with accountability for decision-making, particularly that around high risk cases and untoward incidents, that drove adherence to traditional role boundaries and medical authority. This finding reflects the evolving nature of professionalism within the contemporary organisational context and suggests that the reconfiguration of professional roles is associated not only with transfer of clinical activity, expertise and resource but also the transfer of accountability for the management of risk and the associated consequences. Professionals in this case, rather than competing for jurisdiction over clinical activity that involved the management of significant risk, took great care in renegotiating their roles in a manner that ensured patient safety as well as professional protection from the consequence of being held to account for the mismanagement of risk.

In the case presented enacting work in a manner that conformed with the established interprofessional role boundaries associated with medical authority was interpreted as providing a form of professional safety in the event of untoward incidents. This interpretation was informed by a number of inter-linked factors that reflected and reinforced the impact of institutionalised understandings of medical dominance, authority and responsibility. Most notable was the influence of interpretations of organisational and societal reactions and expectations following negative incidents and the consultant's

position as Responsible Medical Officer (RMO) or the "named consultant" associated with a patient's care. So powerful were these influences that even boundary work, targeted at undermining notions of medical dominance and authority through attempts to "define" and "advocate" new boundaries of responsibility, had little impact (Lawrence and Suddaby 2006).

This thesis also presents an exceptional case in which more extensive reconfiguration, i.e., that involving change in practice and the boundaries of professional responsibility, was enacted in a particular sub-context of the organisation. In the case of team four, non-medical professionals were enabled and willing to enact extended roles that included decision-making around heightened risk in the absence of medical authority over that decision-making. In this context, although professionals remained highly aware of the possibility of being held to account for their decision-making around risk in the event of untoward incidents, this was not associated with adherence to the interprofessional hierarchy. Within this team, in which the meaning of client issues was constructed through an alternative psychosocial or demedicalised frame, the nurses interviewed felt legitimised to lead on decision-making. The adoption of an alternative, non-medical, cultural-cognitive framework mitigated the influence of norms around professional power relations and role enactment associated with the model of medical professionalism (Battilana 2011, Scott 2014).

The primary contributions of this thesis therefore concern theoretical understandings of professional role reconfiguration attempts, providing an alternative perspective to the accounts that dominate the literature. Such accounts draw heavily upon power or conflict models of professionalism that emphasise control and monopoly over professional activity and expertise as a source of professional power (Johnson 1972, Larson 1977, Abbott 1988, Freidson 1988). Attempts to reconfigure professional roles are therefore presented as opportunities for the reallocation of clinical activity and expertise and therefore associated power and status. The literature highlights the competitive activity of professionals, highlighting the tendency of new or subordinate professional groups to extend and claim new territory whilst those more senior defend their jurisdiction and position (e.g., Allen 2000, Timmons and Tanner 2004, Reay, Golden-Biddle et al. 2006, Currie, Lockett et al. 2012). This thesis however, draws upon literature that highlights the evolving nature and function of professionalism as it is impacted by its location within contemporary organisations (Evetts 2009, Bianic 2011). Within this context in which professional accountability and risk management are paramount the reconfiguration of professional roles is understood not only as the reallocation of clinical activity and expertise but also responsibility for the management of risk associated with that activity. Whilst the renegotiation of jurisdiction may present an opportunity or threat to subordinate and superordinate groups respectively, the transfer of responsibility for risk management adds complexity to this interpretation.

In the contemporary organisational context responsibility for risk management is associated with "secondary risks" to professionals themselves which they are driven to protect against (Power 2004). As demonstrated by the findings

presented in this thesis, the professional response to role reconfiguration attempts may therefore involve the careful renegotiation of responsibility for risk management in a manner that prioritises professional protection in the event of an untoward incident as opposed to the advancement and maintenance of professional status and power. In medicalised contexts in which institutional and organisational arrangements reflect and reinforce medical authority and responsibility this is likely to drive adherence to the established and readily accepted medical interprofessional hierarchy. The thesis also demonstrates that in organisational sub-contexts in which client issues are constructed in largely demedicalised terms and organisational representations and expectations around traditional hierarchy removed, pressures around accountability for the management of risk do not necessarily promote adherence to established role boundaries enabling the potential for the creation of new roles.

In addition to providing these contributions to theoretical understandings of professional role reconfiguration attempts this thesis makes secondary contributions to the sociological and neoinstitutional literature concerning the professions more broadly. Firstly, the thesis addresses the need to more fully incorporate the organisation into the study of the professions (Davies 2003, Muzio and Kirkpatrick 2011, Muzio, Brock et al. 2013) demonstrating the impact of the pressures around risk management and accountability at large within the organisational context on the interpretation and enactment of professional work. This contributes to a limited body of work that provides important micro-level evidence concerning the nature and function of professionalism within the modern organisational context and the values and influences that inform professional action (Bianic 2011, Liljegren 2012, Correia 2016). The professional concern with accountability and risk management evident in this study informs theoretical work that proposes the emergence of evolved forms of professionalism that reflect the concerns and requirements imposed within modern organisations (Evetts 2002, Scott 2008a, Evetts 2009, Bianic 2011). Finally, the thesis also supports literature that presents professionals as key institutional agents (Scott 2008a, Lawrence, Leca et al. 2013) with the capacity to engage in a range of institutional work to create, maintain and disrupt the institutional arrangements that underpin professionalised practice, boundaries (Reay, Golden-Biddle et al. 2006, Currie, Lockett et al. 2012).

Practical Implications

The findings presented are highly relevant to contemporary concerns regarding the organisation and management of healthcare, where there is significant pressure for change in professional practice and boundaries and a need for greater understanding of the associated micro-level dynamics. This study therefore has a number of practical implications from a healthcare policy and management perspective. Firstly, this work supports suggestions that the successful implementation of new practice requires the development of change initiatives in which front-line clinicians are engaged and instrumental (e.g., Reay, Chreim et al. 2013). As demonstrated by the successful implementation of new practice within key areas of the case study organisation, the supportive activity of senior clinicians and team leaders is critical. Further this work

suggests that the identification of particularly receptive and enthusiastic professionals and contexts to create pockets of innovative practice as precursors to service-wide change may present an effective strategy.

Secondly, this study emphasises the need for policy-makers and senior managers to pay greater attention to the wider institutional and organisational context in which role reconfiguration attempts will occur. Specifically, those tasked with creating change should be aware that issues of accountability and risk management are a concern for professionals working in public service organisations and that this concern is likely to become particularly relevant and evident during times at which the boundaries of responsibility between different professional groups are unclear and changing. In medicalised contexts, particularly those where organisational processes and structures reinforce assumptions of medical authority and responsibility, concern with being held to account for the management of risk is likely to drive adherence to traditional boundaries and limit the degree to which roles are reconfigured. The findings from this thesis suggest that more significant change may be facilitated by work to create an organisational and institutional context that enables and legitimises extended roles for previously subordinate or non-medical professionals. This might involve work to create a context that promotes clear understandings of the lines of accountability and the alteration of processes and structures to reflect notions of distributed responsibility.

Finally, the study suggests that a potentially effective strategy for creating extended non-medical roles in healthcare lies in the identification of contexts within which client issues are understood in terms other than a purely medical model. Contexts in which psychosocial frameworks for understanding client issues are established are likely to provide receptive contexts for change. Targeting change initiatives within these areas could be an effective strategy. A more radical strategy would be to encourage the creation of such contexts through the identification and organisational separation of specific client groups and or/circumstances associated with demedicalised meaning. Grouping of such cases or circumstances could create largely demedicalised sub-contexts within organisations in which non-medical professionals are enabled to legitimately carry out extended leadership roles.

Limitations

There are a number of limitations to this study that should be discussed. The first concerns the method of data collection which involved solely the use of semi-structured interviews. Although an extremely useful method of data collection the findings of this study could have been enhanced by the triangulation of multiple methods of data collection. Rather than as a means of enhancing or testing validity, a use of triangulation incompatible with a constructionist approach, the use of multiple methods is cited by many as a means of enhancing the credibility, depth and comprehensiveness of qualitative enquiry, providing alternative views of the phenomena of interest (Murphy and Dingwall 2003, Mason 2009, Silverman 2013). Specifically, this study could have benefitted from the use of participant observation as an additional data collection method.

In the planning stages of this research participant observation as a complementary method was ruled out due to difficulty in identifying the potential sites of activity to influence role reconfiguration. However, as the study progressed it became evident that through the process of data collection it would have been possible to identify occasions where activity around role reconfiguration was likely to have been evident, providing ideal opportunities for participant observation. For example, interviews with clinicians within one team revealed that the implementation of nurse-led clinics was being negotiated and that a number of meetings around the issue involving key stakeholders were scheduled to take place during the data collection period. The protocol for this study could have been improved by allowing space for the identification and use of participant observation opportunities during the course of data collection.

The limited duration over which data were collected also represents a limitation of this investigation. As described, the period over which this investigation occurred corresponded with the relatively early states of change, during which managers were utilising a strategy of engagement with enthusiastic professionals to create areas of innovative practice before service wide change was attempted. Therefore the study focussed on particular groups of professionals involved in this phase of the change process. Whilst these early stages of change were associated with the engagement of senior professional groups in supportive action, it is possible that in later stages of change involving larger numbers of teams, the professional resistance typical of the professions literature may have materialised from some parties. It remains unclear how the latter phases of change will be interpreted and enacted within the context of concern with the issues of accountability and risk evident in this study.

The relatively short period of data collection also limits the theoretical contributions made to the neoinstitutional theory literature. Whilst proving valuable insights into the activities in which professionals and managers may engage in order to create and institutionalise new professional roles, the short time period of this investigation renders the findings a mere snapshot of the activities and influences relevant within the organisation at a specific point in time. A longitudinal design, involving repeated interviews with participants over an extended time period, would have permitted the situation of this snapshot within a larger process, allowing consideration of the longer term outcomes of the activities and institutional pressures observed. The longer term impact of the continued institutional practice and boundary work enacted remains to be seen in terms of whether this activity will be successful in fully legitimising and eventually institutionalising new practice for consultants across this service and impinging upon the entrenched boundary between medical and non-medical professions.

Generalisability

Attention is now turned to the generalisability of the findings presented. As outlined in the methods chapter, the aim of case study research is analytic as

opposed to statistical generalisation (Yin 2009). Therefore the question to be considered here concerns to which settings and to what extent the theoretical insights drawn from this case can be appropriately transferred (Lincoln and Guba 1985). As described in the methods chapter the particular change investigated was selected as it is exemplary of those occurring within healthcare services across the United Kingdom and internationally. Like other pressurised western public healthcare systems, policy-makers recognise the need for change in the manner in which services are delivered, a key aspect of which involves attempts to modernise the clinical workforce through the reconfiguration of professional roles (Nancarrow and Borthwick 2005, Currie, Finn et al. 2009). UK policy actively and consistently promotes such change within the National Health Service and *New Ways of Working* (DoH 2005) provides a typical example of drives to shift clinical work across traditional professional boundaries. A number of the theoretical insights gleaned from this case are therefore likely to be of relevance to similar healthcare settings in the United Kingdom and beyond.

With regards to the phenomenon of more consensual role reconfiguration in which a senior professional groups support change, it seems plausible that a number of the motivating factors evident in this study, i.e., significant workload and staffing issues within the context of policy support for change, will be present in others healthcare settings. Similarly, the specific forms of institutional work carried out to create new practice involving extended non-medical roles and challenge established interprofessional boundaries in this setting are likely to be transferrable to other healthcare settings. These activities were targeted at amending structural and normative factors associated with the model of medical professionalism (Battilana 2011): a powerful field-level influence active across healthcare systems globally.

The issue of the transferability of the findings concerning the constraining impact of the organisational and institutional context on role reconfiguration, specifically pressure and requirements surrounding accountability and the management of risk becomes more complex. A particularly important point for consideration concerns the extent to which the impact of risk evident within a mental health service provider organisation can be generalised to other healthcare settings. Specifically, it is important to consider whether the pressures around risk management experienced by professionals within the field of mental health services are different from those experienced by professionals within other healthcare arenas and whether any difference might alter the impact of this pressure on professional role enactment and role reconfiguration attempts.

Mental health services could be considered a field in which the concept of risk is particularly visible and influential with some commentators identifying the management of risk as the central function of such services (e.g., Godin 2004, Morgan 2007). In addition the risks presented may be particularly difficult to assess and manage. According to the Royal College of Psychiatrists (2008, pp.9) "While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a

person's behaviour." Thus, it seems possible that in this context the pressures around managing risk and associated professional concern with issues of accountability may be particularly pronounced, potentially exacerbating the influence of risk management pressure on professional role boundaries and role reconfiguration attempts. Nevertheless, an increasing focus on professional accountability (Evetts 2009, Liljegren 2012) and the management of risk in professional work is evident across healthcare and the public sector more widely (Annandale 1996, Kemshall 2000, Power 2004, Fine 2005, Bianic 2011). Therefore it is likely that these issues will inform the renegotiation of professional roles beyond the field of mental healthcare.

A final point for consideration around the issue of transferability relates to the enabling impact of demedicalisation on the extension of non-medical roles, where again mental health services may represent an extreme context. Unlike other areas of healthcare, the value of viewing mental health issues in medical terms represents a particularly lively and ongoing debate, within which the growing legitimacy of alternative approaches to such issues in the form of the "recovery" movement and psychosocial models are central (Middleton 2007, Middleton 2008, Pilgrim and Rogers 2009). In this regard, mental health services represent a context in which the degree to which professional activity is, and could be, legitimately viewed as demedicalised is greater than in other healthcare areas. However, there are likely to be elements of the activities carried out within other services that are amenable to some degree of demedicalisation and potentially therefore represent receptive targets for the enactment of extended non-medical roles.

Further work

The centrality of concern with accountability and risk management in this study raises important questions concerning our understandings of professional role reconfiguration attempts as well as the enactment of professional work and the very nature of professionalism more generally. This study speaks to a body of literature that considers what it means to be a professional in the contemporary organisational context. Whilst scholars have elaborated upon changing theoretical models of professionalism, work that connects such change to micro-level empirical work is limited and represents an important area for future study (Evetts 2009). The implications of the evolution of professionalism under the pressures of the contemporary organisational environment, including managerially informed accountability and requirements for risk management, for the manner in which professionals understand and enact their work is a central theoretical and practical concern.

There are also a number of areas where further work could productively build upon the findings produced from this thesis in terms of our understandings of professional role reconfiguration specifically. Considering the contemporary relevance of role reconfiguration in healthcare, particularly that which extends non-medical roles, further investigations might examine other examples of relatively consensual delegation to elaborate upon the conditions that facilitate professional engagement as well as the forms of institutional work by which

healthcare professionals and managers enable new practice in which work is delegated to subordinate groups.

In addition, further research is needed to address the questions concerning the transferability of the findings presented in this thesis in terms of the impact of accountability for risk management on professional interpretation and enactment of role reconfiguration attempts in other healthcare settings. Whilst this work clearly highlights the importance of these factors in informing professional understandings of their work, interprofessional boundaries and role reconfiguration in this setting, it leaves a number of crucial questions unanswered: To what extent is professional work associated with accountability for risk management in other settings? How do the concepts of risk and its management inform interprofessional boundaries and the division of labour in other settings? What are the institutional and organisational factors that inform these constructions and divisions? To what extent does pressure around accountability and risk management inform role reconfiguration in other settings? Does the type of risk managed, particularly in terms of highly medicalised clinical risk compared with the risky behaviour of others, influence its impact on professional role enactment and reconfiguration?

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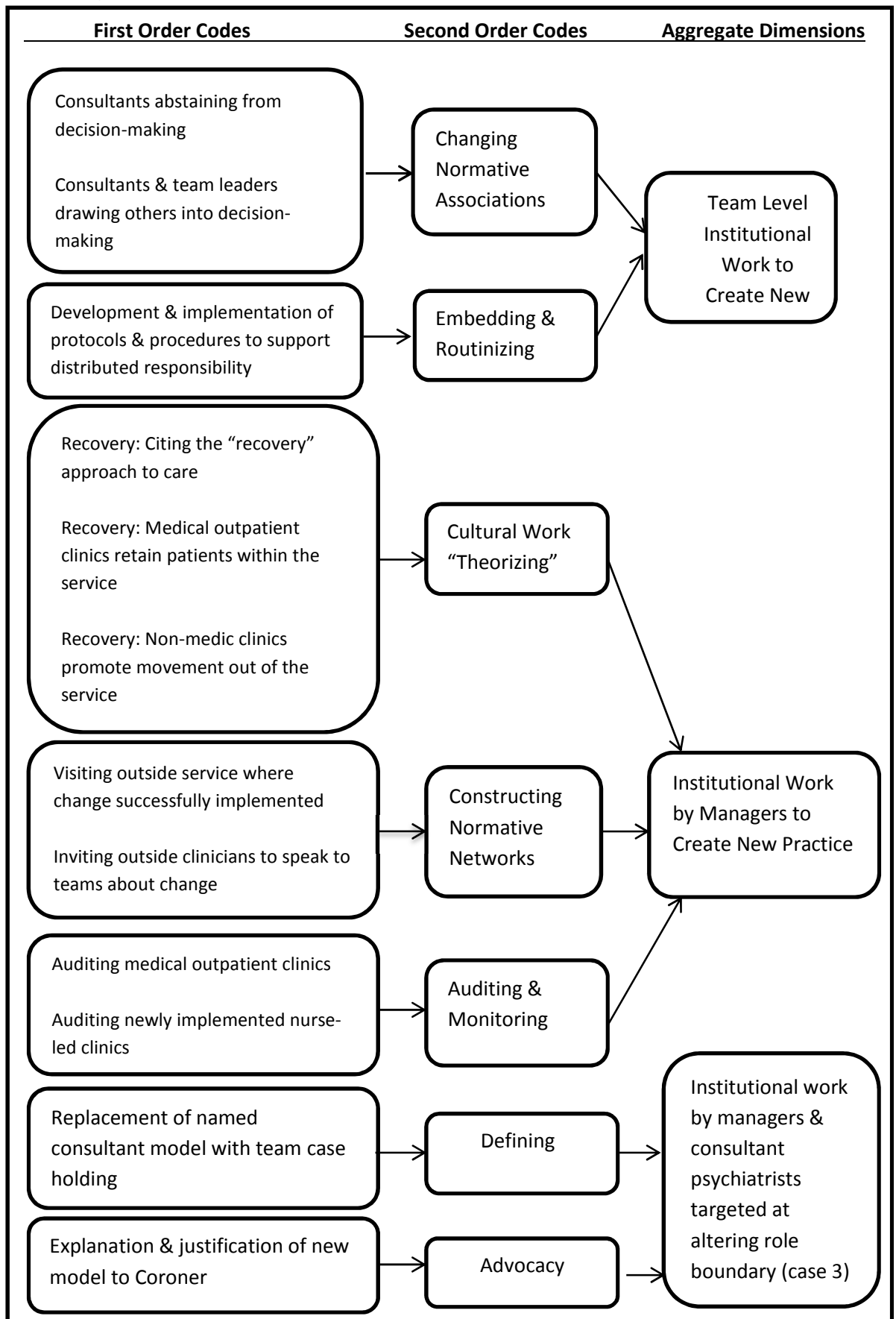
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Appendix A: Coding Structure

Coding of institutional work to create a new role

First Order Codes	Second Order Codes	Aggregate Dimensions

Consultants abstaining from decision-making

Consultants & team leaders drawing others into decision-making

→ Changing Normative Associations

Development & implementation of protocols & procedures to support distributed responsibility

→ Embedding & Routinizing

→ Team Level Institutional Work to Create New

Recovery: Citing the "recovery" approach to care

Recovery: Medical outpatient clinics retain patients within the service

Recovery: Non-medic clinics promote movement out of the service

→ Cultural Work "Theorizing"

Visiting outside service where change successfully implemented

Inviting outside clinicians to speak to teams about change

→ Constructing Normative Networks

→ Institutional Work by Managers to Create New Practice

Auditing medical outpatient clinics

Auditing newly implemented nurse-led clinics

→ Auditing & Monitoring

Replacement of named consultant model with team case holding

→ Defining

Explanation & justification of new model to Coroner

→ Advocacy

→ Institutional work by managers & consultant psychiatrists targeted at altering role boundary (case 3)

Coding of Constraining Influences

Professional hierarchy:

Rules inherent in the model of medical professionalism/field level normative influence

Risk management policy requirements and expectations:

Field level regulative & normative influences

Consultant's position as "named medic" for all patients within services:

Organisation level regulative influence

Consultant's position as RMO in relation to the *Mental Health Act 2007*:

Field level regulative influence

Belief that the consultant has some degree of accountability for overall decision-making/case management

Expectation of Consultant involvement in investigations following negative incidents as represented in the Coroner's Court & Serious Untoward Incident [SUI] procedures:

Organisational and field level regulative influences

Concern with accountability. Professional protection gained from consultant authority over decision-making.

Protection from secondary risks to professionals themselves

Consultant psychiatrists involved in the management of risk:

Institutionalised role boundary

Coding of Enabling Influences

First Order Codes	Second Order Codes

The team's approach is recovery focussed

Emphasis on psychosocial aspects of care

The problems of the team's clients are circumstantial

→ Demedicalised construction of, and approach to, client problems