THE CONTEMPORARY FACTORS SHAPING THE PROFESSIONAL IDENTITY OF OCCUPATIONAL THERAPY LECTURERS

NARRATIVES IN EDUCATION, REPRESENTATION AND REGULATION

John O'Shea

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Abstract

Occupational therapy (OT) lecturers are at the interface between student education and training and professional practice and therefore have unique insights into the contemporary factors shaping their professional identity and that of the profession. Two main contemporary and interrelated factors have been identified. Firstly, neoliberalist government policies which encourage the marketisation of health and social care provision, which has implications for how the profession is defined and for professional autonomy and values, ways of working, education and training. Secondly, how knowledge is constructed and used within evidence based practice and whether this is compatible with an emerging occupational therapy body of knowledge.

These factors are being played out in the fields of representation, regulation and higher education, shaping OT lecturer professional identity and therefore approaches to teaching and learning. This was understood as a structure and agency relationship based on Bourdieu's theories on 'Habitus', 'Field' and 'Capital' (Bourdieu 1998, 1990, 1977). To do this, nine narrative inquiry focused interviews of occupational therapy lecturers from two universities were carried out. These narratives were understood within wider organisational contexts using a document analysis. A thematic analysis was applied to both interviews and documents. Five main themes have been identified: professional identity and artistry; professional and philosophical body of knowledge; doing research, evidencing practice and the neoliberal agenda; the representation and regulation of the College of Occupational Therapists (COT) and the Health Care and Professions Council HCPC); and moving into new ways of working – the selling of OT. These have implications for the development of OT professional habitus, the relationship between COT and the profession and approaches to teaching and learning.

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Chapter 1: Introduction

Occupational therapy

Occupational therapy (OT) as a profession has always struggled with its professional identity. The reasons for this are many but in this thesis I have identified that there are particular uncertainties about the way in which practice can and should be evidenced between competing paradigms; an emerging body of evidence within occupational science underpinning both academic and clinical practice; and the way the profession is structured and defined by its professional representation and regulation. Central to these is the interplay between evidence based practice (EBP) and professional artistry and the way in which the profession negotiates a path between the neoliberal influences on contemporary working and its professional values (Molineux 2011; Turner 2011; Kinsella and Whitford 2008; Clouston and Whitcombe 2008). This has implications for those who teach occupational therapy and for pedagogical approaches to student learning. This thesis attempts to shed some light on these complex issues by understanding the views of occupational therapy lecturers on these contemporary factors which are shaping their professional identity.

The history of OT goes back around 100 years across both the UK and the USA. It is now a worldwide international profession represented by the World Federation of Occupational Therapists. Its history has links to both the arts and crafts and the moral hygiene movements of the late 19th and early 20th centuries (Oxford Brooks University 2011). Historically the professions focused on engagement in activity to improve the psychosocial well-being of those with mental health problems. Alongside this it became involved in treating those with physical disabilities following the First and Second World Wars. OT was and still is closely linked to the medical profession, set within the medical hierarchy and therefore largely dependent on this structure to see patients. This relationship with medicine became formalised in the UK with the establishment of the National Health Service (NHS) in 1948. Dorset House, the first training college, was opened in 1930 funded by Elisabeth Cason (COT and Wilcock 2004; Oxford Brookes University). The British Association of Occupational Therapists (BAOT) was formed in 1974 as an amalgamation of the Scottish and English associations (Oxford Brookes University 2011).

The development of OT as a profession mirrors the development of the wider professions in the 20th century. Occupational organisations, formed to protect the status and position of those engaged in a particular occupation, have existed in this country since medieval times, beginning with trade guilds (Dingwall 2008). Professions as we understand them today have developed out of a technical and industrialised society and the expansion of a formal university education system (Dingwall 2008; Freidson 2001). Initially made up of the clergy and the law, the professions grew considerably in the 19th and 20th centuries to include medicine, science, engineering and latterly nursing, occupational therapy and physiotherapy, amongst others. What these all have in common is a period of 'apprenticeship' and initiation into the profession which provides the initiate with the knowledge, skills and behaviours necessary to be part of that profession (Freidson 2001). Crucially, these 'esoteric' ways of knowing, being and doing were exclusive of the general population but produced 'goods' that the general population and governments required (Evetts 2013; Dingwall 2008). The tradition of the guilds and latterly professions to require membership in order to ply a trade has been adopted by most professions through membership of a professional body which can be conferred solely by the profession and, in the case of most health and social care professions, through professional registration as state sanction (Evetts 2013; Dingwall 2008 Freidson 2001).

Over this time OT has developed significantly as a profession and has attempted to build a distinctive professional body of knowledge within which to express its professional identity (Turner 2011; Kinsella and Whiteford 2009; Clouston and Whitcombe 2008). The notion of 'occupation' as a term has become the corner stone of this development as a way of understanding occupation as a meaningful activity (Wilcock 2006; Whitcombe 2013). The discourse which makes up this body of knowledge is centred on humans as occupational beings with occupation central to what humans do and become and has been central to the development of 'occupational science' as a parallel discipline (Wilcock 2006). Occupational science draws on the broader bodies of knowledge located within anthropology, sociology, critical theory and evolutionary biology. It is through these developments that the profession is evolving its professional status and identity into the 21st century (Wilcock 2006) and it is these developments which are considered necessary for OT's to develop a strong professional identity which is cogent and congruent to its values and closely linked to

social models of health and well-being (Molineux 2011; Kinsella and Whitford 2009; Wilcock 2006).

This on-going development of an academically focused body of knowledge has resulted in a tension between theory and practice (Kielhofner 2005). Challenges between theoretical abstraction and clinical practice are well known across many disciplines including medicine and nursing (Allmark 1995). Although theoretical models and approaches have been developed within OT over the last thirty or so years and these inform the ways in which OTs can and do justify their practice, they are not always articulated as occupational theory by OTs when working with clients or when discussing their practice with other professional groups (Kinsella and Whitford 2009; Kielhofner 2005). Becoming an OT necessitates the engagement and articulation of theory, mostly demonstrated during university education and training, but being an OT working in clinical practice tends to be demonstrated through pragmatic interactions with clients and other team members in much the same way as for nursing and medicine. There is a risk that the drive to develop an academic body of knowledge moves that knowledge one step further from what OTs actually do in clinical practice. Therefore this nascent body of knowledge needs to be relevant and meaningful to those in practice. (Molineux 2011).

OT philosophy and values

Philosophically the OT profession positions itself within the ontology associated with holistic principles of health (Turner 2011; Kinsella and Whiteford 2009; Creek 2003). These principles tend to be somewhat loosely translated to client centred practice, empowerment and equity. Holistic practice is opposite to dualistic practice. Holism considers the relationship between mind and body to be integral to human health and essential to well-being. Dualistic practice tends to reduce health and the treating of ill health down to parts of the body that need treatment. Holistic practice is more akin to the social model of health whereas dualistic practice is more akin to the medical model. Both have their place, to some extent, in health and social care practice, however holistic principles require a longer and more involved intervention with the client. These values sit within the theoretical and philosophical principles that humans are occupational beings and that good health and well-being can be achieved through meaningful occupation (Wilcock 2006).

The values of the profession underpin the way it works with the public and therefore the public expectations of it. The agreement between the state and certain professional groups, including OT, provides an opportunity for professions to legitimate practice and payment with access to a considerable market place (Dingwall 2008). The trade-off for the profession is a loss of some control over the profession's structure and the ways in which its knowledge and skills are developed and its students trained and educated (Dingwall 2008; Freidson 2001). This potentially puts the profession in the position of being an 'instrument' of the state and therefore less likely to challenge the government of the day on policy with which it might not agree (Dingwall 2008; Freidson 2001; Sullivan 2000). This possible invidious position has the potential to put the values of the OT profession at odds with some of its practices. Some professions such as medicine and the law have a high status within society and a greater power. However even these professions find it difficult to successfully challenge government policy although the BMA (2016) has attempted to do so when responding to the recent changes to the NHS across all the regions of the UK. Therefore the agreement between the state and the professions is a double edged sword which legitimates the professions but which dilutes their ability to control their professional status (Dingwall 2008). This relationship between the state and the professions will be discussed in more detail in the literature review.

Representation and regulation

Professional groups in the UK tend to have an organisation that represents their interests and an organisation that regulates professional practice. These professional groups will produce professional publications and provide advice to their members, the general public and state organisations. They might also hold national conferences and similar events. A significant number of professional groups are also regulated by the state via an external body. The prime focus of this type of regulation is to protect the public from poor practice (HCPC 2014 and HCPC 2013). It also allows for government influence on the way regulated professionals practice (PSA 2015). The bodies that represent a professional group and those that regulate it, and are therefore responsible for disciplining its registrants in cases of malpractice and poor professional behaviour, are organisationally separate from each other. The separation between representation and regulatory organisations does not however preclude a close working relationship between them (HCPC 2015 and Guthrie 2009).

The Health Professions Council became the Health Care Professions Council (HCPC) to incorporate social workers following the Health and Social Care Act 2012. Professions that are allied to medicine such as occupational therapy and physiotherapy are regulated by the HCPC. The board of the HCPC is made up of members across these professions and lay people. However the HCPC is responsible for many different professional groups, which in itself might lead to a more diffuse understanding of the professional groups it regulates. Therefore professional representation and regulation and the interplay between these organisations is complex (HCPC 2015).

There is no 'official' relationship between the College of Occupational Therapists including the British Association of Occupational Therapists (BAOT) and the HCPC. COT is the organising body under which BAOT represents its members.[1] It is not mandatory for OTs to join COT to practice. However, the HCPC is the state regulator of professions allied to medicine and it is mandatory for OT's to register with the HCPC to practice in the UK (HCPC 2014). The COT produces guidance documents on curriculum design and the general approach expected of university departments to the teaching and learning of OT students (COT 2014 and HCPC 2014a). This is done in agreement with the World Federation of Occupational Therapists (WFOT) who seek to provide international representation and guidance to the profession. All OT courses at degree level are ratified approximately every five years at their respective universities. COT are invited to attend the ratification boards for the OT courses but do not have any power to sanction these courses. Rather, the sanctioning of OT courses is carried out by the HCPC, who make decisions on courses' suitability to deliver a curriculum that will result in newly qualified OTs meeting the basic level of competency, as outlined in the standards of proficiency, to register as an OT (HCPC 2013 and HCPC 2014). Therefore, COT only acts in an advisory capacity to OTs and to those running and delivering OT courses. COT can also act in an advisory capacity to relevant government departments and to the HCPC, however this is not a direct working relationship but more a 'polite nod of the head' from the state to the COT.

OT students can join the COT as student members and they are advised to do so by university OT departments. There is no student registration within the HCPC. Joining COT

[1] For simplicity COT/BOAT will be referred to as only COT in this thesis.

gives students access to professional publications, local groups and discounts on the cost of attending the national conference (COT 2011). The fees for student membership have traditionally been met by the university OT departments, however this is increasingly not the case as budgets tighten. Anecdotally, the result of this is that fewer OT students are becoming members of COT. This is likely to have an impact on the professional membership of COT on qualification if OTs do not become members when students. Subsequently newly qualified OTs may not feel they need to be members of COT and will be satisfied with their professional registration, which allows them to practice.

The teaching and learning of students

OT lecturers are responsible for the effective day to day teaching and learning of students through innovative, challenging and relevant pedagogical approaches. On the whole OT lecturers will begin their careers in clinical practice before moving into higher education. Both the pre-registration BSc (Hons) in Occupational Therapy and the pre-registration MSc in Occupational Therapy courses tend to be within faculties or schools of health and life sciences or similar. The majority of OT subject groups sit within allied health professional departments which might also include, for example, physiotherapists, dieticians, radiographers etc. There has been at least one example, however, of an OT subject group that, whilst still within a health and social care focused faculty, was positioned within a department with social work, youth work and community studies and careers guidance. This department has subsequently been reconfigured into a School of Nursing, Midwifery and Health. The way OT subject groups are led and constructed within departments and faculties will have an influence on the direction of teaching and learning.

A key focus of student education is the way in which theory (predominantly taught within the university environment) and practice (predominantly taught experientially within clinical placements) relate to each other (Turner 2011; Whitcombe 2013). To achieve an effective balance between theory and practice (although as discussed above this is a contested area) it is necessary for lecturers to build good working partnerships and relationships with OTs in clinical practice. Clinical educators tend to be qualified OTs who take on and supervise students. Practice based education still occurs mostly within the statutory state sectors of the NHS and Social Services and student fees are paid by the NHS to reflect this, although

this will probably change from 2017 if, as planned, the funding of students on health courses moves from Health Education England to the Department of Business, Innovation and Skills.[2] However, a significant number of placement education experiences are occurring within the third sector made up of voluntary, independent and private organisations and some of these placement experiences occur abroad (Whitcombe 2013). Part of the remit for third and private sector placements is to increase the scope of OT practice and many of these placements take place where there is no OT employed and where it would be difficult to use traditional models of supervision (COT 2006). These placements challenge traditional notions of theory into practice and are instrumental in guiding the ways in which contemporary factors are shaping the student experience and the impact on student expectations of the profession in both traditional and non-traditional working environments (Whitcombe 2013). In addition to contemporary placements, course design is also changing to reflect different ways of viewing OT practice with an increasing focus on business-mindedness, leadership and entrepreneurship (COT 2014a).

These changes are influenced by the expansion of neoliberalism (defined and discussed in the next chapter), which is becoming prevalent in the structure and delivery of health and social care services (Paton 2014; Copnell 2010; Sullivan 2000), and this is reflected in the teaching and learning of students. It is necessary for OT lecturers to prepare students for these changes to ways of working and they have a responsibility to provide students with skills and knowledge that reflect contemporary practice (COT 2014; HCPC2014). However, it is also within the responsibilities of OT lecturers to both encourage students to critique the neoliberal discourse when it is presented within course material e.g., entrepreneurship, customer focus etc. and to point out where these approaches might not be congruent with OT values (Hocking 2014; Kinsella and Whitford 2009; Hocking 2004). Whether OT lecturers feel sufficiently knowledgeable or empowered to do this effectively is questionable. Students also have a responsibility to question the focus of their OT education and understand how this reflects their own personal values, the fit with professional values and what they feel is valuable for them to know. This is tied up with the beginning of their journey to understanding and developing their professional identity (Turner and Knight

[2] Following the recent government reshuffle universities have moved into the Department for Education. It is unclear what this change might mean for NHS student funding (Universities UK 2016).

2015; Turner 2011). It is therefore a challenge for OT lecturers to engage students in relevant teaching and learning whilst encouraging a critical approach to neoliberalism.

Neoliberalism is further reflected in the evidence based practice (EBP) movement which is prevalent within health and social care practice and research (Paton 2014; Copnell 2010; Sullivan 2000). The focus of EBP is on the way in which practitioners utilise the best empirical evidence to inform practice based decisions. However, the role of EBP is contested (Gitterman 2014; Paton 2014; Hammersley 2013; Gabbay and Le May 2011; Sugrue and Solbrekke 2011; Copnell 2010; Kinsella and Whiteford 2009; Sullivan 2000). Some of the challenges to EBP are practitioners' knowledge and understanding of different types of research methodologies; knowing what research is the best or whether research utilised is relevant; and the ways in which this is pragmatically integrated into their practice. Theoretical principles as propositional knowledge alongside pragmatic considerations and professional artistry (developed out of a combination of skilful practice, clinical experience, professional values, and judgement) are a key part of the OT's decision making process when it comes to deciding on treatment or intervention approaches (Paterson et al 2005). The acknowledgment of the clinical professional judgment is made by several commentators when applying EBP. However, this is challenged somewhat by the value placed on different types of evidence and quantitative methodologies given prominence by policy makers and commissioners (Hammersley 2013; Gabbay and Le May 2011; Sugrue and Solbrekke 2011; Kinsella and Whiteford 2009; Paterson et al 2005).

This emphasis on research skills is considered essential (COT 2011c), however the way EBP is influencing the teaching of research and how it translates into practice as EBP is questionable. It supposes that clear evidence is available which can be understood and utilised by those in practice (Hammersley 2013; Gabbay and Le May 2011). The argument against this type of EBP does not seek to dismiss or ignore best evidence but instead focuses on the contradictions and the practical usage or otherwise of EBP and the balance struck between practical utilisation of research and tacit knowledge of clinical settings and the political drivers behind the EBP movement. Further consideration is given to the relationship between knowledge, EBP and neoliberalism in the next chapter.

Employment of OTs

The NHS is one of the biggest employers in the UK and is responsible for the vast majority of this country's health service provision (HSCIC 2015). The NHS works in conjunction with local authority run social services and these organisations provide the majority of OT jobs. The NHS also commissions the majority of OT student places within the university system. This is currently administered by the NHS through Health Education England (DH 2015) although as noted above this will probably change in England in 2017. The NHS pays OT students' tuition fees and provides students with access to a discretionary bursary. There are, however, a few examples of Higher Education Funding Council (HEFC) funded OT student places which will incur a cost to the student and where no bursary is available. There have been many changes to the way in which the NHS and social services construct and deliver health and social care with an increasing use of private and independent third sector provision being utilised by the NHS (Paton 2014). This move away from NHS service provision means that OT's are increasingly being employed within the third and private sectors.

This provides further market opportunities for the third and private sectors to become involved in health and social care provision. Many health and social care professional groups will have to develop their profile and sell their skills and knowledge within this changing and ever increasing health and social care market. What was once traditionally seen as the norm in relation to employment and career progression is being challenged by these changes.

It is the underlying political discourse of neoliberalism linked to the evidence based practice movement that is driving some aspects of health and social care policy and the way representational, regulatory and educational fields are directing OT practice. To some extent it is these unseen forces that require explicit examination and critique to identify whether or not policy and guidance are congruent with both the values of the OT profession and its nascent body of knowledge.

The insider position and reflexivity

I am an occupational therapist whose practice is within higher education as a lecturer in occupational therapy and it is therefore important that I acknowledge the stance I take within the research process, and my reasons for carrying out this research. I have been a qualified OT since 2003. I spent more than 5 years in clinical practice before moving into higher education with a short period of crossover when I was doing both jobs. All the interviewees are either colleagues or former colleagues with whom I have worked for a number of years in two universities. OT is a profession within which I have worked over a long period of time and one which I value.

Over this period and during my time as a student I have engaged in and read many debates about the profile of OT within health and social care and within wider society. These debates have included discussions on professional identity and values, both the value of OT to society and the values of OT linked to a developing body of knowledge which informs OTs' professional identity, and which is increasingly expressed in both theoretical and conceptual terms. This theoretical development is shaping the ways in which the OT knowledge base and the role of theory within practice are changing and developing. I have also observed and been part of the changes in OT curricula. As such, I have seen the increasing focus on entrepreneurship, business focused skills and positivist approaches to evidence associated with marketisation of health and social care and EBP. I interpret these changes to teaching and learning as not fully congruent with the profession's values or knowledge base. These changes in OT and the way it is defined and understood have influenced my thinking leading to this research.

I am an insider researcher as I belong to the community and organisation into which I have researched. This type of research comes out of methodological practice and conventions developed within anthropology and ethnography mainly through the method of participant observation. It is also influenced by the tradition of critique that challenges notions of objectivity and power, and where power is located, for example, acknowledging critical stances from groups who might be discriminated against (women, black and ethnic, gay etc.) to expose suppressive hegemonic discourses (Ball 2011; Anderson and Herr 2010; Crotty 1998). Action research is a further example of a methodology which takes the insider

approach as a central method to bring about organisational change by seeking to empower those involved (Anderson and Herr 2010). My research is not action research or based on participant observation and does not seek to liberate OTs although, as noted above, I do take the stance that the current changes shaping OT practice and identity should be critiqued. Where this insider relationship is crucial is as part of the interpretation of the data and allows for a deeper understanding of the context within which the research is carried out (Clandinin 2007).

However, it is also crucial to be able to stand back from this process and to identify oneself within the research (Bourdieu 2004). This is not just about acknowledging bias or some form of phenomenological bracketing of experience but a way of seeing the practice being researched afresh and differently. This new perspective should enable me to bring knowledge from both my own experience and the theory informing my research to the interpretative process whilst being almost 'naive' in questions asked and allowing myself to be surprised by the findings.

I found this self-critical reflexive process to data gathering and my interactions with the interviewees challenging. Keeping research notes helped with this (Pillow 2010) as did many occasions of taking my dog on long walks whilst asking myself questions regarding what I was attempting to achieve and why I was taking a particular approach. For example, after carrying out the interviews I questioned why I had asked particular questions, whether I had asked sufficient questions or whether they were the right questions. I asked myself whether my response to answers was too knowing, did I keep sufficient distance or was this even possible?

When asking these questions and in conversations with my research supervisors I decided that my insider position opposed the seeming 'objective' methodological conventions of researchers doing research 'on' rather than 'with' participants, and that an imposed 'objective' distance from the participants is not possible in this type of research and would hinder the data collection and interpretation. Particularly helpful in understanding this was an unpublished doctoral thesis (McGrath 2006) carried out by a former nurse on why nurses leave the nursing profession. The author reflexively interwove her perspectives with those of her interviewees and relevant documents to provide a depth and richness that would not otherwise have been possible. This I thought coherent with an insider researcher

perspective which tends to remove the distinction between the researcher and the researched and values the researcher's first-hand experience of the research area and those involved in the research. I concluded that the credibility of my findings relied on this type of knowledge co-constructed with those with whom I was engaged as research participants, as much as it did on being theoretically coherent in my interpretations of the data, to achieve relevant and meaningful outcomes. Yates (2005:51) comments on this type of approach when she says:

> …research contributions and theories may be important, without being important to every audience at every point. One prime example here is the move to reflexivity and more extreme forms of self-criticism and self-reflection by researchers. Many methodology writings now emphasise the need to see research as 'constructing' not 'finding' truths; to examine the embodied relationships between researchers and researched; to critically scrutinize acts of writing up the research.

Bourdieu (2004), in The Science of Science and Reflexivity, makes many references to researcher reflexivity when discussing 'scientific objectivity' and methods employed in attempting to achieve this. He comments on the beguiling aspects of positivist methods which result in misleading perspectives of researchers as benign conduits through which empirical data becomes knowledge through the mere application of the scientific method. Bourdieu suggests that those engaged in such practices need to understand their positionality and in some way 'objectify' the process of 'objectifying' to see the rule employed and social constructions held within it. Here Bourdieu is adding the tradition of critique which has held positivist notions of truth to account (Crotty 1998). Kuhn (2012), in his seminal work on the revolutionary processes that occur in research methodologies and theories, describes the difficult process of accepting a new view experienced by scientists when presented with what he refers to as a 'paradigm shift.' He suggests that the new paradigm brings with it a new way of viewing the world which is initially dismissed. For Bourdieu it is this type of methodological reproduction that needs to be reflected on and critiqued by those engaged in its practice in order for change to occur and for all those engaged in all research to be reflexive about their interpretations of data. This reflexivity is crucial, as is our positionality, for data to be recognised as neither neutral or value free (Kinsella and Whitford 2008). Therefore, any truth claims made from data are contestable

and that data must be interpreted within the contexts in which it was obtained and in which it will be applied for it to be meaningful as knowledge.[3] Bourdieu (2004:115) comments:

> I cannot take up a position, as a scientist, on the struggles over truth of the social world without knowing that I am doing so, that the only truth is that truth is a stake in the struggles as much within the scientific world (sociological field) as in the social world that this scientific world takes as its object…and with respect to which its struggles over truth are engaged.

[3] See also Gadamer (2013) on the hermeneutics of the perceptions and mediations of 'truth' through language.

Outline of chapters, and structure of my thesis

This thesis is structured into ten chapters with subheadings within those chapters to guide the reader through the arguments, data, interpretations and conclusions. To assist the reader further I have provided a synopsis of what the following chapters will cover. This allows the reader to obtain a 'quick' understanding of the content of my thesis before reading more fully or to move directly to those sections of more interest.

Chapter 2 contains a mapping of the current literature within this field, placing my research in context to highlight what I am adding to what is known or thought to be occurring regarding the contemporary factors shaping OT lecturers' professional identity. It will, in conjunction with the introduction, set the scene for the following chapters. This will also enable me to relate my empirical findings back to the literature. This will position my research within the main debates on the professions and professional identity, occupational professional identity and values, neoliberalism, health care, OT knowledge, EBP and managerialism. This chapter will also provide a justification for the theoretical context used in my thesis and in doing this I will discuss Bourdieu's theories on 'Habitus', 'Field' and 'Capital' (Bourdieu 1998, 1990, 1977) as a way of understanding structure and agency. The teaching and learning of students and the tension between theory and practice, although touched on within these debates, is discussed within the context of the findings as a product of what is shaping OT lecturer identity rather than being key in this process.

Chapter 3 will outline my methodological approach and associated methods. I will discuss my rationale for taking a narrative inquiry and thematic analytic approach to collecting, organising and interpreting my data set within the broader context of the theoretical framework. The overreaching structural contexts of the fields of representation and regulation will be understood through an analysis of documents drawn from relevant organisations whilst the field of HE will be mostly contextualised by the lecturer narratives. The organisation and management of this data and the use of the NVivo software package will be detailed. I will also cover the ethical issues essential to empirical research. By the end of this chapter the reader should have a clear picture of the research process I have undertaken which has resulted in the data on which my thesis is based being gathered and interpreted.

The analytic approach I have taken considers the interplay between my subjective interpretations as a way of developing an 'objective' understanding of the phenomena investigated. It is, however, important to take a stance when interpreting data within the context of previous research and a theoretical perspective. It is also important that the stance I take and my positionality as an insider researcher are grounded in the reality of what is happening. Therefore I will discuss the pros and cons of being an insider researcher and how, through a reflexive process, I acknowledge this basis but also strengthen my argument through my knowledge of the subject. I will also discuss the way in which I will triangulate my interview data, document analysis and literature review to further strengthen my findings.

Chapter 4 will show how I have organised my data into vignettes of the participants' interviews. These are included to introduce the participants to the reader so that the reader can obtain a sense of the individual participant's story before further reduction of interview data necessary for the pragmatic handling of lengthy transcripts, and to capture the core and the essence of what was said by the participants. These narratives will be further explored for similarities and contradictions, attributed under thematic chapters.

The vignettes are brought together to take the 'story' forward into the following chapters, beginning with professional identity and artistry and moving onto the way this is supported or otherwise by its body of knowledge, followed by its relationship to research and EBP and the influence of neoliberalism on the more specific structures of the fields of regulation and representation. The story concludes with the way OT lecturers and the broader profession are responding to these structuring influences in their working practices and on the teaching and learning of students. Crucially this will be the point at which unique data is added to my thesis. It will be the combination of this unique data with my theoretical framework which should go some way to demonstrating new knowledge. I will aim to show the way in which these contemporary factors are represented by structures within which OT lecturers practice and what this means for their professional identity and approaches to teaching and learning. Conclusions will be drawn and these will be discussed in the final chapter.

Chapter 5 will be arranged around the theme of professional identity and artistry. It will bring the lecturers' narratives to the fore on the specific areas of the value of professional artistry and identity, types of knowledge and conveying the OT identity.

Chapter 6 will focus on the professional and philosophical body of knowledge. It will cover different models and approaches, the emergence of occupational science, language and discourse and making this language meaningful in real terms.

Chapter 7 will discuss the themes of research, evidencing practice and the neoliberal agenda. It will detail neoliberalism and health care, neoliberalism and EBP, ownership of evidence, EBP and research and academic and clinical identities.

Chapter 8 will cover the representation and regulation of the College of Occupational Therapists (COT) and the Health Care Professions Council (HCPC). This chapter will be where the majority of the document analysis will be triangulated with lecturer narratives to contextualise structures within which the agents (lecturers) practice. In doing so it will cover the relationship between the COT and HCPC, the value of the HCPC and the value and relevance of the COT.

Chapter 9 will consider the move into new ways of working such as the selling of occupational therapy. In doing so it will cover changes in language, changes to practice - selling to the third and private sectors, the professional and public contract and changes to teaching and learning.

Chapter 10 will bring all the above together to draw conclusions and make recommendations with the aim of shedding new light on the perspectives of OT lecturers on contemporary factors influencing and shaping their professional identity.

Chapter 2: Literature Review

In this chapter I highlight the key debates within the literature on this subject, bringing together a broad spectrum of literature from research papers, books and other scholarly works. I start by presenting some of the debates on the definition of professions and professionalism and how this links with professional identity. In doing so I outline the history of the professions, the relationship between the traditional and new professions and the transition of occupational groups into professions. I note some of the perspectives on how the professions are internally and externally defined and their relationship with the State, the public and professional values. I then highlight some perspectives on how professional values, knowledge and language underpin professional identity and some of the challenges to professional autonomy. This broader context of professionalism and professional identity is then focused on key perspectives on what is influencing the professional identity of occupational therapy lecturers and of the profession.

I then move on to define neoliberalism in relation to health and social care and the way in which neoliberal policies are changing the structure and delivery of health and social care and associated ways of working. In doing this I bring together perspectives which mostly see neoliberalism as having a negative effect on both working practices and health outcomes. This discussion is then focused on the links between neoliberalism, evidence based practice (EBP) and managerialism and their relationship with professional autonomy, values, generic skills and competencies. I then move the discussion onto the types of knowledge that are valued by OTs and highlight perspectives on how this is challenged by neoliberalism and EBP. I then note some of the ways OT professional identity has been theoretically understood and discuss the relevance of Bourdieu's theories of habitus, field and capital (as a Bourdieuian perspective) on the structure and agency relationship which is central to understanding the structural influences noted above on OT lecturers' professional identity.

The professions and professionalism

Defining a profession and therefore professionalism is difficult and contested (Evetts 2013; Dingwall 2008). Within the sociology of the professions Dingwall (2008) credits Hughes (1971) and Talcott Parsons (1968) as being instrumental in understanding the rise of the

professions during the early and mid-20th century. Parsons was one of the early social theorists on professionalism, who considered the professions to be in a form of tacit continuum with non-professional occupations alongside the development of organised work in the early 20th century. Hughes, when carrying out his research in the USA at the Chicago School of Sociology, took a more empirical, observational and ethnographic approach to understanding professionalism with a focus on the influence the medical and legal professions had on the organisation of the newer professions of nursing and teaching. Hughes further notes the internal conflict within these professions as this process happened, with both the older and newer professions being "self-conscious" of their professional status and roles (Hughes 1971:311). This was observed in 1971 but is still relevant for professions such as OT. Most aspects of a professional occupation are considered to be different from those of any other skilled occupation, however Dingwall (2008) and Evetts (2013; 2003) claim that to make too much of a distinction can be misleading. Freidson (2001) does make a distinction in so much as he refers to both the spirit and value of the profession as being distinct from other areas of work.

The way in which occupations have moved to become professions is in a continuum with both medicine and law which are seen as archetypical professions (Dingwall 2008; O'Day 2000; Freidson 2001) against which other professions can be measured. Dingwall (2008:30) claims:

> Both common sense and sociological theorizing about our society tend to regard doctors as constituting the archetype of a profession. They are, then, likely to be a key reference point, especially for other health occupations claiming recognition as professions.

The professions represent and are a reproduction of middle class occupations where education and training occur within the university system (Dingwall 2008). This is in contrast to traditional working class skilled occupations where training and a limited formal education occur 'on the job' in the form of apprenticeships. For Dingwall, when commenting on the work of Freidson on why and how this occupational separation came about, suggests it is linked to a post-industrial revolution class divide. Societal value placed on occupations tends to favour the professions and in particular a small group of these,

namely medicine, law and the clergy. Whilst skilled occupations e.g., carpenter, mechanic are termed 'vocational' these tend to be attributed a lower status. It is, however, somewhat contradictory that the vocational tenet of a profession and the virtue associated with this are seen as central to professional motivation and behaviour, however, this sense of professional 'duty' is not attributed to vocational skilled occupations.

Whether professions are discrete in terms of key aspects of practice or they are merely formalised occupations is probably a moot point and it is reasonably safe to assert that all professions started as occupations and that many occupations have become formalised as professions. We can see this with the on-going development of the professionalisation of work. Dingwall draws on the example of health visitors and the way their practice has become professionalised and distinct from medicine but where difficulties remain in the differentiation from similar areas of practice such as social work and nursing. Occupational Therapists are similarly going through a process of what might be called 'full' professionalisation and in this respect are attempting to move from under the coat tails of medicine (Turner 2011; Turner and Knight 2015).

As previously noted, any clear definition of professionalism is contested (Evetts 2013; Dingwall 2008) and is considered by Dingwall to be linguistically misleading and decontextualized from the general concept and application of what work is, but there do seem to be some key criteria for defining a profession. These are a body of knowledge, from which theoretical principles can be applied to practice and research carried out; an intensive period of training and education to degree level and above, underwritten by a professional body and/or state sanction; discrete skills and knowledge over which the professional has a high degree of autonomy in practice; a 'contract' with the public and the state to deliver a highly competent service; the ability of the profession to define itself internally aligned to a set of values which are both normative (what the public expects to see professionals doing) and ideological (either state and/or professional hegemony) and where necessary the ability to challenge policy if this is not in keeping with professional values. (Evetts 2013; Dingwall; 2008; Freidson 2001). Dingwall (2008:75) asserts:

> …for professions to be able to perform their proposed function, they must be seen to have at least an arm's length relationship with the state which implies that on occasion they may come into direct conflict with it. A profession which becomes the servant of the state loses its moral authority.

For Dingwall (2008:137-138) this relationship with the State has become increasingly controversial and contested. He notes that there has been a shift over the past 40 years from a demand for professional autonomy and values focused on meeting the public need to one of State capture, control and registration of the professions.

> While professions lose their status as partners in governance, as markets displace expertise in the co-ordination and delivery of welfare, they become increasingly subject to the control of governments. Autonomy and self-regulation are displaced by direction and executive control. In both the US and the UK, for example, autonomous professional licensing boards have given way to state-controlled bodies for the maintenance of discipline and quality.

At the centre of this argument is the relationship between professional vocational virtues, values and professional power as a motivating force behind occupational groups striving for professional recognition and autonomy. However this is also a reason why professional groups are at times at odds with the state. Some of this can be seen in the early struggles over professional authority between the HCPC and the professional groups it represents in the first part of the 21st century (HCPC 2015).

For Freidson the key characteristic of professionalism is the internal construction and control of professional values. According to Dingwall this is a shift in focus by Freidson away from viewing the professions as ideological and paternalistic tyrants that use market capture for their own ends to one where the values and ethics of professions are well placed to challenge social inequalities. It is, however, the shift in professionalism from parentalism to negotiation with clients which in many ways is having a strong influence on the way professionals relate to their practice and their professional identity. This shift from

'professional knows best' to one of negotiation has been noted in the work of Sugrue and Solbrekke (2011) when discussing professional responsibility.

Sugrue and Solbrekke (2011) focus on the necessity for professionals and therefore the professions to engage in critical discourse around what it means to be professionally responsible. They do this by drawing on contributions from several professional groups mainly comprising of teaching and nursing. Similar to other commentators they suggest that professionalism is a combination of expert knowledge, skills and competencies, ethics and professional values (combined with personal values) which result in professional judgement. This is set within the context of professional values and responsibility to provide the best service to the public as part of the public contract. They highlight the difficulty of maintaining the 'essence' of professional values within a market place or managed environment driven by proscriptive procedures that seek to 'exploit' knowledge and skills which are not in full congruence with values. They suggest that the professions have much to lose by a direct challenge to the state and suggest that a pragmatic reflective 'legitimate compromise' between values and employer expectations tends to be the norm.

Sullivan (2000) also identifies three areas within which professionalism has historically been defined and where professions might claim legitimacy. These are 'superior knowledge', 'cultural and social authority' and 'professionalism as an ideology of social reform.' He argues that the first two are bound up in the development of scientific and technical rationality linked to a middle class system of economic reproduction and market values. It is the third perspective which Sullivan considers to offer vocational and moral position where the professions such as medicine can claim legitimacy over and above what is directed by neoliberal policy and market forces. Sullivan takes a similar position to Freidson in that ultimately he argues for the professions to continue to claim their protected economic status within society, as the use of specialised knowledge and skills alone will not provide sufficient legitimacy to the public, but rather the professional will need to demonstrate their socially progressive credentials.

Evetts (2013:788) notes two distinct levels of control exercised by the professions over their practice, which she terms "organizational professionalism", a rational legal bureaucratic concept of managerial control and therefore externally constructed and controlled, and an "occupational professionalism" where professional practice is defined and organised by the

profession and therefore internally defined. Evetts relates these two models to the historical trajectory of the professions shaped by either State control and managerialism and / or professional knowledge, skills and values. When Evetts sometimes conflates these two drivers for professionalism it is clear that this is because they cannot be separated, resulting in a paradox as to the position of the professions. This goes for both the older, more internally constructed professions such as medicine and law and the newer professions, such as OT, teaching and nursing which, although more externally defined, aspire to a cogent internally defined professional identity. Evetts states (2013:787):

> As an ideal-type organizational professionalism is 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 the increased standardization of work procedures and practices and managerialist controls. It relies on externalized forms of regulation and accountability measures such as target-setting and performance review. In contrast, and again as an ideal-type, occupational professionalism is a discourse constructed within professional occupational groups and incorporates collegial authority. It involves relations of practitioner trust from both employers and clients. It is based on autonomy and discretionary judgement and assessment by practitioners in complex cases. It depends on common and lengthy systems of education, vocational training and socialization, and the development of strong occupational identities and work cultures. Controls are operationalized by practitioners themselves who are guided by codes of professional ethics which are monitored by professional institutes and associations.

Similar to Evetts, Muzio et al (2013) suggest that there is tension between managerial practices and the role of the professions and professional autonomy within institutions (whether public, private or independent). However, they go on to say (from many examples and perspectives) that both the traditional professions (e.g. law and medicine) and new managerial type professions should be seen through the lens of the sociology of the professions to understand the process of professionalisation and to identify the role the professions have in the disruption and construction of institutions.

Professional identity

The way professionalism is defined and the language used to describe the professions and their values is axiomatic to professional identity. Language and identity are related to shared values mediated within social, political and cultural discourses (Bucholtz and Hall 2004). In Bourdieuian terms this would be the (individual or group) negotiation of the habitus within fields of practice. Wilding and Whiteford (2008), through a piece of participatory action research with OTs working in an acute hospital environment, found that their reliance on the language of the pervasive hegemonic discourse (that of medicine) had a negative effect on professional confidence and identity. However, this was somewhat addressed through a reengagement with OT focused language and values which was thought to be empowering and promoted their professional identity.

Brown (2015) discusses 'identity work' as a key focus of debate within academia. It is this academic interest that Brown considers crucial to understanding the formation of identity within an occupation or work context rather than from a specific professional context. Brown cogently acknowledges structure and agency as important to the 'reflexive self' in understanding identity formation, the transactional tensions in this process and the way in which identity formation is fluid and dynamic within particular fields.

Structure and agency is also a key theme for Moate and Ruohotie-Lyhty (2014), when discussing teacher education in Finland. They suggest that the development of identity or identities is closely linked to the person's agency within an organisation or organisations and a multi-contextual environment in which agency can, depending on the organisation, be expressed.

Cruess et al (2014) suggest, when discussing medical training in Canada, that teaching professionalism on its own is not sufficient and there is a requirement to help students to understand the process of professional identity formation that they go through during their education and training. Whist making this point they differentiate between the knowledge and skills that are learned and gained during this process which are necessary to bring about the shift in the self, and a socialisation process linked to identity formation which is required to understand the professional application of knowledge and skills and associated professional behaviours. Although Cruess et al do not make reference to the 'reflexive self'

in the process of identity formation it is implicit in what they are saying when they relate the socialisation of a person into a profession to develop their professional identity. They further highlight the challenges this presents for students in the process of moving from one identity to another, of inhabiting different identities but reflexively knowing how to negotiate these identities, which is necessary to becoming and being a professional.

Crigger and Godfery (2014) discuss professional identity formation in student nurses and the way in which this can be demonstrated as ethical virtues, similar to Freidson's assertion. They suggest that identity formation is in some way replacing the focus on professional behaviours in nursing education as a reflexive process of developing a consistent and meaningful approach to the way student nurses respond to their practice. They relate the process of identity formation very closely to what they consider to be the virtues of the nursing profession from which student nurses can learn from their mistakes and go on to develop a cogent professional identity and flourish in their profession.

Sugrue and Solbrekke (2011) also emphasise the relationship between the professional community and a unity of the values and practices as professional 'dispositions' which shape professional identity. They note that this is both a process of identifying with the professional community and its values and a reflexive process to challenge those things that are incongruent with its values. Sugrue and Solbrekke (2011: 192-193) suggest:

> [D]eveloping a professional identity within a professional community necessitates getting to grips with its traditions, its expert knowledge and related skills, while the vulnerability and the professional humility derives from saturating these elements of what it means to be a professional in its various moral commitments and values – you might even say, these values lend unity to professional preparation. Consequently, professional preparation is also about creating a professional identity, as well as creating a professional disposition, a way of being in the world that respects tradition, but also challenges it when it conflicts with professional judgments.

Bell et al (2015:3) note the negative effect that evidence based practice (EBP) can have on professional identity and autonomy. In doing so they discuss patient-centeredness as central to the professional identity of nursing (as with OT practice and identity), whilst noting that it is not valued within EBP and economically driven health care models.

Furthermore, research to understand this construction of nursing professional identity does not appear to value patient-centeredness as central to the nursing identity formation. They assert:

> The whole evidence-based practice movement has been seen as devaluing the complex interpersonal element of the caring components of nursing. That is, the emphasis on evidence-based practice, outcomes-based practice, and quantifiable efficiencies has been seen as ultimately threatening the fundamental "caring" strengths of nursing identity and practice, and the quality and safety agenda.

Gitterman (2014) takes a more nuanced view and argues that the professional identity of social workers in the USA is being pulled in two directions between the art of the profession and interventions based on what he describes as scientific evidence through the utilisation of EBP. He suggests that although EBP should not be literally applied in the transaction between the social worker and the client it can assist practice decisions and should not be rejected out of hand. Gitterman does not, however, evaluate what he means by 'scientific' and 'evidence.'

Health Professional HE Lecturer Identity.

Smith and Boyd (2012), in their study on the professional identity of nurses, midwives and allied health professions (AHPs) lecturers, note the different career trajectories of those who come from professional backgrounds (e.g., health, medicine, education, etc.) and more traditional routes to becoming a HE lecturer. They obtained the views of nurses and AHPs via a survey from which they note that new lecturers find the process of shifting from a practice to an academic identity challenging. In part this tension plays out in the relationship between practice, teaching and research. They note that traditional academic routes into HE tend to require doctoral study and by extension engagement in research which supports an academic focus on a lecturer's identity. In contrast, those from professional groups tend to acquire HE lecturer positions through previous professional experience and expertise. As such, they do not necessarily relate their clinical experience to that of lecturer identity which is centred on being an academic. To understand the way new lecturers navigate these influences on their professional identity in new areas of practice when moving from a role as expert to that of novice they draw on Wenger (1998) and Lave and Wenger's (1991)

theories on communities of practice and legitimate participation. To bridge this gap they suggest that nursing, midwifery and AHP academic departments should support the transition from practice to academic identities through positive modelling to legitimise academic practice.

Hurst (2010) also found when interviewing physiotherapy lecturers that the transition into academia challenged their practice based identity which they tended to favour over an academic identity. However, the physiotherapy lecturers recognised the requirement to engage with and become proficient in the academic roles of teaching and research, fulfilling competencies that embrace both HE and HCPC requirements. Hurst notes this as a form of dual identity which is formed within a community of practice but which requires departmental support for a successful accommodation of both clinical and academic practice identities.

Macfarlane and Hughes (2009) also note the challenges of developing an academic identity for lecturers who are on teaching focused contracts in HE. They emphasise the separation between teaching and research which exists alongside the expectation from universities of lecturers on teaching contracts to become more research active. They suggest that synergies between teaching and research can be developed in the form of, for example, research-led teaching as a way of bridging this gap whilst managing workloads where lecturers can develop 'hybrid' identities.

OT professional identity

The above strongly suggests that professionalism and professional identity are bound up in many conflicting and competing structures. Within these structures it has been noted that OT's find it difficult to articulate what is unique about their profession and what they do (Creek 2003; Ikiugu and Rosso 2003; Mason 2006; Mackey 2007; Clouston and Whitcombe 2008; Rudman and Dennhardt 2008; Wilding and Whiteford 2008; Edwards and Dirette 2010; Turner 2011; Turner and Knight 2015). Therefore, attempts to define what an OT professional identity is, or might be, remain problematic (Creek 2003; Mason 2006; Davis 2006; Rudman and Dennhardt 2008; Turner 2011; Turner and Knight 2015).

Turner (2011) and Turner and Knight (2015) argue that the profession of occupational therapy has reached what equates to its 'adolescence' as a new profession and is moving to

'early adulthood', and put forward suggestions as to what occupational therapy needs to do to develop to full maturity and therefore to a full professional identity. Edwards and Dirette (2010), when drawing on data from a large sample of occupational therapists across one state in the USA, argues that occupational therapists struggle to define themselves in the workplace, leading to increased stress through the lack of professional validation, which in turn is linked to an unclear professional identity. Clouston and Whitcombe (2008) discuss the location of professional power as limiting how occupational therapy is defined and understood, whilst Mackey (2007:95), when using Foucault's theories on power and discourse, suggests that the profession's relationship with the State is not neutral and can run contrary to professional values, which need to be to the fore in the therapeutic relationship. Mackey calls for "a new kind of identity, a new conception of self," to address new ways of working that occupational therapists face within ever changing health and social care services within the UK. Kinsella and Whiteford (2009) argue that the epistemic values of OT are at odds with the neoliberal discourse which prefigures positivist approaches to evidence based practice (EBP), which denudes any meaningful critique of the dominant positivist epistemology. Paterson et al (2005) attempt to understand the way in which professional artistry is situated within OT practice and which values are attributed to a process of decision making which draws together aspects of professional identity, skills and knowledge. Molineux (2011) asserts that OT's need to be clear about how their professional values relate to practice, underpinned by a clear body of knowledge. Fortune (2000) is concerned with a lack of cohesion between OT practice and its philosophy, resulting in what OT is and what OTs do being defined by others as a set of skills used to fill gaps within health and social care provision. Fortune suggests that for this to change there needs to be a clear relationship between professional philosophy and practice to ensure a clear and cohesive professional identity. OT lecturer identity is not prevalent in the literature except for one mention by Frank (2012). She comments on the formation of occupational science as an academic discipline and its relationship with OT practice which highlights, somewhat uniquely, the dual role of academics and clinical practitioners which potentially brings about different professional identities.

These perspectives on OT professional identity need to be seen within the context of changes to working practices borne out of neoliberalism and EBP. The relationship between

the OT profession and neoliberalism is discussed below but first the broader context within which neoliberalism is influencing approaches to health and social care will be discussed.

Neoliberalism and health and social care

Neoliberalism is driving changes to health and social care policy in the UK and is therefore one of the main structural influences on professionalism and professional identity. It has been the predominant global economic force since the 1980s, championed by the governments of Margaret Thatcher in the UK and Ronald Reagan in the USA (Paton 2014; Steger and Roy 2010; Harvey 2005). Paton suggests that neoliberal policies towards health care fit into two areas. Firstly, 'arational' policies which are driven by short term political expediency to favour government policy and secondly, policies which are ideologically driven irrespective of evidence to support their efficacy. Paton (2001) has also discussed neoliberalist policies towards the NHS as a way of disenfranchising the public via the decentralisation of the State and reduction of its investment in public services such as the NHS. Either way these neoliberal policies prioritise the deregulation of the state to maximise opportunities for private capital. In doing so the emphasis is on concepts of freedom and choice, whilst curbing the freedoms of certain groups e.g. unions, professions, minorities etc. to maximise exploitation and minimise opposition. (Paton 2014; Eliason 2015; Steger and Roy 2010; Harvey 2005; Bourdieu 1998). Eliason (2015:2) places neoliberalism at the forefront of health-related policy when he asserts:

> Neoliberalism is the primary ideology driving our government, economy, and health care delivery today. It involves an erosion of government regulation and funding of health and human services and replaces government funding and oversight with a private market economy.

Further to this Paton (2014) asserts that this fragmentation of services has not led to any significant improvements with the one possible exception of reduced waiting times at the start of the 21st century under New Labour. Cooper et al (2010) et al also claim there is an indication of lower mortality rates which they associated with increased competition within

the NHS. Paton notes, however, that it is the choice offered through the NHS internal market that has led to some improvements and not the involvement of the private sector.

However, the level of competition for the delivery of health services has been taken further in England with the implementation of the Health and Social Care Act (2012) which encourages third and private sector health and social care providers to compete directly with the NHS. This is an extension of the internal NHS market to bring about direct competition between providers (Paton 2014; Pownall 2013; Speed and Gabe 2013; Millar 2011). Pownall (2013), when discussing the effects of the 2012 Act, suggests that it is a resurgence of neoliberal policies designed to fragment the NHS through increased competition from the third and private sectors in the delivery of health and social care. In doing so Pownall asserts that the workforce faces a high degree of uncertainty in where and how they will work whilst any benefits to the public are unclear. However, these changes have not gone completely unchallenged and there have been some safeguards put in place to ensure that the private and third sector organisations bidding for NHS services are qualified to provide those services (BMA 2016).

Some of the effects of these policy changes on health and social care professions are noted by Eliason (2015) when discussing the nursing profession. He prefigures the neoliberalist focus on individualism and individual responsibility for good health which is devoid of social context and need. This results in a health industry that profits from the latest drug, piece of equipment or health trend but which does not focus on preventing ill health caused by inequality and / or discrimination. He frames neoliberalism within health care as divisive of community and family life in favour of perceived individual gain which ultimately benefits large corporations.

On a global scale Navarro (2008 and 2007) suggests that the World Health Organisation (WHO) is not sufficiently challenging the neoliberalist policies of countries such as the USA and UK; policies which result in poverty and therefore are not living up to some of their key principles on the causes of ill health associated with social injustice. Navarro (2007) reviewed a range of evidence to conclude that there is overwhelming evidence supporting the view that inequalities (and these are attributed to neoliberalism) lead to poor health outcomes. This assertion is further supported by Pickett and Wilkinson (2010) in their extensive piece of social epidemiology in which they conclude that health outcomes are

poorer for all members of society in those countries (e.g., the UK and the USA) with the greatest discrepancies between wealth and poverty. Mooney (2012) reflects on the criticisms made by Navarro about the WHO's willingness to accept neoliberal economics as a way of funding world health projects. He goes on to say that the very basis of neoliberalism with its focus on consumerism and individualism results in high levels of mortality and morbidity in the world. To counter these, he argues that there need to be community based initiatives that involve the public in real decision making. Mooney (2012:383) says:

> …if global health and global inequities in health are to be improved, another form of political economy must be found-one based on community values rather the individualistic values of neoliberalism.

McGregor (2001) similarly describes neoliberalism as based on individualism, decentralisation and deregulation of the State in favour of privatisation and a free market. She goes on to say that policies based on these neoliberal principles cannot deliver fair and effective health care and, similar to Mooney, she offers an alternative based on community rather than individualist values. McGregor also touches on the use of neoliberal language (e.g., cost effectiveness, efficacies etc.) which presents these policies as rational within a market based economy. Labonté and Stuckler (2016) discuss the discourse of free market rationalism when they draw on a range of evidence to argue that the neoliberalist policies which led to the global economic crash in 2008 are continuing in the form of 'austerity' and this is having deleterious effects on global health. They further argue that the economic case for continuing austerity is not justifiable and that socially progressive policies and taxation will not only provide better services but also increase economic growth.

Giroux (2005, 2004), in a comprehensive critique of neoliberalism, gives his opinion on the way neoliberalism is undermining the social contract between taxation and public services. He also contends that neoliberalist policy in education constrains and devalues critical pedagogy in favour of commoditised skills and knowledge. Alfred et al (2007) make similar points when they discuss the effects of neoliberalism on access to adult and higher education with the increase in tuition fees restricting access to higher education for mature

students. Although the evidence they draw on to make their arguments relates to the USA, similarities can be drawn with HE in the UK where education is becoming commoditised. This is most notable in the recent changes announced by the UK Government to the way in which health students' education will be funded (Department for Health 2016).

Neoliberalism, evidence based practice and managerialism

The neoliberal agenda has been central to NHS reforms, increasing the presence of the markets whilst replacing professional values with a 'pick and mix' approach to utilising and commoditising skills and competencies (Paton 2014; Copnell 2010; Davies 2003). This continuing shift towards marketisation of health and social care services currently provided by the NHS or local authorities portrays these policy changes as rational approaches to economic management (BMA 2016). It is also suggested by Speed and Gabe (2013) that the decentralised State leads to increased state regulation and decreased professional autonomy as the focus shifts from one of professional values to marketisation and managerialism. The commoditising of the professions such as OT runs in parallel with an EBP movement and the disempowerment of health professionals (Speed and Gabe 2013; Sullivan 2000) derived out of the relationship between neoliberalism and externally derived competencies and regulation. Knowledge based on statistics from outcome measures is preferred as it is more easily translated into claims of effectiveness of service provision (Paton 2013; Kinsella and Whiteford 2008). Although it has been argued that some professional groups have held too much power and are not always representative of the populations they serve (Dingwall 2008), it has also been argued that the loss of professional agency will lead to a decrease in the ability of professions, such as OT, to challenge policy that runs contrary to the profession's values whilst simultaneously 'decentring professional agency, knowledge and skills required for a cohesive professional identity' (Clouston and Whitcombe 2008; Copnell 2010).

Harlow et al (2013:536) compare the effects of managerialism derived from neoliberalism on social workers in the UK and Sweden and suggest that "managerialism may be a means of making material the ideology or discourse of neoliberalism", which in turn will lead to reconfiguration of social work services to be more focused on generic and tradeable skills rather than professional values and autonomy. They give the example of evidence based

practice and policy which further disempower professional judgement and have "given rise to questions concerning the construction of social work and its epistemological underpinnings… [where] the application of positivist principles to the generation of social work knowledge is alien to a practice that is socially constructed." (Harlow et al 2013:542-543). However, similar to Kinsella and Whiteford (2008) they note some limited benefit from EBP due to increased funding. They also note that the regulatory framework within the UK which makes 'social worker' a protected title offers some certainty regarding work roles. However, they argue that in both countries there is 'resistance' to managerialism and the reconfiguration of the social work profession to be focused more on skills than values. Upton et al (2014), in their review of OT literature on the uptake of EBP, find that OTs can have difficulty in implementing EBP due to a lack of time and a lack of access to and knowledge of research. They also note that some OTs are resistant to EBP as they see it as undermining key professional values such as client-centred practice. However, Upton et al discuss these findings as mechanistic barriers to EBP without any significant critique of managerialism and the drivers behind EBP. These findings are similar to what Samuelsson and Wressle (2015) found in a study involving Swedish OTs.

Neoliberalism and OT

The views on neoliberalism discussed above affect the delivery of health and social care and as such OT practice. The way OT lecturers understand and respond to this is central to the shaping of their professional identity. Clouston (2014) finds, from interviewing occupational therapists, that there are links between difficulties in obtaining a good work-life balance and a neoliberalist managerialism and market based culture. For Kinsella and Whiteford (2009) this results in managerialist approaches to working with professionals, such as OTs seeking 'approval', and therefore not sufficiently critiquing the effects of neoliberalism on their work, their colleagues and clients. Thibeault (2006) asserts, in relation to OT values, that the OT curriculum taught to students within higher education should promote students' ability to critique neoliberalist policies. However, as those universities are also caught up in the neoliberal agenda through the marketisation of education there is a clash between OT values, the teaching and learning of students and the expectations of students and higher educational institutions (HEIs). For Galheigo (2011), OT's ability to critique neoliberalism is

essential when addressing human rights issues that either arise from or are not considered economically worthwhile within neoliberalism.

Rudman (2013) discusses the role of occupational science in challenging the way the neoliberal discourse promotes the individualisation of occupation through 'enacting the critical positioning of occupational science'. In doing so she builds on her own findings in Rudman (2010) where she highlights how some health related behaviours and occupations (activities and ways of doing) are seen as deviant within the neoliberal discourse. In Farias and Rudman (2016) this is taken further to make links between neoliberalist restructuring of retirement to focus on individual responsibility and the purging of the State's responsibilities in ensuring adequate fair resources to those entering retirement. Similarly, Lo Bartolo and Sheahan (2009) discuss the neoliberalist discourse being dominant within the Australian work policy and refer to the 'Work Choices' scheme. They go on to argue that, through a critical analysis of neoliberalism, an alternative discourse can be formed to promote occupational justice.

Frank (2012) agrees that OTs need to critique social issues and notes that, as occupational science emerges as a discipline, its focus is increasingly on developing a critical discourse on occupational justice and related concepts. However, Frank is not completely dismissive of neoliberalism and suggests that some opportunities have arisen from the decentralised State which have prompted the development of "transnational identities and networks" enabling global collaborations.

It also noted that the increasing role of the market within health and social care provision provides opportunities for the profession to sell its services. The emphasis on 'selling' OT is resulting in a shift in the teaching and learning of students with an emphasis within OT curricula on leadership and entrepreneurial business focused skills (Clouston and Whitcombe 2008; Turner 2011) with OTs increasingly employed within the third and private sectors. However, OTs are being encouraged to accept the neoliberal discourse as normative and a 'natural and rational' approach without any critique of what this actually means (Kinsella and Whiteford 2008 Wilding and Whiteford; Paterson 2005). It might also mean a change to the teaching and learning of students, where entrepreneurial and business focused skills shift the emphasis from serving the public to selling to the public.

Knowledge, neoliberalism and evidence based practice

Over the past twenty or so years OTs have been attempting to develop a more congruent body of knowledge through the ownership of the term 'occupation' within the discipline of occupational science (Frank 2012; Molineux 2011; Wilcock 2006). As a relatively young profession, OT strives to be accepted within the hierarchy of medical science and to communicate to government and the public within the current accepted notion of research and evidence based practice. However, OT is increasingly defined by and understood through sociologically focused paradigms within the discipline of occupational science. This is an emerging body of knowledge more closely related to the profession's ontological nature which emphasises a social and culturally responsive approach to health (Frank 2012; Hocking 2008; Clouston and Whitcombe 2008; Kinsella and Whiteford 2008).

This tension between different ways of knowing is most notable in the interpretivist turn through the 20th century seeking to put human experience at the centre of knowledge and to reject reductionism (Kinsella and Whiteford 2008; Crotty 1998). This has presented challenges to researchers using competing and different paradigms and has been a feature of knowledge construction (Kuhn 2012) but is now playing out within a market based rationalism rather than one of discovery and knowledge for the sake of knowledge. Hocking (2008) notes the ontological challenge this has for OTs when discussing the history of OT, veering between and occasionally converging around 'rationalism' and 'romanticism' through the twentieth and into the twenty first centuries. She notes the ontological leanings of OT towards romanticism and the therapeutic use of craft as subjective and transformative process. Hocking sees this as in contradiction to the rationalism of scientific measurement, which has directed OT practice interventions that aim for specific products aligned to evidence based practice against which they are measured. She notes the attempts to reclaim some of the art of OT as located within a body of knowledge which values different ways of knowing and subjective experience. Overall she claims that this tension between 'rationalism' and 'romanticism' has had a direct effect on the profession's body of knowledge and identity.

As part of the development of the OT knowledge base Farias and Rudman (2016) identify that occupational science is going through a process of inward critique to establish its

credentials as an academic and professional body of knowledge, and that now this inward focus is turning outwards to apply critique of social injustices through the lens of occupational science. This they consider necessary, in order for occupational science not to be framed as a value free science but one concerned with the political and social.

The above suggests a sociologically focused direction of the OT body of knowledge which is epistemologically based on subjectivism or constructionism. However, the EBP movement and the influence it has on the types of knowledge produced is pervasive. Kinsella and Whiteford (2009) suggest that the growth of EBP is a rejection of the interpretivist turn (which seeks to critique hegemonic power) in favour of reductionist and standardised approaches to the management and delivery of health and social care which are directly influenced by neoliberalism. They further suggest that EBP challenges the knowledge base upon which an OT epistemic community is based. Kinsella and Whiteford (2009:254) assert:

> The issue at stake, however, is that evidence-based practice is, as we have argued earlier with respect to theory choice and knowledge development in general, not value free. Rather, evidence-based practice as it is generally framed and understood is underpinned by value judgements about both what constitutes evidence and which kind of evidence is 'best', irrespective of context or application. So, given that different types of evidence are generated from different knowledge paradigms, in effect this means that particular knowledge paradigms, for example, technical/rational/empirico/deductive, are accorded more status than others, for example, interpretive/critical/experiential/inductive. The formal representation of this value judgement with respect to knowledge paradigms and epistemic traditions is through the creation of hierarchies of evidence.

There is a tension, which is reflected more broadly in the literature, between knowledge based on interpretivist approaches and advocates of EBP. Those who favour EBP present evidence as a hierarchy of data which places meta-analysis of randomised controlled trials at the top and more qualitative ways of knowing at the bottom, without any cogent consideration of the context in which data has emerged and the ways in which this data is interpreted and turned into knowledge (Kinsella and Whiteford 2009; Hammersley 2013). Positivistic paradigms frame ways of knowing as statistical data presented as 'fact', rejecting more subjective knowledge as biased and unreliable (Hammersley 2005). For Hammersley it

is not possible, nor should it be desirable, to separate out the generalised application of research from practitioner judgment on the value of evidence to specific areas of practice. Gabbay and Le May have, through an ethnographic study with GPs (who might be thought of as more scientific in approach), similarly noted that any application of EBP will need to be mediated within the context of their practice. Beck and Young (2005) suggest that the narrowing of evidence through the regularisation (similar to EBP) of knowledge production is leading to a de-professionalisation of the professions, with specific reference to academics, which is related to managerialism and a tick box approach to knowledge production and student satisfaction. For most authors this is not a rejection of different types of evidence and the knowledge produced, but the decontextualisation of evidence, and the way in which quantitative evidence is used to beguile professions into accepting such approaches as the pinnacle of evidence through a misleading assertion of objectivity, the suggestion being that anything which is not scientifically rigorous is subject to bias and lacking in credibility. However, the very methodological rules followed to ensure this type of rigour lend themselves to particular types of interpretation and therefore bias. Various authors comment on this and suggest that it is the reflexive acknowledgment of bias which is important, not one methodological rule superseding another (Kinsella and Whiteford 2008; Hammersley 2005; Bourdieu 2004).

Kinsella and Whiteford (2008) note the epistemological differences between the paradigms favoured within EBP and those of OT. They go on to suggest that EBP is difficult for OTs to resist as jobs, funding and professional credibility can depend on its application in a world of neoliberalist informed policy and regulation. However, they note that a form of 'underground rejection' of EBP, and its consequent removal of professional autonomy, is occurring. This rejection brings together different paradigms and ways of knowing interlinked with professional artistry which they refer to as a 'wise practice'. In some way this is OTs responding pragmatically to the relevance (or otherwise) of what they know about the specific contexts and environments within which their practice occurs and an emerging eclectic body of knowledge based on occupational science which can provide a space for a diverse critical discourse. Here Kinsella and Whiteford take forward the argument given by Paterson et al that professional artistry and the types of knowledge valued by OTs are essential to OT professional identity and should not be side-lined by positivist approaches to EBP and knowledge. As noted below under 'Habitus', knowledge

and how this is constructed and valued is intrinsic to professional identity and to what some authors have described as a 'professional habitus' (O'Conner 2007; Artaraz 2006; Houston 2002).

Theoretical context

A few authors have explored the topic of OT professional identity through other theoretical perspectives. Coulston and Whitcombe (2008) argue that external and historical social constructs have mostly defined OT, with a focus on post-modernism; Mackey (2007) attempts to use Foucault's ideas on power, discourse and reflexivity to understand how OT identity can be developed through a more effective discourse; Reid et al (2008) discuss how professional pedagogy in higher education develops professional identity and draws on some of Wenger's (1998) ideas of trajectory and communities of practice, as does Davis (2006) when identifying how communities of practice can support or hinder OT professional identity. Turner (2011) loosely applies theory derived from Erikson on psychological growth and the development of the growing person to suggest that OT as a profession and therefore its professional identity is in late adolescence and Mason (2006), in an unpublished doctoral thesis, relates her study to the power of the professions and applies symbolic interactionism as an analytic tool to understand OT professionalism. I believe that using a theoretical framework derived from Bourdieu as a way of understanding structure and agency relationships across three fields of practice will provide new professional insights into the professional identity of lecturers and possibly OTs in general.

Bourdieu

Bourdieu's writings on practice have clearly set a theoretical benchmark from which we can understand the way in which agents are influenced by and influence social structures through a reflexive understanding of their position within these structures. For Jenkins (1992:68) "the importance of Bourdieu's project lies in his attempt to construct a theoretical model of social practice, to do more than simply take what people do in their daily lives for granted and to do so without losing sight of the wider patterns of social life." It is also important to note that Bourdieu was attempting to forge a space within the discourse of anthropology and social science between existentialism and structuralism and between

objectivity and subjectivity from which we understand how practice is formed and forms. Jenkins (1992:18) goes on to say:

> In these two movements - reactions to Sartre and existentialism, on one hand, and Levi-Strauss and structuralism, on the other - lie the roots of Bourdieu's attempt to overcome the 'absurd opposition between subjectivism and objectivism'. This he regards as key and the ultimate dualistic category which structures and organises social science and, at the end of the day, the root of social science's inadequacies. As a principle framing sociological and anthropological thinking, this opposition derives further force from its affinity to common-sense notions about the nature of the social world.

Bourdieu's approach is an ontological 'third way' of doing and becoming, where the nature of being is an interaction between the material world and individual interpretations and actions within that world. As a way of understanding this interplay and how it shapes and is shaped Bourdieu employed the analytic concepts of Habitus, Field and Capital to the transactional processes that individuals engage in when carrying out various forms of practice.

Habitus, field and capital

Habitus is the all-encompassing contextualised and ritualised space we inhabit (Bourdieu 1998; Grenfell 2012). It is a space that is made up of manifold implicit and explicit ways of doing and expressing oneself and which carries with it different types of capital e.g., social, cultural, economic and, relevant to this research, professional. The habitus therefore is not a fixed cultural and social set of actions within a particular time and place but spaces and environments that are dynamic places of enculturation inhabited and changed by those living and acting within them (Maton 2012). It structures the individual's ways of doing but is also structured by those participants as reflexive individuals as "the crucial mediating link between a series of dualisms often portrayed by other approaches as dichotomous, and brings together the existence of social regularities with the experience of agency" (Maton 2012:54).

Habitus exists within the concept of 'field' and it is "the field [which] mediates what agents do in specific social, economic and cultural contexts" (Thomson 2012:73). The field is a

contextualised area of practice and mode of production and particular dispositions (Bourdieu 1998). The ability to move across fields successfully necessitates a reflection on the habitus structured ways of doing and being. Bourdieu was mostly concerned with practice as a thing we do implicitly as an expression of the habitus but also explicitly and formally as a practice within a professional field.

Professional habitus has been discussed by several authors as a way of understanding how professional identity is structured by particular types of knowledge and practices. O'Conner (2006), in nursing education and training – although using a perspective derived from the works of Basil Bernstein, locates professional habitus as central to identity formation in the negotiation of roles within the 'apprenticeship' models. Artaraz (2006) draws more classically on Bourdieu to understand the problems of an emerging professional habitus of Connexions workers, made up of a range of social work type professions, and the bureaucratic structures through which habitus is being formed and mismatches created between existing habitus. Houston (2001) uses Bourdieu to understand how social workers can become more reflexive, culturally sensitive and responsive in their practice.

In doing so he describes the relationship between habitus, field and capital and notes that the professional habitus of social work should not constrain but enhance the profession's ability to understand and respond to social and cultural inequalities.

Other studies have identified the way educational habitus and related fields of practice have been theoretically applied. Colley et al (2003) refer to vocational habitus when looking into the reasons why students 'choose' and achieve in vocational education and training (VET) courses. In doing so they apply Bourdieu's concepts of habitus and field to understand the structure and agency relationship between 'vocational habitus' within nursery nursing, health work and engineering and the social and cultural relationships of students taking up these courses (e.g. the gender stereotyping of occupations which results in more females going into nursing then males). They suggest that this evolves as a process of co-constructed identities developed within and between the vocational habitus and individuals' expectations in response to social norms or beliefs. Further they suggest that there is a process of re-structuring of the vocational habitus and the individual's beliefs as they move into the vocational field that opens up choice (i.e., more females going into engineering) and that an accommodation of this process should be part of the VET curricula. Hardy (2010)

when doing research with teachers in Australia identifies a tension between a teaching habitus, which is expressed through dispositions of student centred and collaborative working and a habitus of professional development workshops structured by neoliberalist managerialism. He suggests that there needs to be a more reflexive approach taken by those who develop and design these workshops to understand the teaching habitus which is central to the teacher's identity.

The interaction between habitus and field, and according to Grenfell (2012:100) whether these are "well formed" or not, enables or constrains types of capital which are the cultural, social and economic resources and displays of 'power' reproduced and obtained within particular fields. Bourdieu related these to symbolic capital and 'symbolic violence' which we discern today as displays and expressions of cultural and social elitism but which are also bound up with human expressions of identity and displays of perceived success. Professional capital is a way of displaying status and ownership of types of practice which develop and shape professional identity. The habitus may dictate certain displays of capital, however a reflexive understanding of one's habitus and the ability to relate these abstract notions to real areas of practice, which are professionally meaningful within and across fields, empowers individuals to move between fields and be successful in various areas of practice. In so doing the individual will take with them various forms of capital and will acquire new types of capital (Bourdieu 1998). This 'change' might, however, be at the expense of the previous ways of doing and forms of capital. The exchange of capital is noted by Watson et al (2009) in their study on the backgrounds of pre-registration OT students. They found that forms of capital become real and relevant as they are acquired, disposed of and exchanged, with lesser or greater degrees of success, by students engaged in the process of professional education and training. Therefore, accepted professional capital accumulated through education, training and practice forms the basis for the professional habitus. In this respect and according to Grenfell (2012:103) "The institutionalized form of capital (formal education), to varying degrees for different groups, attempts to inculcate (to make embodied) a habitus, the principle of which is congruent with the dominant principles of the various fields in which capital exists in its objectified forms."

Structure and agency

The movement between fields and the transactional process of capital as an expression of habitus sit within the sociological convention of structure and agency and the ongoing debate on their relative influence on social practices. (Archer 2003; Bourdieu 1998, 1990, 1977; Giddens 1984). Structural forces can determine outcome and are therefore to some extent measurable and reducible (e.g., genetic, social, cultural). Agency is the ability to influence by our actions and the conscious reflexive ability to own those actions which are individualistic, context specific and interpretative.

Bourdieu's concepts were clearly based on the relationship between structure and agency and the agent's ability or otherwise to act within certain structures, although probably not to fundamentally change them. Bourdieu talks about how we as actors/agents can stand back reflexively to understand the roles we have and can take on within structuring structures. The reflexive individual is able to move across 'fields of production' (and its structuring habitus) by reflecting on their history to understand their nature, and therefore adapt behaviour accordingly (Bourdieu 1990). Other writers, for example, Anthony Giddens (1984) and Margaret Archer (2003), have also been central to this sociological discourse of human action. Giddens does not consider the interplay between structure and agency as a simple duality but rather a fluid interaction between these forces across time and space which he calls 'Structuration' and which frames structure and agency as complex and mutually reliant interactions. Archer understands actors as personality types who develop an internal conversation as a personal negotiation around structure and agency in ways which are not reducible to either but move the individual towards their particular roles and goals. What is important within all these concepts is not just that humans can and do take action but the theory that such action will be shaped, mediated and will occur, implicitly or explicitly, within overlapping structures, although one structure might be more dominant at any given time relative to the context within which that action occurs. The extent to which a structure is influential in determining which action is taken is difficult to ascertain but it will vary depending on many social, cultural, political, environmental and biological factors. It is clear, however, from authors such as Pierre Bourdieu, Anthony Giddens and Margaret Archer that the relationship between structure and agency is not a simple duality of

opposites and that human behaviour, social interaction and identity are not simply reducible to either of these.

It is the reflexive relationship between structure and agency and an understanding of the habitus and its effects on the nature of being within a field of practice which can result in a mutually recognised and cogent professional identity. Professional capital successfully carried across fields of practice contributes to a cohesive professional identity recognised by those within those fields as the social and cultural capital of the profession. The habitus of those within these fields is simultaneously inculcated by the structure of the field (and the influences on it, and within it) and the actions and agency of the individuals within it. Bourdieu (1998:32-33) describes this thus:

> …as a field, that is, both as a field of forces, whose necessity is imposed on agents who are engaged in it, and as a field of struggles within which agents confront each other, with differentiated means and ends according to their position in the structure of the field of forces, thus contributing to conserving or transforming its structure…[however], the symbolic work of constitution, or consecration that is necessary to create a unified group (imposition of names, acronyms, or rallying signs, public demonstrations, etc.) is all the more likely to succeed if the social agents on which it is exerted are more inclined, because of their proximity in the space of social positions and also because of the dispositions and interests associated with those positions, to mutually recognize each other and recognize themselves in the same project.

Summary

In this chapter I discussed what constitutes a profession and the way in which professions are internally and externally defined. Key areas of professional knowledge, language and values were noted as important in the development of professionalism and therefore professional identity. To frame this theoretically, professional identity and professional habitus were detailed from a Bourdieuian perspective to understand the relationship between structure and agency, fields of practice and types of professional capital.

OT professional knowledge and values were noted as one of the main areas of tension with authors commenting on the importance of OT's projecting a clear professional identity and

differentiating the profession from hegemonic paradigms dominant within evidence based practice. The requirement for OTs to clearly locate occupational therapy within a body of knowledge that both theoretically and practically understands occupation as a concept in relation to occupational therapy practice was highlighted. These developments were placed within the broader context of neoliberalism, EBP and managerialism to note the changes to working practices and the effects of these on professional autonomy. Most authors were critical of neoliberalist policies. This might be because of the deleterious effects of neoliberalism on the delivery of health and social care and the values of professions such as OT, but it might also be that as the dominant economic driving force it is subject to a high level of criticism. Several theoretical perspectives from which OT professional identity has been understood were discussed, however, these all focus on OTs in clinical practice rather than in academia therefore there is a gap between what is generally understood across the profession and the specific views of OT lecturers.

This all suggests that there are gaps within knowledge and that further understanding is required on the structuring of OT lecturer professional identity within its professional habitus; the way in which this professional identity and the whole profession is being pulled in different directions by tensions between its emerging knowledge base, its professional values, neoliberalism and EBP. This is further linked to changes in working practices, and how these are played out within the fields of representation, regulation and higher education and what this means for approaches to teaching and learning. Therefore, the aim of this study is to understand the contemporary factors structuring OT lecturer professional identity within the three fields of representation, regulation and higher education linked to neoliberalism, EBP and emerging disciplinary knowledge discourses and the implications these factors have for the teaching and learning of students.

The research questions are:

- In what way are the contemporary factors of neoliberalism, evidence based practice and disciplinary knowledge, represented within the three fields, shaping the professional identity of OT lecturers?
- What is the tensions between these factors and OT professional values and knowledge?
- What are the implications of the above for OT lecturer identity and what might this mean for approaches to teaching and learning?

In the next chapter I will detail how I designed my methodology and the methods used to meet the aim of this study and answer the research questions.

Chapter 3: Methodology and Methods

This chapter will outline the methodology and methods I used to answer the research question and address the associated research aims. It details the way in which I understand the data within a constructionist / interpretivist epistemology and theoretical perspective congruent with the broader theoretical framework based on Bourdieu's approach to structure and agency. It details the method of a narrative inquiry used to construct my approach to gathering this data and thematic analysis used to code and organise the data. It also outlines the considerations of doing insider research and the importance of a reflexive positionality. The application of research ethics is discussed.

Methodological approaches

It is important that the evidence obtained is credible as research and therefore reflects the phenomenon under investigation. There are many methodologies and associated methods that researchers can and do apply to achieve credible results. These tend to fall into two main paradigms: quantitative and qualitative, although there are mixed approaches which tend to be based on pragmatic rather than philosophical foundations (Pring 2000). The application of a chosen methodology and methods should be determined by the practical considerations of the subject that the researchers are attempting to understand, and the philosophical perspective which guides the methodological approach. This is because to choose a particular methodology is to say something about the way in which we make sense of the world and subsequent knowledge claims (Crotty 1998; Pring 2000; Yates 2005). This then becomes a question of epistemology. Therefore, in order for research to be credible it must be set within a methodology which is epistemologically congruent with the area of study; so to measure difference and determine cause and effect relationships will produce different knowledge than to understand human perspectives and experiences (Crotty 1998).

Philosophically, positivism (a belief that the world is what it is outside of individual experience and any one interpretation); constructionism (that knowledge is based on intersubjective co-constructions and interpretations of the world); and subjectivism (an individual's own interpretation and meaning of their experience) are ways of interpreting, understanding and obtaining knowledge of the world which sit within and are contrasted by

quantitative and qualitative paradigms. Quantitative (positivist paradigms) use methods which seek objective outcomes by describing and measuring difference in order to test hypothesis about the world to ascertain facts. Qualitative paradigms are theoretically tied to human experience as unique and / or interconnected, changing and constitutive and will therefore demand certain methodological approaches (Denzin and Lincoln 2011; Crotty 1998). Qualitative methodologies therefore tend to be concerned with understanding individual or group human experience and the uniqueness of that experience which is not necessarily reducible to cause and effect relationships. In order to make claims about the world, qualitative researchers will present human experience as contextualised accounts from which similarities and contradictions can be presented to understand the interplay between individuals and / or groups and their environment. Whichever approach is taken, all research will differ depending on the context in which it is carried out, the aims of the research and those involved in the research process, namely the researchers and research participants. For Crotty this makes all research unique and informs us about the ways in which this can be done whilst attaining credibility as research through a clear articulation and application of research conventions and theory. Crotty (1998:13-14) asserts:

> In a very real sense, every piece of research is unique and calls for a unique methodology. We, as the researcher, have to develop it […] Yet a study of how other people have gone about the task of human inquiry serves us well and is surely indispensable. Attending to the recognised research designs and their various theoretical underpinnings exercises a formative influence upon us. It awakens us to ways of research we would never have otherwise conceived of. It makes us much more aware of what is possible in research.

Theoretical perspectives and the philosophical stance underpinning a methodology are not always evident in research but these are the keystone upon which sound interpretation of data should be based. According to Gulson and Parkes (2010), theory offers a robust and logical basis from which to locate and interpret findings to produce good knowledge. Ball (2010) suggests theory is necessary to research as a device to problematise questions that are both robust and reflexive.

My research is focused on human experience within organisational constructs, that is to say, the fields of regulation, representation and higher education. I have employed a qualitative

methodology and methods to gather and interpret data underpinned by a constructionist / interpretivist epistemology within a theoretical framework based on Bourdieuian understanding of structure and agency, as detailed in the previous chapter. Epistemologically this reflects the position that knowledge is constructed and co-constructed through intersubjective (Scott and Usher 1998) interactions of individuals with the material world through which their experience of those interactions results in co-constructions of meaning and meaning making, where "both subject and object contribute to the construction of meaning" (Crotty 1998:9). This is interpretivist in the sense that all data is not value free and therefore requires interpretation through the medium of language for knowledge to be constructed (Crotty 1998). I have used a narrative inquiry approach to gather 'stories' from participants via conversational semi structured interviews and organisational documents that represent these three fields. Thematic analysis was applied to these sets of data and understood within the theoretical framework.

Narrative research allows for different analytical methods to be employed and this methodology is consistent with that. Riessman (2008:17) notes "readers can expect narrative analysis to take diverse forms precisely because investigators rely on diverse theories and epistemologies." Chase (2011) suggests that stories are a reflection of diverse viewpoints, beliefs, values and agendas. The very notion of having several analytical lenses which might represent one epistemology or another in conjunction with a theoretical framework should not devalue either the narrative account or the co-construction of knowledge between the narrator and researcher, but should allow a robust and pragmatic contextualising of narrative that allows conclusions to be drawn based on what is happening. The mix of approaches, if applied coherently, should aid the credibility of the research.

Riessman (2008) further comments on the position of narrative inquiry as having a long tradition in ensuring the 'validity' of research. She highlights the use of narrative inquiry in both the natural and social sciences from which relationships to wider populations can be made from a theoretical standpoint rather than through statistical determinism. The knowledge produced becomes transferable to a wider group in ways that are both trustworthy and have what Riessman describes as 'validity', but which in a qualitative methodology is better described as credibility.

Further to this Riessman (1998:17) notes: "[t]he professions, too, have embraced the idea of narrative, along with investigators who study particular professions - law, medicine, nursing, education, occupational therapy, and social work" as a way of providing credible and meaningful evidence. Chase (2011:2) suggests that this credibility extends into "…narrative [as] meaning making through the shaping or ordering of experience..." [and which] "like qualitative research generally, narrative research often critiques cultural discourses, institutions, organizations, and interactions..." (Chase 2011:430).

The interviews – sample, recruitment and construction

To obtain the interview data I chose to gather a purposive sample of OT lecturers working in two UK universities. I obtained consent from the head of the OT departments within these universities to contact potential participants. The two universities were chosen to obtain a slightly wider range of views than would be possible from a single university. Ethical approval for this research was applied for and granted by the Ethics Committee of the University of Nottingham's School of Education (see below under 'Ethics'). I obtained permission from the respective Heads of the OT departments to contact staff using a staff email list. To the email I attached a copy of the participant information sheet and consent form. The aim of this was to assist potential participants in making an informed decision about taking part and to give their consent. Approximately fifty OT lecturers were contacted. Ten lecturers responded and agreed to be interviewed, however, one respondent did not reply to a follow up email to arrange a date and time and place for the interview to occur and was taken off my list of interviewees. In total six lecturers from university one and three from university two were interviewed. Whereas the purposive sample was based on the experience and knowledge the group offered to my study the selection was made on the basis of convenience and my access to this group (Merriam and Tisdell 2015). I was initially looking at recruiting no more than 12 interviewees to provide sufficient comparisons across the data whilst keeping the amount of data manageable within the scope of this study (Robinson 2014). As the number of respondents was small the selection was a matter of choosing those who responded. If the number of respondents had been greater than I could have accommodated in my research, I would have selected participants on a first come first served basis (Robinson 2014). As the participants were

given information on my research to assist with informed consent and subsequently gave their contest there was an element of self-selection bias (Robinson 2014). However, the purposive homogeneity of this sample and the data collected within a narrative approach values all contributions as valid and credible. All participants chose to be interviewed at their workplace in a private room at a mutually agreed time and date. All the interviews were digitally recorded on a password protected tablet device and mobile phone. All transcripts were word processed, anonymised to protect the participant's identity, assigned a code and a pseudonym for ease of recognition and stored on a password protected computer.

This is a small sample. However, as with most forms of qualitative research, I was more concerned with capturing depth of participants' experience from a small context-specific sample rather than attempting to be representative across the population as a large random sample might claim to be within quantitative research. As such it is the transferability of the knowledge produced and how meaningful it is to those in similar contexts which is of importance here rather than any form of statistical significance (Anderson and Herr 2010). The depth and richness of the data was achieved by the narrative approach taken, all participants having years of experience and accumulated knowledge of the OT profession and higher education as a specific area of practice (see table of participants' details below). It is the value associated with personal knowledge of the organisation and those involved in it which is important in making credible interpretations of the data. Clandinin (2007:30), when referring to Geertz (1983), supports this approach, suggesting "that local knowledge forms the most important basis for understanding human culture and personal interaction."

Following each of the interviews I reflected on what was discussed and my reaction to the way in which the questions evolved out of the subject themes from which the questions were drawn. The initial focus of the questions was on the lecturers' journeys into higher education (HE). This was done as a way of beginning the conversation and to provide some personal context to their current position in HE.

Participants were not asked precisely the same questions, instead they were asked questions under several themes and these questions were adapted as the interview progressed. The broad themes reflected the fields of regulation, representation and higher education. Therefore, questions were focused on types of evidence and research, EBP, new

ways of working and consequent changes to use of language and focus within teaching and learning; how these changes relate to professional values and the role of professional artistry; and their views on the role of COT and the HCPC. In-depth and lengthy answers to the questions were encouraged and when for example participants said, as most did, "I have talked too much" or "Is this what you want?" my reply was "This is all very interesting, please continue." As a result, many of the responses given by participants are lengthy narrations of their professional experience and views on the subject areas. I had asked participants to bring an object or 'archetype' that represented their professional journey or identity as a means of starting the 'conversation' rather than forming some type of metaphorical analysis. Only two participants did bring an object with them from which they made some interesting analogies. The participants who did not bring an object still gave in-depth accounts of their professional journey and views on the questions asked. There were clear similarities across narratives although there were also key differences. All participants were asked if they would like to read through their interview transcripts to check the accuracy of what was recorded but all participants declined.

All participants had a long period of time within clinical practice before moving into the university sector and one participant had recent clinical experience. One participant had moved between NHS senior management roles and education several times. It was interesting to note the different career trajectories which had brought them into occupational therapy firstly as clinicians and then as lecturers and/or researchers. Out of the nine participants eight were female and one was male.

OT is a female dominated profession and whilst there is no up to date data on the female to male ratio in OT, Grant et al (2004) cites 2001 data as showing a ratio of 10:1 in favour of females. Critical theories on gender and female representation in the workplace might highlight some of the challenges faced by the female orientated professions in obtaining professional legitimacy within a male hegemony and management culture (Bolton and Muzio 2008; Blättel-Mink and Kuhlmann 2003). However, to continue this critique in relation to OT professional identity would make for a thesis in its own right and is not the focus of this study. Where gender does feature in data it is discussed.

The table below gives brief background and demographic information for each of the participants. This is included for the reader's information only and does not form part of the

data analysis. All names have been changed to maintain the anonymity of the participants. Chapter 4 provides participants' narratives as vignettes which gives the reader more sense of the participant's story as told during the interviews. When vignettes are used in research to report data they usually fall into one of three categories: a 'portrait' which aims to capture participants' experience and what they say; a 'snapshot' which captures an aspect of the research which is representative and descriptive; or a 'composite' which is a combination of experiences and research examples (Blodgett 2011; Spalding 2007; Ely 1997). Whichever approach is taken it is important that the vignettes work to enhance the research and that "the examples they provided suggest that authors design the vignette to convey a particular purpose at the time of writing their vignette." (Spalding 2007:959). I have constructed vignettes that mostly reflect a combination of snapshot and portrait approaches. Therefore, they are "used to introduce [the participants'] characters, foreshadow events and analysis to come, highlight particular findings, [and] or summarise a particular theme or issue in analysis and interpretation." (Ely et al 1997:70).

The codes next to the participants' names in the table below represent the university they are from and the order in which they were interviewed.

Interviewee Details			
Participants University 1		Participants University 2	
Caroline (1:1)	Full time Senior Lecturer with many years of clinical practice experience before moving into HE	Marion (1:2)	Part time Senior Lecturer with many years of clinical practice experience before moving into HE. Still does some private clinical work
Jean (2:1)	Full time Associate Head of Department with many years of experience in senior management roles in the NHS before moving into HE	Geoff (2:2)	Full time Senior Lecturer (the male participant interviewed) with many years of clinical practice experience before moving into HE. The only participant to have had a previous career and degree before moving into OT

Jane (3:1)	Full time Senior Research Fellow with many years of clinical experience before moving into HE. Is now a researcher on secondment from an OT lecturer position	Roz (3:2)	Full time Senior Lecturer with many years of clinical practice experience before moving into HE
Beth (4:1)	Full time Research Fellow with many years of clinical experience before moving into HE. Is now a researcher on secondment from an OT lecturer position		
Maxine (5:1)	Full time Senior Lecturer and Course Director for the BSc (Hons) in Occupational Therapy with many years of clinical practice experience before moving into HE		
Nicky (6:1)	Full time Associate Head of Department with many years of experience in management roles in the NHS before moving into HE. Only recently stopped doing some clinical work at the time of the interview		

Ethics

To carry out my research it was necessary to have ethical approval from the Ethics Committee in the School of Education before I could proceed with gathering empirical data from research participants. I did this in accordance with the University of Nottingham School of Education's ethical principles adopted from the British Educational Research

Association's Revised Ethical Guidelines for Educational Research (BERA 2004/11). They suggest the main ethical principles for all educational research should be conducted within an ethic of respect for:

> The person, knowledge, democratic values, the quality of educational research, [and] academic freedom…and demonstrate responsibility towards participants through voluntary informed consent; openness and disclosure; right to withdraw; protection of children; vulnerable young people and vulnerable adults; incentives; avoidance of detriment arising from participation in research; privacy and disclosure. (BERA 2011:4-8)

In my study the risk of causing harm to participants should be minimal as all participants were provided with information about the research and were able to provide informed consent. I have also acknowledged my stance within this research and relationship to the interviewees, the universities and the OT profession. This has been done through a process of continuous reflexivity which is central to the interpretative process.

The documents

A document analysis provided a secondary and supporting data set. Whereas the field of higher education was represented by the narrative interviews, the document analysis represents the fields of representation and regulation (including policy). Documents were obtained from the relevant organisations (see document summary table in appendices for further detail) through a search of organisational websites, databases and citation tracking. The data from the document analysis was combined thematically with the interview data and is represented in all the themes but is most notable within Chapter 8 as this chapter explicitly relates to the relationship between OT lecturers, the OT profession and the fields of representation and regulation.

Documents of all types can be used within a narrative inquiry using a thematic analysis (Riessman 2008) and “can help the researcher uncover meaning, develop understanding, and discover insights relevant to the research problem” (Merriam 2009:163). Document analysis also has a long tradition in research and is used across quantitative and qualitative methodologies.

There is an element of 'objectivity' in documents and what they say (Merriam and Tisdell 2015), however a qualitative interpretation akin to hermeneutics would place this 'objectivity' within the critical interpretation of the meaning (Kinsella 2009) and highlight the reasons why these documents were produced and the 'story' they convey (McGrath 2006; Riessman 2008). Therefore, the objectivity of documents is not value free (the same rationale applies here as I discuss above) and relies on interpretation to be meaningful. I do not use a hermeneutic approach per se within my analysis but my theoretical framework by its construction and the nature of qualitative research will involve some hermeneutic principles.

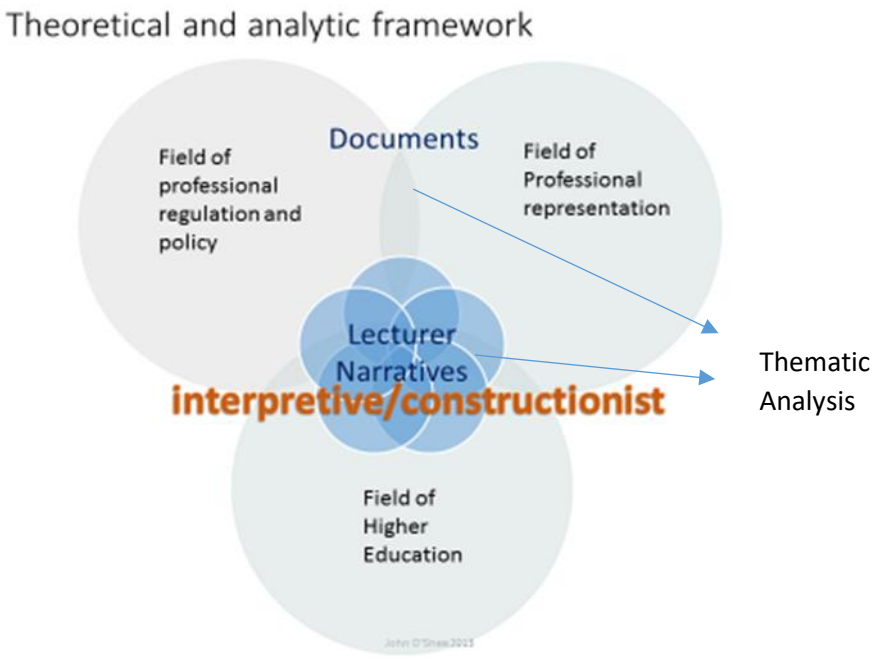
Thematic analysis

Thematic analysis was applied to the data generated in the interviews and documents and triangulated to identify commonalities and contradictions and to demonstrate the relationship between the different participants' narrative accounts within the fields of regulation, representation and higher education (further detail is given below under 'Stages of data analysis'). I took a theoretical approach (Riessman 2008; Braun and Clarke 2006) to the coding and interpretation of the data rather than a purely inductive approach which looks for theoretical assumptions to emerge from the data by limiting prior assumptions and theoretical perspectives (Riessman 2008; Braun and Clarke 2006). Riessman (2008) notes that, in thematic analysis, theory tends to guide the interpretative process and makes the distinction between thematic analysis within a narrative inquiry and other qualitative analytic approaches e.g. grounded theory. She suggests that it does not attempt to remove prior theoretical assumptions which grounded theory might, but instead uses coding systems which are derived from theoretical positions. However, these approaches do not sit in total opposition and an inductive approach will require some theoretical justification prior to coding and a researcher using a theoretical approach should be open to whatever emerges in the data (Braun and Clarke 2006). Therefore, this was not a case of imposing a hard and fast theoretical template but a way of understanding the narratives emerging within this framework, so that I remained open to what emerged from the data.

Other narrative approaches (of which there are many) look at the use of language and phrasing and/or metaphors within the text to unpack meaning (Riessman 2008). However, this analysis will not focus on linguistic and/or metaphorical constructions as some sort of discourse analysis but rather the thematic content of the interviews and documents, Riessman (2008:53) notes:

> All narrative analysis is, of course, concerned with content – "what" is said, written, or visually shown – but in thematic analysis, content is the exclusive focus. The general approach is probably the most common method of narrative analysis and, arguably, the most straightforward and appealing in applied settings .

The diagram below outlines the relationship between the theoretical framework, data and the analytic process.



Stages of data analysis

Following verbatim transcription of the interviews I read through the transcripts whilst listening to the interview recordings. This was done in part to check the accuracy of the transcription but also to obtain a sense of the interviewee's story. At the end of each transcript I wrote a short account of where I thought the interviewee was positioned in relation to the three fields of practice and the key influences on professional identity. This was then developed further into more comprehensive vignettes. This was done in an attempt to maintain a sense of the whole narrative prior to the reduction of these narratives into extracts of data to be coded, compared and contrasted and attributed to themes. These vignettes gave a sense of the positionality of the interviewees on topics that standalone quotations might miss. Each extract of data represented within text boxes was given a "two-part code" (Tuckett 2014:page number) which anonymously identified each quotation to the interviewee and the university (see table of participants above).

The same coding process was applied to the documents for consistency and to triangulate data between the lecturers' narratives and organisational documents. To do this the

'Explore' tool in NVivo was used to cluster key quotations from the data sets (both narratives and documents) under the respective codes. In coding in this way I followed the six stages of thematic data analysis below.

1. Familiarisation with the data: Following transcription I read through all the interviewee transcripts whilst listening to the interviews to ensure accuracy and to get a richer sense of the interviewees' narrative. I re-read the transcripts and wrote a short piece based on my initial reflexive thoughts on the participants' narratives identifying areas of professional capital and agency. All documents used were read thoroughly and I summarised these into a document analysis table identifying areas of structural influence on professionalism and professional identity.
2. Generating initial codes: I uploaded all interviewee transcripts and documents onto Nvivo and coded key sections of text using the 'Nodes' tool. These codes were derived from the aims of the research, the literature review and the theoretical framework (see screen shot in appendices for list of codes).
3. Searching for themes: Thematic analysis was applied to both interview and document data as a form of triangulation. Coded data was cross checked using Nvivo 'Explore' to look for tensions and commonalities in the lecturer narratives and the documents. I formed the coded data into initial overarching themes made up of several sub themes.
4. Reviewing themes: Interviewee and document data was re-analysed to check that these initial themes were supported by the data.
5. Contextualising and naming themes: Further analysis and triangulation of data was done by contextualising my initial themes within the theoretical framework and the literature review. The reflexive pieces written when I first analysed the interviews were constructed into vignettes of each of the participants' narratives to give an in-depth account of where they were placed within the field of HE. All stages were iterative, involving going back over the data and literature many times, adjusting and refining my themes until the final themes and sub-themes were named.
6. Producing the thesis: My final themes were written up as a series of findings and discussion chapters, the chapter titles representing the overarching themes and sub-headings representing the sub-themes. (Adapted from Braun and Clarke 2006:87).

I believe that this analytic approach, within the methodology and theoretical framework detailed above, provides a transparent process coupled with a clear analysis of the data leading to credible answers to my research questions. In the next chapter I will provide the reader with a sense of the lecturers' journeys and perspectives in the form of vignettes before moving onto the thematic chapters.

Chapter 4: Lecturer Vignettes

The vignettes have been compiled from the lecturers' interview narratives to present a snapshot of their professional journeys. Events influencing these journeys and their professional identities provide a sense of personality, depth and texture that is otherwise lost through the reduction of narratives to data under themes within chapters. Data reduction is necessary within a narrative thematic analysis to make sense of the findings in order to address the research questions, however, maintaining some sense of the interviewee narratives adds credibility to the data (Riesman 2008; Clandinin 2007). It is also important that these views are valued and recognised as insider knowledge and understood within this field of knowledge production (Anderson and Kerr 2010).

The thematic chapters, which follow on from the vignettes, bring together an overview of the lecturers' narratives using selected extracts to illustrate the key topic areas. These views will be further examined within the fields of representation and regulation through an alignment with documents from the College of Occupational Therapists (COT) and the Health Care and Professions Council (HCPC) and relevant government policy and legislation as a form of triangulation of the data. To protect the anonymity of the interviewees, the lecturers represented in this study have each been given a pseudonym and a number, which represents the university they are from and the order in which they were interviewed. For example, 1:1 represents university one, interview 1 and so on.

Caroline (1:1)

Caroline, like most of the participants, found herself lecturing in occupational therapy (OT) after many years of clinical experience and the need for a career change.

> I guess my life is embedded in my thoughts about being an OT. It's hard now so many years on to disentangle them… I guess part of that is about some of the steps I've taken or some of the routes that I've taken in my own career about the – either leaping off into the unknown. And sometimes finding that worked very well and sometimes finding… like coming to the university…

Moving into lecturing gave Caroline the opportunity to re-engage with her profession. This sense of belonging to OT was prevalent throughout her narrative and was linked to her

sense of professional development and autonomy. Her perspective of professional development has advanced in tandem with her understanding of the way in which OT professional identity has advanced and the importance of this in OT becoming an autonomous profession. For the profession to achieve this Caroline emphasised the importance of the OT 'discourse' of occupation. She has a clear sense of a personal understanding of the value of OT and how this relates in practice both in clinical settings and in education.

The emphasis on the use of occupational focused language underpinned by OT values is central to her identity as an OT. More implicit in shaping her identify as an OT are the changes in practices around innovations necessary for OT to develop as a profession, with a key focus on making sure the profession has a cohesive perspective and can communicate this to other stake holders.

Caroline feels that the profession has moved from being a skills-based to a concept-based profession but is concerned by the way in which these concepts are made relevant to the skills base of OT as applied in clinical practice. Caroline expressed some concern with the COT's emphasis on research and the accessibility of the British Journal of Occupational Therapy (BJOT) and she identified some of the disconnect mentioned by other participants between the COT and OT's, however, she is mostly positive about the COT's ability to represent the profession. There is a clear sense of a personal understanding of the value of OT and how this relates to practice both in clinical settings and in education. This seems key to how her identity as an OT is shaped and something which is reflected by some of the other narratives.

For Caroline it was clear that the field of regulation both structures and regulates practice but does not do more than this. The field of representation mainly via the COT is seen as more guiding and participatory but also vague at times in the way it represents OTs and promotes OT identity. The field of higher education is unsurprisingly more structuring here but is also where she articulates personal agency in the way she works with colleagues and students. Her professional capital is expressed in terms of curriculum development focusing on 'occupation' and in being involved in research and in demonstrating values attributed to being an OT.

Jean (2:1)

Jean began the conversation by drawing on a metaphor involving many different strings attached to a book that allowed her to go off in various directions but which kept her tied to an OT philosophy and way of doing things.

> The book, in itself, has got several pages, but also you can change the pages dependant on what story you want to follow. It's composed - on each little tag that's gone into the book - composed of different kinds of fonts, different kinds of styles of text, and different illustrations. So in many respects, this represents what an occupational therapist means to me, in that there is a whole, there is a complete, if you like, entity there. But within it, there are many ways of working with others, be it service users or students, there are many different stories, different ways to hear that story and to learn from it, really. So I suppose in a nutshell, this is what symbolises OT for me. I suppose - at the [edge] of the booklet, there are these different strands going off it, which keep it all together. So in some respects if you like, these represent, for me as an educator now, within occupational therapy, still being grounded to practice to our profession. But at the same time, I also see them as in-reaching to me.

Jean talked about how she moved into higher education from many years in practice. A key element of this was her wish to move away from management and to get back to working with people. She chose to do this through her own sense of personal agency. She also emphasised the differences in expectations and opportunities of working in higher education and in clinical practice and the adjustment required.

> So I came to this institution [HEI 1], and I was totally unprepared for what was going to happen to me, in the sense of this dislocation from an identity that I'd known so well. I knew what was what. If people came to ask me something, I could help them, I could guide them. I'm not somebody who gives people answers, but I tend to guide.

Jean continued her narrative to give some very interesting comments about the increasing marketisation of the NHS and the pressures this put on her, in a previous job as an NHS manager, to cut services, which did not fit with her OT identity and way of viewing the world. All of this led Jean to a career change away from management and into lecturing.

Jean's focus is mainly on how she as an individual has responded to structural pressures and her sense of agency within those structures and what she thought about her position within these structures and her notion of what OT is or should be. This has led to many career changes which enabled a decision to allow career aspirations to meet OT values. Jean's OT identity is bound up with a complex set of personal and professional motivators and values.

She was very clear on the role of the HCPC as a structural governing organisation and one which has no place in representation of the profession and cannot and should not reflect her deeper professional values and aspirations. However, she is similarly clear that the COT is not fulfilling this function and therefore, for her, there is a gap between how OT's might link into coherent professional identity and how this is represented for them by the COT. Jean notes that one of the key shifts in contemporary working is the focus on the delivery of health care via community services and the public health agenda. For Jean these are the main factors that appear to be shaping her professional identity. When discussing whether EBP adds to or detracts from her sense of professional identity and agency, Jean was keen to emphasise the importance of practice based on evidence but that this has to be balanced with clinical judgment and professional artistry. She commented on the location of professional identity as centred on the representational organisation, but feels that this organisation struggles to meet the needs of its members and to provide direction, in part due to a lack of resources.

Jean showed a very strong sense of personal and professional agency linked to what she considered OT to be and has changed jobs to reinforce this. However, the change of habitus as she moved from the clinical and managerial practice into the educational field took some adjustment.

Jane (3:1)

Jane is an OT lecturer who has been on secondment for the last two years in a research fellow post and although still an OT she also works outside the profession. Like some of the other participants Jane identifies strongly with OT, although her own career path has been varied and she had a different career path in mind when starting out in OT:

> I came into the profession as I thought it was a step towards being an art therapist, which is what I was interested in initially, I wanted to do art, I wanted to do a foundation course, I wanted to go on to do a degree and pursue art therapy. I was advised that occupational therapy was a very creative, engaging profession which would be a good starting point…

Jane's move into higher education was more opportunistic (similar to most interviewees) rather than a deliberate move although there was some focus on wanting to make links between theory and practice. She felt that being in higher education would provide her with more of an opportunity to do this.

> …we started having students here, I always had students when I was a practitioner and I got friendly with one of them - I did a masters actually, I was invited through the Trust to do a masters in mental health at Birmingham University. That was an AHP masters and it was the first year of this masters that was offered as a freebie. …One of the lecturers on the occupational therapy programme which was here then went on that masters and we shared a lift, we both lived in Leamington. We knew each other through students, because she was a placement coordinator, and she invited me to come and do some guest lectures and I really loved it, I really loved that. It was a step in the direction of thinking about education. Having got my masters I was thinking I want to be a lecturer, and a position became available. A post was advertised and I got it and came in to work here. So I never thought I'd end up back in the university I graduated in, but there I was… I was trying to implement theory into practice just before I left practice. It was sort of taking shape but I think I was a bit frustrated with the resistance of a wider team and a wider discourse. I think I felt perhaps coming in lecturing would strengthen that, would enable me to come in and equip myself better with I guess more of a theoretical educational perspective for the profession and re-root me again.

In our conversation Jane emphasised the importance of theory into practice and the way in which this relates to her own research and was equivocal about how practice is evidenced and different paradigms and methodologies used to produce knowledge. However, Jane was very keen to emphasise the multifactorial contexts of OT practice with a tendency towards the maintenance of traditional roles whilst developing new and different ones although she was unsure what this would mean for the profession. Jane commented on 'struggling with her professional identity.' This was in part due to not wanting to have to continually define this and not wanting to put herself in the 'spotlight.' Although, she thought, there was a need for OTs to feel they can be more 'visible'.

Jane acknowledged the agentic role of OT in developing services and used some 'business' focused language when talking about this although with acceptance that this discourse needs to be challenged. Jane was positive about how OT students become socialised into the profession which develops their OT identity. Jane was clear about her loyalty to the profession and aligned herself with the COT as her professional body although she was not certain about its role in taking the profession forward. She was positive about the direction the COT is taking in supporting research and the position of British Journal of Occupational Therapy (BJOT) within the journal rankings.

Beth (4:1)

Beth started her journey into OT within a very traditional setting. She talked about her own experience as a student OT at a traditional OT training college and expressed her view that students value real life practice examples whether these are from clinical practice or research and academic practice.

> We had two houses in a very posh residential area of Glasgow. It was a bit like a young ladies' finishing college type thing. There was one - and the lecturers felt like they'd never seen a patient for years - but there was one OT lecturer that had just come from practice and I kind of thought, that's what I want to be like. It was her ability to be able to relate the learning to practice and to show the links and to make it come alive for you.

Beth was a lecturer in OT but is now on an extended research secondment in assistive technology. Beth did not comment on her clinical experience but went straight into

discussing her PhD and the research she is now involved with. For Beth credibility of research is linked directly to how effectively this relates to practice and can be communicated. She considers it important that OT students and OTs are able to draw on a range of evidence and bodies of knowledge in their practice. Beth was less certain about the place of occupational science within OT. She acknowledges that qualitative methodologies are probably more closely associated with the OT body of knowledge, however she considers it important that OTs should be able to understand different types of methodologies and methods, at least when reading and applying research.

Beth is broadly supportive of the role of the COT although feels that they do not always understand the current agenda when promoting different types of working or research. She is also supportive of the progress BJOT has made with its research standings but acknowledges that this might be alienating some OTs who are looking for a practically grounded view of clinical practice. Beth is supportive of OTs building a relationship with commercial companies and has had experience of doing this sort of collaboration. However, Beth did comment on the short-sightedness of the COT at times in understanding some of the partnerships that researchers are involved with and their importance to OT practice.

Beth is very keen to see OTs embrace technology and would like to see pedagogical approaches to this developed within OT curricula. She is also very keen to see OTs working with the public using assistive technology rather than focusing on high demand care. She also considers the third and private sectors as key areas for OTs. Beth, like most other participants, sees client centeredness as central to OT practice and therefore identity.

A key focus for Beth was building relationships with commercial companies and the need for OTs to embrace technology. She was equivocal about OT's body of knowledge and the relationship with the COT and HCPC and how this relates to research, EBP and pedagogy. Her professional identity is bound up with that of a researcher and the ways in which her research informs OT practice from which she obtains professional capital.

Maxine (5:1)

Maxine talked about how she moved into being a lecturer from clinical practice to try something new because she was becoming frustrated working within the NHS. She was keen to emphasise the synergy between being an OT and teaching and the opportunities offered by working in HE. This pragmatic approach to moving into higher education seems to sum up Maxine's overall narrative.

> As I got more senior in the areas I was working, increasingly I was imparting knowledge to other people. I was also becoming increasingly disinterested or - I don't know - stressed and challenged by working with the NHS, seeing things go round in circles and think we're back to here again and feeling that - I didn't quite feel that I could do it again at that point. I needed a change.

> I think OTs do a lot of teaching. It comes naturally. It's part of - I mean, we're more facilitators and teachers really. But it was natural and I realised I actually really enjoyed that part of my role… So an opportunity came up. I did look at lecturer practitioner posts, but people had said to me that's like doing two full-time jobs. But then a job came up here that was looking at student support for [in-service] students that I thought was perfect for me. I was lucky and I got it. I mean, since I've been here, I started off in student support. We had a small team of us then on student support as opposed to one person - really enjoyed that. Then year tutor and now course director, because I think what you do find in university is that opportunities knock on your door on a daily basis. It's whether you're able to take them or not really.

In her narrative Maxine made several comments to do with structural change and the need for OTs to move with this, mainly focused on the third and private sector. She has a very pragmatic perspective and is very positive about the future of OT and the roles that OTs can work within. She placed a strong emphasis on OT becoming more concept-based rather than skill-based. She was keen to see OTs being able to articulate and utilise occupational focused concepts to inform practice and to 'sell' services. For Maxine it is key that students (and ultimately OT's) should be able to link these concepts to OT's models of practice and approaches in order to express what they are doing as OT's. She sees the move towards

more positivistic research within EBP as a challenge but feels that OT's should see it as just another way of providing evidence.

Similar to Jane she feels that OT's can do themselves a disservice at times by not shouting loudly enough or being pushy enough about what the profession has to offer. She feels this is something that OT's need to do more to address in the current climate where there is uncertainty over funding of OT training and education and the commissioning of OT services. Maxine was somewhat unsure as to what the changes in working practices will mean for the way OTs deliver their service but felt that this does not matter if the client is getting the best service. She was very positive about what OTs can offer and about opportunities for the profession. She was broadly supportive of the COT, although thought they were struggling to effectively represent the profession.

She emphasised that teaching should be more focused on leadership and entrepreneurship than on specific conditions related to acute care. Some of the issues discussed, for example the role of the third and private sectors and the use of EBP to 'package' services were seen as positive without much critique of this discourse. There was significant focus on core values and which of these are key to maintaining professional identity, although there was some acknowledgment that it can be difficult to communicate these values to others outside the profession

The field of higher education appears to be a strong influence on Maxine and provides professional capital, although this does not always translate across to the representational field. However, the broader structural influence of values and ethics is clearly located in the representational field which underpins her practice. Clearly the structural drivers from government policy on OT are a major consideration but she is not sure how OT professional identity and agency translates across to this, although she acknowledges the structural changes within HE to accommodate this agenda. Her agency is very clearly located within her professional identity. Like most interviewees she sees the regulatory field in broader terms but not central to her professional identity.

Nicky (6:1)

Nicky has worked in several NHS trusts in both clinical and management positions mainly in mental health. Nicky moved from London to the West Midlands and was surprised to find a lack of integration between professions and considerable professional competition. This along with an incident over which Nicky felt unsupported led her into higher education although she continued doing some clinical work up until recently.

> I got a bit of a culture shock because I hadn't realised there was professional competition between different professions and I felt like I'd stepped back into the Dark Ages. I felt slapped in the face by professional silos and professional competition really.

> I applied for a job here at the university and I got it and I absolutely loved it. I came in in the practice placement team and then just gradually my role evolved and I applied for different posts and moved around a bit.

Similar to the other interviewees, Nicky's move into OT lecturing was not a deliberate career move but one which was taken up as an opportunity following a difficult time within NHS managerial structures. Nicky is keen to differentiate her current managerial role in HE from that of her OT lecturer and former clinical roles in which she considers she is now truly able to be an OT. This is reflected in her approach to teaching and learning and helping students to make links between theory and practice. During the interview Nicky expressed a very positive view of the profession and feels that it does define itself well, although this could be done more strongly. Nicky commented that the COT provides some guidance on curriculum but that overall it is very limited in what it provides. Nicky suggested that the COT needs to be revamped or overhauled to give more direction to the profession. This view went to the extreme suggestion of replacing the COT with a new organisation that might be more contemporary and provide more relevant representation to the profession. Nicky did not comment on the role of the HCPC other than to acknowledge its role as a regulator.

Nicky was adamant that the profession needs to be more clear about what it does in order to 'sell' itself and this is mentioned many times. Nicky was very focused on skills and how OT skills can be developed and transferred to other contexts. She did not have much to say about the relationship between research and EBP and professional agency except to say

that research needed to be translated and presented in an effective way in order to support the selling of the service. In this respect Nicky was as concerned with the presentation style of evidence as with the evidence itself. Nicky was not so concerned with any lack of OT professional identity, which she considers to be strong within her department and possibly generally, but more how this is 'sold' and how it translates to those who use and commission OT services and to OT students attempting to make relevant links between theory and practice.

Nicky expressed the view that the third and private sectors and generic working was something that will continue to grow with the focus on the client rather than on any one professional service. To some extent for Nicky this is about breaking down professional silos and she seems to suggest that OTs are in a good position to advance their role and the profession if they can communicate clearly what OTs do. Within the above there was no critique of the neoliberalism resulting in the fragmentation and selling off of services.

Nicky seems to respond positively to the field of policy and regulation and the structural influence this is having on the OT habitus through the changes in working practices. Nicky sees the move into curriculum design to reflect a 'business minded discourse' as a necessary part of this. This appeals to her as a way of 'selling' services although she seems to feel that the field of representation does not do enough here. For Nicky professional capital comes from a clear sense of professional identity which should translate into new ways of working.

Marion (1:2)

Marion did not say why she moved into HE although she did comment on many years of experience in clinical practice mainly within learning disabilities. Marion is the only one of the interviewees who works part time as a lecturer whilst doing her own private OT consultancy work. The main focus of Marion's narratives was on relating practice based examples to client-centred practice, which, she feels, should be at the centre of what OTs do.

> I suppose for me the crucial thing has been, I qualified in 1985, it was quite a long time ago, and think that the thing that has remained consistent is the client centred approach.

Marion is also clear that the profession should be focusing on long term conditions rather than acute care. This is further reflected in her view that OT needs to move towards the third and private sectors. She is clear that evidence and research need to reflect what happens on the ground and be pragmatic, and feels that it is problematic if EBP is the only consideration and replaces 'common sense' decision making. She also commented that the artistry of the OT working with clients is central to practice, but feels this is now too constrained by EBP protocols. Marion does not have much time for the COT and does not think that it is providing the type of representation it should for its members. In part she suggests that this is because the COT is caught between the competing agendas of transitional ways of working and new developments and is not adequately responding to either in a way which is meaningful to its membership. She is more positive about the role of the HCPC in providing a clear structure within which OTs can practice. This is more the case in relation to OTs working in the third and private sectors, which Marion is enthusiastic about. She suggests that the Standards of Proficiency (SOP) and other guidelines from the HCPC translate easily into the third and private sectors.

There is a clear sense that she thinks there is an increasing focus on formal research in BJOT which is alienating too many of the COT's members. She suggests that two distinct strands to the profession are developing; those involved in research and those who are in clinical practice who either don't understand the research, don't value it or consider it relevant but are nevertheless expected to apply it. Marion thinks that there are too many academics who don't understand what happens in practice and that there is a 'dissonance' between what happens in academia and what happens in practice. These factors contribute to her view that OT is a very diverse profession within which each OT has their own view on what the focus of the profession should be. She does consider that this can be a strength, however she appears more concerned about the way in which such diffuse professional identity might undermine the profession's credentials.

Marion appears to have a very strong sense of professional agency in relation to her own practice but feels that the HE field is too focused on research rather than practice and that this sometimes unthinkingly translates into an EBP 'tick box' approach. To exemplify this, she related one example of a student who was more concerned with following what she considered to be the best and recommended practice as described in a BJOT article rather

than what was relevant to the clients within a particular clinical context. However, she does not make a link between EBP and policy and regulation and was very positive about the moves towards the third and private sectors where she feels there are many opportunities and also positive moves in the OT curriculum. This is further represented in her very positive comments about the HCPC guidelines. She was very dismissive of the COT as it currently stands. Both Marion's work in HE and her private work provide her professional capital from which to project her identity. Fundamentally she feels the OT identity should come out of the vocational desire to work with clients whilst maintaining the core values of OT.

Geoff (2:2)

Geoff was the only male OT lecturer interviewed and the only male OT lecturer to work at University Two. This is probably a fair representation of the profession whose membership is mostly female. Geoff was the only interviewee who came in to OT as a mature student after doing various previous jobs and who had an undergraduate qualification. He is involved in community publishing. Out of all the interviewees he is the most widely published on OT approaches to global community working in theoretical book based texts rather than empirical research. One point he notes is that OT is a profession where virtually anything is relevant and he was able to apply his previous experience to this. He worked for many years in mental health as an OT with varying levels of satisfaction with the role, experiencing many of the challenges discussed by other interviewees of OT services being too constrained. He did not say why or how he moved his career into HE except that he was involved in writing about OT from an international perspective at this time.

> Well, I was a late comer to occupational therapy and I didn't really hear about the profession until I was about 29, 30 and within a few months I'd applied for a course at Derby. ...what you find out later is that nothing you've ever done is really irrelevant in terms of occupational therapy, you can use everything that you've done, any kind of experience and it would probably drop in. So that's quite a good thing about it, it will probably drop in at some point. You'll be able to find some way of using the things.

> I got into the international occupational science web list and there were discussions going on there. That's how I met Frank. He was developing [an OT book] and they needed to have an English person to help them write it basically. I'd had experience of community publishing so I'd already written a [few previously] …So they invited me to join them on the board and that was it, I didn't look back.

Geoff tends to speak from a political context and sees the use of OT language such as 'productivity' as tied up with capitalist hegemonic structures and feels that there needs to be critical discourse within the OT profession around concepts, theory and ways of working. He feels strongly that these need to be critically discussed in a way that reflects what the profession is about and how it can or should work with clients and communities. However, Geoff expressed some interesting, although at times contradictory, points about neoliberalism, when discussing the growth and innovations occurring in deregulated HE markets in Chile.

Geoff has some interesting thoughts on what the profession needs to address within itself in order to go forward using concepts such as occupation and holistic practice, as currently he seems to think these are used in a trite way. He is keen to see a focus on OTs working with clients in ways that are meaningful to the client rather than focussing on outcome measures, targets and cost and feels that OT's (including students) should be willing to challenge those structures. He commented that when he did the diploma his training and education were more hands-on and much of this has been lost over the years within the degree course. The theory that has replaced this, he suggests, is too narrow and does not support effective critique of neoliberalism and OT within a 'capitalist framework'.

Geoff thinks that the COT does not fully represent the profession and that it needs to modernise and be more representative of its membership. He recognised the structural context of the field of regulation and policy on both OT teaching and learning and contemporary working in both statutory services and the third and private sectors. He feels that most of what the COT does is to roll out the same concepts of OT and to pander to policy without offering a clear critique of either. For him, this hinders the progress of OT and therefore its professional identity. He considers that BJOT's focus on improving its research standing is making it inaccessible to most of the membership and therefore engagement

with the COT and research tends to be on a tick box basis rather than anything substantial or meaningful, although he does think there is some good work occurring at a regional level. He goes on to say that the COT is too willing to 'toe the government line' to gain recognition, which makes it look ineffective. He says that more needs to be done to make the profession more confident in promoting to a wider audience what OTs can offer. He speaks from an international perspective from which OTs in this country could learn in respect to positioning themselves within the market place, although within a socially progressive context. Geoff feels that OTs need to be more specific about what they do and why rather than relying on the term 'occupation' as this does not translate well to other professions and the public. He does think, however, that OTs can critique what they do within political discourse and apply this where there is need in society.

Structurally Geoff is very politically focused and wanting a critical discourse to be at the centre of OT curricula to make it relevant. He is very focused on writing and has an international perspective on OT, which is where he sees the representational fields playing out more positively. This international arena is where his professional capital is obtained and agency expressed within the academic field.

Roz (3:2)

Roz, like most other participants, came into OT lecturing from a varied clinical and academic background. Roz took a sabbatical from her clinical work to pursue a Master's degree which reflected her interest in sociology of health and social care which in turn led her into a post in higher education. Similar to most of the other interviewees, moving into HE was not her initial plan and she would have liked to continue with some clinical practice element.

> I think I probably reached the point in my career, because I'd been practising about 10 years, where there were options for management really in terms of my career progression, and I could have done that and I did do that a bit. I didn't particularly - I knew that wasn't going to be my bag. So I decided to do a master's degree, which I did at Warwick University. My background is sociology, so I did it about sociology. I didn't do it in OT, I did a masters in sociological research and health of course.

> I didn't really intend to go into teaching at that point, I just wanted to confer some of my practice. So I got a job up here, which was a brilliant job, but it was time limited, it was only a six month project, which was fab. … but I just really enjoyed it. My masters really helped my practice there definitely, in understanding a lot of issues that I was dealing with. …Then they offered me a permanent job there, but a job came up… as well and someone actually approached me to apply for it. I was torn between practice or education and I decided to do something different, so I went into education. It was a bit of a fluke actually, I never really intended to go into education. Actually in retrospect I really miss the practice element. I wish at that point somebody had said you can do it half and half, that would have been great, if I had to choose.

There was a lot of equivocation within her answers, however, Roz made clear assertions about the lack of direction from the COT suggesting that it was out of date in terms of their use of language, representation and approach. In particular Roz did not think the use of the title 'chairman' was appropriate in a mainly female profession. She also stated that the profession is largely made up of white middle class women which is resulting in the COT struggling to be representative of the profession and its client base. She does acknowledge that there is progress being made but feels this is insufficient.

Roz sees the knowledge base of OT as firmly rooted in occupation and that it is about working with individuals and communities. Roz made several comments about the importance of collaborative working between OTs and those that use their services and seems to think that the OT curriculum should have more emphasis on teaching OT out in communities where their clients live and not so much within HE institutions. Roz compared her experience as a student to today's students and expressed concern that most students are not politically engaged which means some of the critical context within which they might apply OT is missing. For Roz the link between the OT knowledge base, social critique and practising OT is crucial and students should engage more in critical thinking and this should be reflected in the pedagogical approach to teaching and learning.

Roz did not comment much on the HCPC and does not see a significant role for the HCPC in developing the OTs' professional identity. She also does not see the COT as currently doing this but she is not too concerned as long as the teaching and learning experience students receive supports their professionalisation and professional identity. There was very little

comment from Roz on research and EBP except to say that OTs draw on many different perspectives within their practice, but she did feel that qualitative approaches were supported whether this is located within social or medical models of health. For Roz it is not the debate between social or medical models of health that is important but rather the location of OT practice within occupation.

Roz was critical of the drive towards marketisation but qualified this within the context of the various opportunities that might come from more diverse professional roles. However, she was not keen on the use of neoliberal language but did realise that students would probably need business focused skills within contemporary practice. She also noted that if, as expected, students are required in future to pay for their OT degrees then more emphasis will have to be given to translating OT practice within the neoliberal agenda.

Roz is very focused on politics and critique particularly on gender issues. She recognises the structural influences of policy on teaching and learning and how this is shaping professional identity within the field of HE. The neoliberal agenda and the way this is reflected in the curriculum is a challenge for her, as she commented on needing to adjust her views if required by the structures within HE and if demanded by the students. She is very dismissive of the COT as a coherent and critical force within the representational field. For Roz the field of HE is contested by its relationship with the other two fields. Professional agency for her seems to come from a wish to engage in many debates on the role of OT and how occupation is understood.

Summary

What it means to be an academic or a clinician is changing, as are the ways in which practice is understood. This is reflected in the reduction in the gap between academic and clinical practice as research becomes an ever increasing focus within the profession, and the relationship between those in clinical practice and higher education becomes closer. Similarly, academic roles (both teaching and research) increasingly provide a career opportunity for OT's. Research was also an area that figured in some lecturers' journeys, all of whom had completed a masters and some of whom had completed or were studying for a doctorate.

All of the interviewees tended to focus on the change of role from clinician to lecturer. In many cases this change in role was not a deliberate or a planned move but one which was taken up as an opportunity. However, their professional identity was located more within a clinical rather than an academic practice. This links in with the sense of being a professional and the ways in which this influences their approaches to teaching and learning. The relationship between professional identity, artistry and professionalism is discussed further in chapter five under the theme of 'Professional identity and artistry'.

Within the narratives, occupationally focused concepts were touched on several times as central to the OT identity and one of the key areas discussed was the way in which OT is moving from a skills-based to a concept-based profession. The key concepts and theories which are at the centre of this shift are examined further in chapter six under the theme of 'Professional and philosophical body of knowledge'.

There was a mixed view on the relationship between research and practice and EBP although Geoff was the only interviewee to explicitly link EBP and neoliberalism. Unsurprisingly the two interviewees who are on research secondments commented in most depth on this. There was some divergence of opinions as to the type of research produced and whether this reflects an epistemology (discussed in the previous chapter) congruent with OT values and philosophy. These issues are considered at more length in chapter seven under the theme of 'Research, evidencing practice and the neoliberal agenda'.

All interviewees differentiated between the COT and HCPC as representational and regulatory organisations respectively. Mostly interviewees were supportive of the COT although there was considerable concern expressed by all interviewees over the organisation's ability to remain relevant and to effectively represent OTs. Some of this concern was directed at the COT's increased focus on research which was seen as alienating to some in practice, whilst some of the interviewees suggested that it was out of date in its use of language and approach. The HCPC was largely seen as just a regulator although Marion was much more enthusiastic about its role and the way in which it can be utilised when working in the third and private sectors. This is discussed further in chapter eight under the theme of 'The College of Occupational Therapists (COT) and the Health Care Professions Council (HCPC)'. As these two organisations constitute the fields of

representation and regulation this chapter is where the majority of the document analysis is brought into the findings.

The role of the third and private sectors and generic working was touched on by most of the interviewees and most agreed that this presented a challenge to the profession but also clear opportunities. The focus was mostly on OTs' confidence to sell their profession and to clearly articulate their professional identity. There was some concern about the way in which OT values and concepts can be articulated within the neoliberal agenda and the lack of critique of this within HE. However, all seemed to feel that business focused language and skills are valued within teaching and learning in order to prepare students for contemporary working. This is discussed further in chapter nine under the theme of 'Moving into new ways of working – the selling of OT'. The next chapter will be the first of the thematic chapters 'Professional identity and artistry'.

Chapter 5: Professional identity and artistry

The value of professional identity and artistry

The professional identity of OT's and OT lecturers is structured within the OT habitus as a set of professional attributes and capital obtained through engagement with the fields of representation, regulation and higher education. Professional artistry is a combination of skilful practice, clinical experience, professional values and judgement (Paterson 2005) and an expression of professional capital which translates across many different areas of practice as structured and structuring ways of doing and being. This process of professionalisation and identity formation was clear within all the OT lecturer narratives as part of their OT career journeys from clinician to HE lecturer. All of the interviewees expressed challenges within clinical practice and the difficulties in maintaining a sense of professional identity due to managerial and organisational expectations. Although challenged by competing organisational structures (government, HEIs, the COT and the HCPC), all interviewees retained a sense of belonging to the profession which was enhanced by their move into HE. This move promoted a fundamental re-engagement with OT theory and practice centred on occupation, together with teaching and learning approaches which enhanced their professional identity.

This relocation of their professional identity within the field of HE appeared to facilitate a fresh participation within a community of practice (Kinsella and Whiteford 2009; Reid et al 2008; Davis 2006; Wenger 1998) which had been somewhat lost in their clinical practice due to an increasing emphasis on EBP and managerialist approaches which focus on skills rather than values. The shift into HE was not without its challenges for those lecturers who had to adjust to different working patterns and expectations as noted in Jean's vignette. However for some the transition was more straightforward. Nicky comments:

> I applied for a job here at the university and I got it and I absolutely loved it. I came in in the practice placement team and then just gradually my role evolved and I applied for different posts and moved around a bit (Nicky 6:1).

The linking of professional capital (values, knowledge base, sense of professionalism) and an individual sense of professional artistry and the associated community of practice was key in supporting this change in working.

For Kinsella and Whiteford (2008) professional artistry within a field of practice is fundamental to making links within a community of practice and therefore to professional identity and autonomy.[4] They see this as a bulwark against neoliberalist EBP in favour of more OT-led evidence informed practice. This wish to reclaim professional artistry from the EBP movement is also key for Paterson et al (2005). Kinsella and Whiteford emphasise the role of the professional (epistemic) community as central to this process of reclaiming the profession, as do Moate and Ruohotie-Lyhty (2014) when discussing teacher education.

All the interviewee narratives reflected to some extent on belonging to an epistemic community which is understood here as situated within the OT habitus. This is exemplified by Caroline whose change in career trajectory gave her the opportunity to re-engage with her profession. This sense of belonging to OT was prevalent throughout her narrative and was connected to her sense of professional development and autonomy. Her perspective of professionalism has developed in tandem with her understanding of the ways in which her OT professional identity has advanced and the importance of this in her becoming an autonomous professional. To achieve this Caroline emphasised the importance of the language used and confidence expressed in asserting what OT is, both in practical and clinical terms. For Caroline, OT professional identity should be supported by OT 'discourse' underpinned by occupational focused language. She says:

> So I came to university here and started to work for the first time with a group of OTs which I hadn't done for years. I noticed actually that it was quite comfortable and quite nice but it took me a couple of years to realise why…we spoke the same language… I think we just need to use occupational terms and occupational language and accept ourselves as a very valued profession (Caroline 1:1).

[4] The assertion of professional autonomy from within the profession of OT is also stated in WFOT (2007:1) "Occupational therapy (OT) is an autonomous health care profession. Occupational therapy services are determined (designed) only by qualified occupational therapists many of whom are graduates of a World Federation of Occupational Therapists (WFOT) directly approved (accredited) program."

Like Caroline all interviewees gave some suggestion that tacit knowledge and professional artistry were important to OT practice in general and specifically to their practice in HE. As noted above, professional artistry is structured by and structures the OT habitus through its application in practice. The application of professional artistry can be understood in both explicit terms and codified within individualised approaches to assessment and treatment informed by professional values and knowledge, resulting in what Anderson and Kerr (2010) describe as 'practitioner knowledge'. It is implicit as knowledge built up over time by practitioners who do not formally reproduce or disseminate this knowledge or only reproduce it at local level, for example when demonstrating OT practice to students on clinical placement. This tacit knowledge, which is gained through experience, combined with relevant theory should enhance professional credibility. However, the relationship between knowledge and action is not straightforward as it relies on some degree of formal knowledge production as co-construction of knowledge which represents different practice areas, and which is relevant to all stakeholders. The formulation of OT knowledge has increasingly moved from the practice-led and tacit within pre-registration training and education to the formal and academic. This can be seen in HEIs in the UK where, over the past twenty-five years, OT education and training has moved from a graduate diploma to graduate degree and post graduate qualifications.

Types of knowledge

Geoff commented that when he did the diploma his training and education was more hands-on and much of this has been lost over the years within the degree course. The theory that has replaced this, he suggests, is too narrow and does not support effective critique of the contexts within which OTs work.

> …you might find that if you're interviewing somebody who did a degree as opposed to a diploma they might think about it differently I suppose. But when we had the diploma we went off and did things like [unclear] went onto the Derby railway works for an afternoon and I looked at people doing stuff in a noisy factory environment, because some of the people on the course had never been in a factory… So when we turned it into an academic course we lost all that and it becomes theory. But the theory is condensed (Geoff 2:2).

The move to degree level courses has increased the research base of OT and its professional credibility, however this has been at the expense of some of the more vocational aspects of OT practice. This has been exacerbated by approaches to EBP which supplant tacit knowledge for certain types of formal knowledge. EBP as a process is strongly influenced by the field of government policy and regulation and as a result lecturers have a responsibility to engage with and teach EBP, reflecting neoliberal drivers on professionalisation and professionalism.[5] However, as discussed in more detail under the theme of 'Doing research, evidencing practice and the neoliberal agenda' this can result in a disconnect between those in clinical practice and those in HE. In bridging this gap, interviewees made reference to the utilisation of their career narratives to give students examples of 'real' OT practice. This helps the development of students' professional identity[6] and artistry[7] by linking practice and theory (Allmark 1995; Meerabeau 1992) whilst adding to the credibility of the lecturers as OT's.

This is exemplified by Beth when she draws on her own experience as a student OT at a traditional OT training college to express her view that students value real life practice, and for Nicky when she draws on her clinical experience.

> It was from a very early experience in my own education by being given that kind of reward and encouragement and [the lecturer] being able to draw on her practice examples. She shone above all the other lecturers because she had this real life experience that she was able to bring into her teaching (Beth 4:1).

> I have so many stories from that that I use in my teaching; lots and lots of things happened, interesting things, so I do draw on all my experiences when I'm teaching the students (Nicky 6:1).

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[5] Relevant documents are HCPC Education Annual Report and Standards of education and training 2014; Guthrie (2009) Continuing fitness to practise: a HCPC report; HCPC (2013) Standards of proficiency: Occupational Therapists 2013 and College of Occupational Therapists' learning and development standards for pre-registration education 2014;

[6] See HCPC Professionalism in Healthcare Professions 2011; THE COT (Creek 2003) Occupational therapy defined as a complex intervention; THE COT Developing the OT profession 2006; THE COT The British Association and College of Occupational Therapists Strategic intentions 2013-2018; UK Regulation of Health Care Professionals Regulation of Social Care Professionals in England 2014;

[7] It is interesting to note that professional artistry is not mentioned in any of the documents.

For the lecturers it was important that this association with their own clinical practice provided a form of credibility and professional 'badge of honour' (Launer 2010). It is an articulation that they too have gone through the same rite of passage to become OTs and demonstrates to students and clinicians that OT lecturers are also OTs. This link to practice was important to the interviewees so as to mitigate the perception that being in academia can be perceived as 'marginal' i.e. outside the normal conventions of work (Bourdieu 1988).

For Marion teaching and practicing client-centeredness was fundamental to both a clear sense of professional identity and artistry. She suggested that client centeredness defines the profession and some of this has been lost in the increasingly academic focus and EBP, which she feels devalues professional artistry. Overall it appears that she wants the profession to go back to fundamental vocational client centred approaches and she made a few comments about 'stripping back'. To some extent she feels that the shift in academic emphasis and expectations when OT training and education changed from a graduate diploma to a degree has not been helpful and that students can be too focused on their degree rather than on what it means to be an OT. Also, for Marion, professional artistry (as a form of implicit professional identity underpinned by client-centeredness) has been subsumed by what Evetts (2013:787) describes as "rational-legal forms" within EBP and managerial systems (discussed further in subsequent chapters) which demand that systematic procedures are followed which replace the therapeutic relationship and client-centred practice. Marion comments:

> Oh it's gone [professional artistry]. I'm just completely out on a limb I think with that…Every individual has got completely different – so you start with the client you don't start with a piece of paper…and I think, you know, the theory almost is let's get back to what makes people tick, rather than what makes systems (Marion 1:2).

> It meant that we valued, potentially then, our tacit knowledge as practitioners, but we'd got some principles to work from, which were internal to ourselves. Whereas now, the reference point has, I think, tipped the other way and become more external in evidence based practice (Marion 1:2).

The suggestion here that central to OT and OT lecturer professional identity and professional capital is a need to maintain a good therapeutic and client centred relationship which is not deferred to managerialist or EBP structures. The importance of this was highlighted by Jane and Beth who note that understanding and maintaining professional artistry is key to a compassionate and client centred approach, which although not exclusive to OT, is fundamental to a professional vocation that aims to work with and for people. This, combined with occupational approaches, would seem to underpin OT and OT lecturer professional identity. Jane and Beth comment:

> …that we have to be able to capture what's competent within our practice…, and what's come out strongly is professional artistry…We can engage people through our professional artistry or people disengage because of a lack of our professional artistry. So how can we capture effective artistry of practice?... (Jane 3:1).

> I mean it's the classic thing that we've always struggled for is about defining a profession that for me is about people and how people function. That's an incredibly diverse thing to capture… I suppose the thing I'm saying is about client centeredness and that's something that we absolutely must have to maintain (Beth 4:1).

Jane also commented on the way in which the vocational[8] drive to become an OT is associated with those personal attributes which students bring into the profession. These attributes are combined with OT professional values within the field of HE with the aim of developing a clear and sustainable professional identity. Morrow et al (2011:37), in research commissioned by the HCPC, also noted that "the emergence of professional identity therefore also appears to be a result of an interaction between the individual and experience, with some respondents basing it on their perceived qualities, some on experience, and some on the statutory achievement of professional registration." Jane comments on the professionalisation of students through linking up personal qualities

[8]The vocational aspect of professional values is not that prevalent within the documents. Skills for Health - Modernising Allied Health Professions (AHP) Careers – DOH 2008 p.9 mentions 'professional and vocational competence' although does not talk about personal values. However, Morrow et al (2011;12) in the HCPC document Professionalism in Healthcare Professions, do relate personal values to becoming a professional when they say "a sense that professionalism is based on well-established, or even innate, personal qualities and values."

with professional values when she says:

> …if you speak with undergrads and what's brought them into the profession, some might have come because they couldn't get on other courses, but I don't know, maybe by the end of their training they're more in tune with why they've come into this, or they could reason in a way why they've come into the profession, because the graduates we've spoken to all talk about having had experiences of the power of occupation in their lives and that experience in itself has fuelled a desire to want to look at occupation with others, because they know it influences health and wellbeing... because they come in and then they get socialised into the profession and their knowledge helps strengthen and validate perhaps who they [are] - this is me (Jane 3:1).

Conveying the OT and OT Lecturer identity

Professional identity is therefore linked with skilful practice, clinical experience, professional values and judgement which underpin professional artistry, and an epistemic community sharing the values of the profession. For this to be meaningful it needs to be conveyed within and outside the profession. For OT lecturers both their clinical and academic professional identities are in play here, making salient links for students between education, training and practice. This enables them to express their professional identity whilst supporting students to develop theirs. However, communicating within the profession is only part of the picture. It has been noted that OTs find it difficult to confidently align what they do with their professional identity and to get this across to the wider world (Turner and Knight 2015). Jane illustrates this when she says:

> I've struggled constantly with my own professional identity, you know that frustration of having to constantly project it and explain it. Then thinking about that, as an individual I'm probably not someone who really wants to project themselves under the spotlight… I don't know, perhaps that's a generalisation, but it does feel we don't necessarily want to stand and project ourselves right at the forefront. From the people I've worked with, I think we're often not visible through what we do and we're not often visible through articulating that clearly, which has been a big frustration which is where I felt professional theory could really help give that voice… because I was very gung-ho about having to have that language and that underpinning rationale and now I understand the importance of professional artistry and that importance of and the attributes of the self with a professional knowhow, but also that experiential and practical knowhow in artistry which I think we're so good at (Jane 3:1).

For some interviewees this is complicated further when they don't work in OT specific roles and either have to explain that they are an OT, or feel they do not fit the perception of what an OT is and does. Beth's work is relevant to OT practice although she is in a research post with a job title that does not contain any reference to OT. However, she is now keen to make clear links between her research role and OT and to make sure her OT identity is articulated. Beth comments:

> I mean where I'm working at the moment, I don't know that people would know that I was an OT other than I tell them. So the role that I'm in - in fact there was one - where we did a dissemination event after the first year - the Falls project that we've done across the region. It was only afterwards where somebody said oh but you didn't say you were an OT? This was somebody on the project team. I said well does that matter? I kind of introduced myself and said, Principal Lecturer in Assistive Technology… So I'm much more conscious of that now… - I'm an Occupational Therapist and a Principal Lecturer in Assistive Technology - because - for me it's about letting people know that my skill set comes from an OT background as well (Beth 4:1).

The lack of confidence in projecting a clear professional identity (which is discussed further in Chapter 9 'Moving into new ways of working – the selling of OT') was key for some of the interviewees but it was noted that this was not unique to OT and has been observed in other professions including nursing, social work and veterinary science (Bell 2015; Gitterman 2014; Mossop 2012). This was noted by Jane:

> Well, I think it's very interesting when you look at other professions. I've been working more recently with artists and it's really interesting, doing some work around art and health and how they are concerned about their identity and that sense of being flaky, it's so intriguing (Jane 3:1).

> Yes, is it a proper job, what do you do? I thought there's an affinity there. You only have to look at other professionals. When I was doing my masters we were with nurses and consultants, medics, social workers and we were looking at our role and understanding of one another and everyone was somewhat concerned, frustrated about being pigeon-holed and that there's more to us than that (Jane 3:1).

Summary

This chapter has discussed the value of professional artistry and identity to OT and specifically OT lecturers, how this translates into practice and communication of professional identity within and outside the profession. These areas were highlighted by the interviewees as they discussed their career narratives as a relocation of professional identity from clinical practice to academia. This process was a challenge but the shared values of OT were more apparent in HE, which supported lecturers in feeling part of the OT community, which was at times missing in clinical practice. However, to maintain professional credibility as OTs as well as academics most used 'stories' from their clinical experience to make meaningful links between theory and practice for students. These stories expressed a professional artistry built up over years which the lecturers could share as professional knowledge. Drawing on this professional knowledge supported communication of their professional identity within the profession but this was more difficult with those outside of OT. It was noted, however, that this was not unique to OTs and most professional groups are concerned about a lack of clear professional representation.

It was clear that, for the interviewees, their professional artistry comes from the tacit and implicit combination of knowledge, skills and values which underpin the professional habitus. Professional artistry is central to OT and OT lecturer professional identity as a way of working with clients which reflects the profession's values of client-centred, holistic practice centred around humans as occupational beings. However, it was noted by some of the interviewees that OT practice is at risk of being subsumed by the increasing use of check list criteria which might not always relate to client needs. Central to the application of effective professional artistry is having the professional confidence to step outside of those tick box procedures, bringing the focus of occupational therapy back to the person. This is demonstrated implicitly as a form of OT habitus which is initially formed within the field of education then shared and developed within practice. The way in which evidence is linked to professional identity and artistry is a challenge for the profession. The underpinning of this with the philosophical body of knowledge is the main theme of the next chapter.

Chapter 6: Professional and philosophical body of knowledge

Different models and approaches

The lecturers' narratives centre on client-centeredness, holistic practice and humans as occupational beings as the core values which underpin the professional and philosophical knowledge base of OT. They also discuss the dichotomy between social and medical models of health which influence both clinical practice and student education. OTs are continually attempting to define themselves between paradigms of medical determinism, social constructionism and pragmatic responses to client and service user's needs (Molineux 2011; Kinsella and Whiteford 2009; Hooper and Wood 2002). This makes it difficult for OTs as a profession to decide which knowledge is best used to inform their practice. That is to say, is it a socially focused or a medically focused profession? This is an epistemological contradiction making it difficult to project a clear professional identity. Both Roz and Nicky comment on the many disciplines that constitute the OT knowledge base. Roz also suggests that these different approaches are contested as is the profession's relationship with social and medical models of health and the ways in which occupation is understood within these debates.

> Massively changed, it's always contested, it's contested all through its history, OT, isn't it? I think it's always been quite unclear about where it sits and that's one of the problems really. But I think it has to sit in occupation. I think we have aligned ourselves with other professionals and other disciplines over the years. It laps obviously with medicine and then more with social models and disability models…We kind of sit between them, well in fact we don't really even sit between them, I think we sit somewhere completely different, which is about occupation… it was quite interesting that it was an assumption actually that we had moved to a social model, but it's not just about that. It is about occupation, which has got roots in obviously social sciences and in medicine and in psychology and in philosophy and in anthropology and all sorts of things (Roz 3:2).

> But definitely more from the social sciences, I think we're much more aligned with and I think psychological approaches, but I'd say more from the social science traditions (Nicky 6:1).

The emergence of occupational science

Occupationally focused models and approaches have been developed as tools to encourage OTs to have confidence in understanding the occupational needs of clients and service users and to use occupationally focused language, however these have not become a body of knowledge in their own right. This has changed over the past twenty-five years with the development of occupational science. Occupational science is the study of humans as occupational beings and is one of the key theoretical paradigms now informing OT education and practice. Occupational science draws mainly on theoretical principles drawn from anthropology and sociology (Wilcock 2006). This emergent parallel academic discipline has increasingly defined OT as a branch (although some might argue root) of occupational therapy (Wilcock 2006; Hocking 2014; Yerxa 1993).

This occupationally focused theory which later emerged as occupational science probably began with and was most notably articulated by Mary Reilly (1962) in her paper 'Occupational Therapy Can Be One of the Great Ideas of the 20th Century'. It is this seminal paper which has given some congruence to the profession and has contributed to the development of occupational science in the 1990s as a knowledge base from which the profession attempts to theoretically and practically own the ground it occupies.[9] For Maxine the development of occupational science is a fundamental shift in the way the profession frames its knowledge base.

[9] For some examples of how these concepts are used to guide practice see HCPC Standards of proficiency 2013; The COT Building the Evidence for Occupational Therapy Priorities for research 2011; The COT (2004a) Guidance-International Classification of Functioning Disability and Health (ICF); Ottawa Charter for Health Promotion in occupational therapy services 2004; and Creek (2003) Occupational therapy defined as a complex intervention.

> I think occupational science has given extra weight to what we've known all the time since the beginning of the profession. I've certainly found that coming back and teaching reminded me even more strongly than when I did my training of what the values and the core ideas and philosophy of OT are and made me think, yes, that's what we're all about and that's what's really powerful… I think we're going back more to where we should be, because I suppose [it] was 1985 when I qualified and then we were in an era of being very much medical oriented and following a medical model. Whereas I think OT since then [OT] has made itself a bit reborn, hasn't it, in terms of going very much back to occupation (Maxine 5:1)

This is a process that, as Turner (2011) and Turner and Knight (2015) have noted, is still in its early stages of development but is increasingly defining the profession. In this respect the way the profession is defined in theoretical terms takes account of and acknowledges the traditions from which it draws to develop its knowledge base. Concepts based on occupational science are included in OT curricula in the UK and elsewhere (COT 2014). However, OT clinical practice in the UK applies occupational science to a lesser extent and tends to use more traditional client centred models and approaches which aim to understand the occupational wants and needs of the individual in relation to their environment.

Language and discourse

The use of occupationally focused language as a professional discourse is important in forming and shaping the OT profession and what it is that makes an OT (Wilding and Whiteford 2008). Language is central to collective narratives, professional identity formation, association with a professional community and 'ways of doing and being' (Brown 2015; Brown 2006; Bucholtz and Hall 2004; Bourdieu 1998; Wenger 1988). Within these communities "…language, as a fundamental resource for cultural production, is hence also a fundamental resource for identity production" (Bucholtz and Hall 2004:382). The ownership of language shines a light on the context from which emerges a critique and a potential challenge to hegemonic discourse (Brown 2006). In this respect using language as a professional discourse enables OTs to challenge deterministic, positivist and medically focused models of practice as an imbued language of practice in favour of socially focused models. Language therefore is key to a unifying practice which structures and restructures

the habitus (Bucholtz and Hall 2004; Bourdieu 1998) where the OT and OT lecturer professional identity is developed. This use of language as a key component to professional identity is exemplified by Caroline when she comments:

> I think we just need to use occupational terms and occupational language and accept ourselves as a very valued profession (Caroline 1:1).

The lecturers' narratives reflect the importance of defining OT through the use of occupationally focused language drawn from its body of knowledge. However, this puts the OT profession, probably more than most health and social care professions with the exception of social work, between an esoteric intellectual endeavour and a practice which is largely atheoretical and based on core competencies and professional behaviours.[10] In so doing it prefigures 'occupation' as the cornerstone around which OT language is built.

Making this language meaningful in real terms

Geoff notes that these ways of defining and using occupation tend to make OT practice appear more complex than necessary without providing a meaningful critique of the social and political contexts within which this practice occurs.

> Occupational therapy is common sense dressed up in a load of occupational based language, the principal word of which is occupation. You can stick anything you like in front of - you can stick anything you like after the word occupation and make it into an occupational concept so in the end it becomes completely redundant. We haven't really critically addressed that - the occupational science community hasn't really got to the bottom of that (Geoff 2:2).

Some attempts have been made to take this critique forward (Farias and Rudman 2014) although the relationship between the meaning of occupation and the theoretical, political

[10] The rational for professional competencies is given in the HCPC Standards of Proficiency 2013; Standards of Education and Training 2014; and College of Occupational Therapists' Learning and Development Standards for Pre-registration Education 2014; The COT Code of Ethics and Professional Conduct 2015; UK Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century 2007; UK Regulation of Health Care Professionals / Regulation of Social Care Professionals in England 2014.

and social contexts within which it is used is problematic when translating into a meaningful practice. Geoff comments on the requirement for OTs to reflect on what is meant by occupation within the socio-political contexts in which people live when he says:

> we've got to actually employ a properly reflective practice to the nature of occupation. Properly reflective in terms of the way that we critique and position our understanding of why it is important to get people to do stuff that they value… and is about them expressing their identity in the world around them (Geoff 2:2).

Some of this is occurring within occupational science, providing space for an international critical discourse on social inequalities which are at odds with the profession's values (Farias and Rudman 2014). In addition Hocking (2014:591), when referring to the WFOT minimum standards for OT education (Hocking and Ness 2002), suggests "… students, educators, and practitioners should be very clear about what occupational therapists bring to the task of making their society more inclusive by addressing the needs of its most vulnerable members."

It is noted by Evetts (2013), Dingwall (2008) and Freidson (2001) that the professions should be willing to critique the social political context within which they work, e.g. through challenging government policy, if that policy is incongruent to its philosophy and values. In this respect terms such as 'occupational justice', used widely within occupational science, need to mean something in the real world. Both Roz and Geoff were the most vocal on this point and Roz suggests:

> … what I would say we need to have more of is the political elements of situating occupation more politically, so that when we look at occupation we look at it in discourses of human rights, but we also look at it in terms of how some people are excluded and some people are allowed and you can get privileged occupations. It's challenging things like why do we have this thing in work/leisure self-care, what are those discourses, where do they come from (Roz 3:2).

Geoff and Roz's narratives were very politically focused, in contrast to other narratives. Marion was more concerned with an over-emphasis on the theory in which this language is rooted which for her detracts from client-centred practice. Marion suggested:

> I think it almost needs to be stripped back again. I think it's got slightly unwieldy, with students not knowing whether they're coming or going with models and approaches. I think they need to know where things have come from, like a behavioural approach or a humanistic approach or whatever. But, I think sometimes the OT theory has not been as clear, and it isn't for students. Very few students understand models and approaches and I [am] not sure I do myself, and I am not sure it has added anything to what people do from where I am sitting (Marion 1:2).

Some of the interviewees' narratives were more focused on aligning a clear expression of occupational concepts with values and skills than on over-theorisation or politics. They suggested that a concept-based profession gave a clearer rationale and professional legitimacy. Maxine and Marion could be seen to represent opposing ends of opinion on this with Maxine generally very positive about where OT is heading and Marion feeling that it has all gone too far. Where they do agree is that the change from a skills-based to a concept-based profession is happening and changing the professional identity of OTs. Maxine gave an example of this when she suggested that:

> I think the focus on the reasoning and evidence and justification for what we do has changed completely from when I started. We were trained. OT is very much more concept based now than it ever was. I think those are sometimes challenging. We're not a skills-based profession as such. We used to be, I think. I think we're more of a concept-based profession now… (Maxine 5:1).

This all plays out within the field of HE with OT lecturers' focus on the teaching and learning of OT students. The use of theory and associated language, underpinned by an emerging OT body of knowledge, helps to develop students' professional identity and this is evident in most of the narratives. For example, Caroline notes that theory enables students to understand and discern what they do and supports their decisions, which are expressed as an 'artistry of judgement'. Further, both Caroline and Maxine suggest that the use of occupationally focused theory and language is essential for students to develop their professional identity and to be OTs.

> …the theory that's come around … has really enabled our students … to articulate what they are doing and why they have got this artistry of judgement to be able to justify what they are doing through their language rather than 'I'm an OT, why won't you recognise me (Caroline 1:1).

> If they [students] can't link what they're doing in any way to being occupation focused and to somehow be conceptualised within an OT model, then they're probably not doing OT… adapt and be flexible about what we do and how we do it, not to compromise in any way our core values, our philosophy and our focus on occupation, …that frames the whole impact of occupational health and wellbeing which is what we're all about (Maxine 5:1).

What came through all narratives was that effective teaching and learning occurs because of the embodiment and implicit sense of what it is to be an OT, which is reshaped by the OT habitus and expressed through language and discourse. For example, Jean, Maxine and Nicky say:

> I think we do have quite a clear philosophy unlike, maybe, some other disciplines… I think …that what I also hadn't appreciated was that my philosophy as an OT - how that's come out - it's deep wiring (Jean 2:1).

> No-one else thinks like we do. So in a way, our concept basedness that I talked about earlier, it needs to be seen as our strength (Maxine 5:1).

> I think we're better than a number of the other professions in the faculty, because I think we have actually got quite a strong professional identity. Talking to different colleagues, I think actually we're quite strong. We don't think we've got a strong professional identity, but if you talk to some of our other colleagues in the faculty, then they will describe much more issues to do with how they feel their profession's being treated at the moment, like social work and what their core role is within society. So I think we're quite strong (Nicky 6:1).

Summary

Within this chapter the separation between the social and medical models of health was linked to contested ways of framing evidence and developing knowledge. There are a multitude of theories and concepts that influence and shape OT practice and therefore have an influence on the professional identity of OTs and OT lecturers. These have influenced OT practice and identity in a variety of ways but have mainly manifested themselves in the differences between medical and social models of health and how these models suggest practice should occur. Epistemologically it is argued that OTs sit more closely to social models of health and ways of understanding the world. However, much of their practice is carried out within medically focused environments resulting in a contradiction between the profession's use of language, their identity and where most practice is situated.

In an attempt to move beyond a medically defined practice the discipline of occupational science has emerged. Although it takes an academically eclectic approach to understanding occupation, drawing on many theoretical perspectives, importantly it attempts to understand humans as occupational beings through the analytic lenses of sociology and anthropology. This has supported an occupationally-focused discourse which, through the use of identifiable language, has helped to develop a professional identity that has more of a grounding in an OT habitus rather than more broadly within medical approaches to health and social care. Further to this, the emergence of occupational science has provided an opportunity for OTs to critique hegemonic structures which might not be in agreement with the profession's values and the needs of service users. Some concern was expressed by the interviewees that the over use of theory would shift OT practice away from its client centred principles. Some interviewees also felt that a critical reflection on the use of this language was considered necessary to keep OT practice relevant within the changing social and political landscape.

Occupational science, alongside more traditional OT models and approaches, is feeding into approaches to teaching and learning through OT curricula within the field of HE. In doing so it is playing a major part in shaping the thinking of the interviewees which in turn passes down to their students. This is fundamental in the teaching and learning of students as it will

be the point at which their emerging professional identity is structured through this professional discourse.

The structuring effect of an occupationally focused discourse and body of knowledge is bringing about changes to the way OT is defined and expressed. It is further noted that what it means to be an OT is deeply felt and valued by those interviewed and, although this cannot be generalised, it is something which appears significant within the profession in developing its language as corollary to its identity. This will form part of the professional capital which arises mainly from the fields of higher education and representation. The occupationally-focused discourse and associated emergent body of knowledge appears to be a positive direction within the profession, however, to what extent this is congruent with the types of evidence and research favoured within neoliberalism will be discussed further in the next chapter.

Chapter 7: Research, evidencing practice and the neoliberal agenda

Neoliberalism and health care

Ways of working within health and social care and higher education are increasingly being driven by a neoliberal discourse (Paton 2014). Neoliberalist approaches to the delivery of health and social care prefigure market competition and consumer choice as the best way to deliver cost efficient services that meet the public's expectations. Quality is perceived to be obtained through a process of continual improvement (Davies 2003). This is driven by government targets, EBP, consumer feedback and quality control measures. These policies are resulting in an increasing involvement of the third and private sectors in both health and social care and higher education.[11]

The perceived efficiencies gained from these changes to the delivery of health and social care services are determined by measures of cost effectiveness, patient throughput and applying 'best evidence' without any real critique of what these mean in practice (Paton 2014; Hammersley 2013; Gabbay and Le May; Davies 2003). The seemingly rational discourse of 'it must be cost effective' or 'it must be based on evidence' is set in sharp relief when juxtaposed against 'arational' ideological (Paton 2014) moves to de-centralise the State; the longer term consequences of these policies can be seen in both an increased cost to the public and the effect on a workforce which is continually having to re-configure itself to respond to these changes. Clouston (2014) notes that the neoliberal changes within the workplace are increasing both OTs workload and job insecurity. Gabbay and Le May 2011; Beck and Young 2005; Davis2003) suggest that EBP limits professional judgement in favour of standardised and decontextualized practices. Paton (2014) describes this as an interplay between short term 'irrationalism' (policy made on the spot by pragmatic politicians) and long term 'arationalism' (policy driven by ideology). It is the latter which has been driving the provision of health and social care towards a market based economy since the early

[11] The relevant documents behind the restructuring of health and social care services and student education and training in line with the UK government's neoliberal agenda are: Department of Health (2010) Equity and excellence: Liberating the NHS; Department of Health (2012 and 2011) Liberating the NHS; Department of Health (2011a) Report to the National Allied Health Professional Advisory Board on the outcomes of the Modernising Allied Health Professional Careers Programme; Assurance and Safety – The Regulation of Health Professionals in the 21st Century; Note: some of this is different for Scotland and Wales.

1990s and which is driving both the changes to ways of working for health and social care professionals and the way in which practice is evidenced.

Neoliberalism and EBP

The utilisation of research as evidence based practice (EBP) and the 'EBP movement' (Hammersley 2013; Gabbay and Le May 2011) has tracked the neoliberalist drive within health and social care. On one hand EBP is seen as a rational process for providing evidence, usually framed within a medically focused positivist paradigm, whilst on the other it becomes a commodity to be used and traded by policy makers and managers within health and social care and education. As noted previously this way of generating knowledge is considered inconsistent with OT values. Beth makes this point when she says:

> .. there's a kind of tension between how qualitative research is viewed, as opposed to other types of research… the kind of research that you feel stands up in an academic sense and the kind of research that I think OTs - a lot of OTs are more qualitative because that's the way we are with people and that's the way that we approach - understanding how people work in situations and sort of what they want really (Beth 4:1).

The instigation of EBP is derived from a hegemony of knowledge which suggests that statistical determination can be applied to highly contextualised and complex human interactions and areas of practice (Davis 2003; Clouston 2014). This results in an imbalance between neoliberalist expectations of what constitutes good evidence and the values of professions such as OT, leading towards a "… dichotomy between its ontological, person-centred approach and the medically dominated constructs…" (Clouston and Whitcombe 2008:314). Although it might be argued that the ontology of the profession is not limited to client-centred practice, the influence of EBP on lecturers' practice and on students was evident in most of the narratives. Marion made the point that approaches to teaching and learning that centre on EBP can result in students applying a top down approach when using evidence in clinical practice rather than understanding the client's 'needs and wants'. For example, she says:

> …we just had one of the third year students, she just did a knitting, she read it in BJOT, oh the evidence base is there for knitting. She was in an adolescent mental health unit – not the most engaging of people. They were girls, but, you know, people who have been out of education, slightly bordering on NIETS [not in education or training]. So she decided to take up knitting. Anyway the girl who was in charge on the unit said I am not doing knitting. And she was shocked and I said didn't you ask then, didn't you do a kind of prep of what people want to do. Hadn't even thought of that. Hadn't even asked what they wanted to do. Course people at 17 who have not the most easy of lives they are not just going to pitch up and want to do knitting. And the fact that the student – at level six, third year, hadn't even asked what you want to do (Marion 1:2).

EBP as a term featured more prominently in the documents from the fields of regulation and representation. [12] To some extent these structural influences are shifting the perceptions of OTs on the types of evidence they should value and engage with in their practice. Although there is a drive for qualitative approaches to evidence generation to be taken seriously as EBP, it is positivistic approaches which remain dominant (Clouston 2014; Hammersley 2013). This poses challenges for OTs in both clinical practice and in higher education when challenging assumptions around the rigour of qualitative research, which is seen as subjective and biased. However, OTs are not alone in finding this challenging or finding different paradigms difficult to accommodate and the debate between these different ways of knowing is a longstanding area of contention (Kuhn 2012; McWilliam and Tan 2010; Pring 2000; Crotty 1998). Although qualitative methodologies are epistemologically congruent with OTs values and their ways of working it was thought by some of the interviewees that OTs, including students, still needed to be conversant with quantitative methodologies when reading or undertaking and applying research. For example, Jane and Beth comment:

[12] Relevant documents are: HCPC Standards of Proficiency for OTs 2013 and Standards of Education and Training 2014; The COT Building the Evidence for Occupational Therapy Priorities for Research 2007; Code of Ethics and Professional Conduct 2015; College of Occupational Therapists' Learning and Development Standards for Pre-registration Education; Guidance on the Use of The International Classification of Functioning, Disability and Health 2004; Occupational Therapy defined as a Complex Intervention (Creek 2003). Strategic Intentions 2013-2018; WFOT (2007) OT Professional Autonomy and WFOT (2006) Evidence-Based Practice Competency Standards.

> So we have to do that with the evidence base of knowledge, that there is knowledge out there that can help provide a backbone of understanding… So evidence-based practice is hugely complex and I think it has to be a whole mixture of that understanding of propositional, experiential and practical knowing and how we can nurture that in an academic setting… So I think we have to be brave enough as therapists and researchers to say look, there's other ways of doing research, there's other methodologies out there we can take ownership of, we can help develop (Jane 3:1).

> I think, to be a rounded researcher but that doesn't say that you need to shy away from numbers, …you need to understand it - if you're reading a research paper or if you're looking at reports to understand it. Your preference for your own research might be in a qualitative approach (Beth 4:1).

Whose evidence?

However, the epistemological challenge to knowledge construction is about more than methodology. The relevance of research and EBP to OTs' and OT lecturers' practice is also an issue of professional agency and the 'ownership of knowledge' which reflects and underpins professional identity, making it less susceptible to external pressures. For example, Jean comments:

> I think one of the things that I worry about, or have worried about for some time, is that, because of this externality, this locus, almost shifting outside of ourselves, for some practitioners, it makes their - how can I say - their inner strength in regards to knowing the way forward, their sense of identity as an occupational therapist, much more - it makes it malleable, vulnerable (Jean 2:1).

As a way to resolve this Jean suggested a change in the language to describe and label EBP so the emphasis can be shifted away from the prescriptive to a practitioner owned process. This included a change of name to 'evidence informed practice.'

> Whereas now, the reference point has, I think, tipped the other way and become more external in evidence based practice… we need to shift the orientation to be evidence informed practice, in the sense that whilst we are being informed by evidence, we are not being led by it in its totality (Jean 2:1).

It would seem that what lies behind this reaction to a prescriptive EBP is similar to what Gabbay and Le May (2011) refer to as 'practice-based evidence for healthcare.' They suggest a call which "challenges the evidence-based practice movement to rethink its assumptions [where] too much effort has gone into insisting on an idealised model of how clinicians ought to use best evidence, while not enough has been done to understand why they don't." Jean expresses her concern when she comments on the disconnect between ways of measuring outcomes as evidence (similar to the discussion in the previous chapter) which can undermine both tacit practitioner knowledge and the professional values of less experienced practitioners.

> Excellent clinicians. Now, one of my friends - she's very good as a clinician, she trained in the '70s - but has agreed, for example, protocols of care in regards to tendon injuries. She's confident enough to step outside those protocols, as an OT, for the benefit of the patient, because she knows that, from what they're saying to her, that protocol isn't working. So she can step outside that. But I can see that maybe other OTs, perhaps less experienced, or because that's the only way they know, would stay in that protocol to the letter. Therefore, I question how does that then link up with our philosophy? Does that challenge, for example, one of our bedrock values around being person centred? I guess it does. So that's one of the things that I find really difficult (Jean 2:1).

Evidence based practice and research

The value attributed to EBP within neoliberalism provides a form of professional legitimacy (Kinsella and Whiteford; 2008; Davies 2003). This is also mirrored in approaches to the teaching and learning of OT students with an emphasis on research and EBP in OT course curricula (COT 2014 and 2014; HCPC 2014). OT lecturers now have to be able to teach research alongside OT skills, concepts and values and to achieve this OT lecturers and OTs in general should be research active (WFOT 2016; COT 2007). Publication from research is becoming a major factor for those wanting to progress in their career. The push for a higher research output is reflected by the COT research agenda and the British Journal of Occupational Therapy (BJOT) improved research impact factor (COT 2016). On one hand this is a positive development if it supports and develops both the knowledge base and the values of the profession. However, it is a challenge for the profession if the overriding influence of neoliberalism and EBP demands ways of producing evidence and developing

knowledge which are mostly incongruent with these values and ways of constructing knowledge.

Academic and clinical identities

Given the prevalence of EBP and the increasing importance of research to the profession, the increase in BJOT's impact factor would seem opportune, however some lecturers felt there was a further disconnect found in academia and in clinical practice around the value they attributed to BJOT. Mostly it was thought by the interviewees that BJOT was too research focused and therefore alienating to those in practice. They suggested that there is a disconnect between the drive from the COT to push the OT research agenda, the relevance and accessibility of this to those in practice and the requirement to engage with EBP. For example, Beth and Caroline comment:

> I think the journal's in a difficult position because obviously it's been trying to improve its standing in terms of the quality of the research which is published. Which means, therefore, it's been kind of upping the kind of papers that have got the statistical analysis and then the kind of rigour perhaps to do that. From comments you hear people saying well the last three months it's not been worth me having the journal because I've not been interested to read anything in it. That's kind of sad really that people are not interested in that… If you're trying to build your career as a researcher you want to try and get published in the journals (Beth 4:1).

> And maybe there needs to be something between OT News [not a research based publication] and BJOT. So another forum. Where people can talk about things. Not sure...I don't have the answer… think we need to make sure that what we provide, what the COT provides, feels and looks accessible. So there is something about the image, and there is something about the language (Caroline 1:1).

However, this perceived need for OTs to engage in EBP and to be more research focused (the two things do not always sit easily together) is increasingly defining OTs' and OT lecturers' practice. Therefore, on the one hand there are OTs (mostly within academia) attempting to develop a cohesive and cogent body of knowledge through developing a research focused profession. On the other hand, there are OTs in clinical practice

attempting to fulfil the requirements of EBP but not identifying with academic practice. From this comes a restructuring of the OT habitus and the 'ways of doing' in relation to different types of research, theory and EBP and it would seem that there are differences in the way this is occurring for lecturers and clinicians. Most interviewees expressed some concern about this. Marion gives an example when she says:

> And there is a bit of a dissonance, I think, between the shop floor, the pragmatic, people who are actually doing the stuff, and the people who are theorising about it and that dissonance goes on in the teams and it goes on in the profession… (Marion 1:2).

In this respect OT lecturers are moving towards an academic identity rather than a clinical one. This reflects a disconnect between clinical practice, focused on pragmatic clinical and client centred skills and ways of knowing, and an academic practice which frames knowledge as abstract and formal (as discussed in Chapter 5). Epistemologically the former develops knowledge through practical experience and the latter through theorising and methods of data gathering, analysis and interpretation. These different approaches reflect the traditional theory into practice gap (Raelin 2007; Almark 1995). For this gap to be narrowed and to prevent the de facto formation of a second OT habitus, the shared values of the epistemic community (that which structures and is structured by the OT habitus) need to be at the forefront of both academic and clinical practice. Caroline suggests:

> I think we still got a bit to learn between that overlap between theory and practice. And sometime people still see it as an unnatural divide. I think with the new philosophy, it's not new actually it's been around a long while, but this embedding of… theory based practice and practice based theory need to come together and give all equal weighting and equal credit. Whereas before one has been seen as separate and one more hierarchical than the other (Caroline 1:1).

The bridging of this gap requires a connection between those engaged in research and knowledge construction, which reflects the profession's values but which can also reach out to those whose practice is increasingly defined by the EBP agenda. This would perpetuate a shared identity which is important for the effective teaching and learning of students whose education and training occurs in both university and clinical practice. It is also a pedagogical

necessity that students are able to engage with and make links between theoretical concepts and apply them as propositional and pragmatic knowledge when working with clients. It is therefore important to bridge this gap, firstly for the effective co-construction of knowledge, which is essential for the development of the OT body of knowledge, and secondly for the development of the cohesive professional identity necessary to challenge neoliberalism and approaches to EBP which do not reflect the profession's values.

Summary

Within this chapter the relationship between neoliberalism, EBP, research and professional identity has been discussed. These changes to the delivery of health and social care projected though managerialism, which values measured outcomes via standardised processes, in turn make both clinical practice and any associated research outputs easier to commodify. This is part of an ideological drive by the current and previous UK governments to lessen the involvement of professional representation and encourage more third and private sector involvement in the delivery of health and social care. This in tandem with a hegemony of positivism has in part resulted in a demand for health and social care professionals to utilise research as EBP. However, positivism represented as quantitative methodologies is considered to be epistemologically incongruent with OT values and ways of constructing and co-constructing knowledge.

Concern was expressed around the use of research as EBP where the research outcomes lead interventions rather than informing a client centred approach. Some of this can be seen as structural influence on OTs to produce EBP that is in line with a neoliberal agenda. The deferment of professional agency to EBP was a concern that was also reflected in Chapter 5 'Professional identity and artistry'. However, it was thought that professional agency and capital could be maintained through a change of language from evidence based to evidence informed practice, however it is unclear to what extent this would challenge the neoliberal influences on professions such as OT.

In academia OT lecturers are engaged with research as part of the EBP agenda but also in reaction to EBP through the development of OT focused theory. As part of this, COT has an increased emphasis on research with positivism strongly influencing the types of articles published in the BJOT. It was felt that the level of research required to be published in the

BJOT was now too far removed from practitioners' and some lecturers' experience to be seen as relevant. OT professional identity and the structuring and restructuring of the OT habitus are influenced more and more by these approaches to EBP as research and OT theory. However, the unity of this identity is challenged by the perceived split between theory and practice that an increased focus on research can cause. It is therefore important that those in clinical practice and those in HE maintain clear professional relevance to each other. This is crucial for an effective approach to teaching and learning as it is primarily students who move between education and clinical practice. It might be possible to bring together EBP, OT theory and practice, however it is not within the OT body of knowledge where professional capital seems to be located but rather within neoliberalist approaches to EBP. To some extent these neoliberalist drivers come from government policy which is reflected in the field of regulation and the profession's challenge to these through the field of representation. The relationship between these two will be discussed in the next chapter.

Chapter 8: The representation and regulation of the College of Occupational Therapists (COT) and the Health Care Professions Council (HCPC)

The relationship between the COT and HCPC

The COT purports to represent and speak for those qualified and working within occupational therapy within the UK. The HCPC is the statutory regulator for allied health and social care professionals and is responsible for ensuring that those practitioners on its register are competent within their area of practice. The COT will seek to promote, represent and define OT and OTs whilst HCPC will state what OTs need to do to practice in the UK. These two organisations represent the main structural influence on OT practice in the UK within the fields of representation and regulation.

Prior to 2001 occupational therapists were regulated by the Council for Professions Supplementary to Medicine (CPSM). The CPSM came out of the Professions Supplementary to Medicine Act 1960 and was the first legislative move towards the professionalisation of 'medical auxiliaries' such as occupational therapists (Oxford Brookes University 2011; Mason 2006). The board of the CPSM was made up mostly of the professions it represented and the medical profession. Some of the key differences between the CPSM and the HCPC are that the board of the HCPC is made up of many more lay representatives, it is not overseen by the medical profession and although it consults with professional bodies it is completely independent of them (HCPC 2015a). It was the "Health Professions Order 2001, later re-named the Health and Social Work Professions Order 2001" (HCPC 2015:23) which established the remit of the HCPC. The Health and Social Care Act 2012[13] resulted in a change of name from the HPC to the HCPC which is now also responsible for regulating the social work profession. This legislation also brought into law changes to the way the health and social care regulators are themselves monitored by the Professional Standards

[13]Also see Enabling Excellence Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers 2011

Authority for Health and Social Care, changed from the Council for Healthcare Regulatory Excellence.[14]

This extension of government oversight is encapsulated in the 'Regulation of Health Care Professionals / Regulation of Social Care Professionals in England' (UK Government 2014). This is a comprehensive document which seeks to draft legislation which is designed to bring about consistency in the regulatory organisation of health and social care professionals. It is a proposal for clear regulation of the regulators and brings their discretionary decisions more closely under government control. This process reflects what Dingwall (2008) suggests is a project of the State to externally define professionalism and control the process under which the professions practice rather than this being done by professional groups.

The HCPC set out the requirements for registration and practice in several documents (HCPC 2016; HCPC 2013; Guthrie 2009). The HCPC-commissioned research report by Guthrie asks the HCPC to be mindful of how it ensures fitness to practice. In doing so Guthrie (2009:15) provides some definitions of professionalism related to competence and professional behaviours. He suggests that the 'interlocking [process of] checks and balances" that involves the regulator, professions, government, public and employers in ensuring fitness to practice and professional standards is central to this process. The document gives some indication as to the way in which professional identity is structured through the process of registration. Its emphasis is on the HCPC's own process of maintaining professional practice rather than on how professionalism is defined or understood by professionals. Guthrie finds that the process of regulation and revalidation that the HCPC employs is sufficient to maintain professional competence. He further suggests that the structural influences on the way in which the regulatory field defines professionalism should be embedded early on in the education and training of students. Guthrie (2009:28) claims:

> If such findings were extended to the professions regulated by the H[C]PC, they might suggest that more regulatory effort should be focused on promoting understanding of professionalism in pre-registration education and training, as this is the area which is most likely to predict future professional behaviour .

[14] UK Government (2014) Regulation of Health Care Professionals / Regulation of Social Care Professionals England follows on from Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (2007).

The HCPC does not currently require students to be registered nor do they have to be members of the COT. The HCPC did, however, in 2016 publish a guide for students on courses it validates on ethics and conduct, and a resource[15] on the registration process, but it would seem that the influence of the HCPC on the profession is not at the forefront of students' education and training and students are not sufficiently aware of its role. For example, Jane noted:

> I don't think they [students] make that connect. I think they know the College of OT is out there to represent us and we have a conference every year and we have a journal. The HCPC is there to give them their ticket to practice and they have to have their portfolio of evidence ready. But I'm not sure how they understand all those relationships connecting with who I am as a professional (Jane 3:1).

The COT also produces standards for OT education and training and curriculum design (COT 2014 and COT 2014a.) These standards are underpinned by the World Federation of OTs guidance on OT course education (Hocking and Ness 2004; Hocking and Ness 2004a). However, it is the generic Standards of Education and Training (HCPC 2014) that must be met for graduates to be able to register with the HCPC. The role of the HCPC in administering these standards of education and training (SET) and how they are implemented is detailed in their Education Annual Report (HCPC 2015a) outlining the remit of the HCPC in approving registered courses. It gives reasons for visits and data associated with recommendations. In doing so it requires HEIs to submit to review and to notify them of any changes to the validated programme.

The report (HCPC 2015a) clearly outlines the legal remit of the HCPC as the regulatory body for courses which aims to produce qualified health and social care professionals who will be eligible to register with it. It therefore demands of these courses that its standards for education and training be met. It is worth noting however that these standards and associated curricular demands relate to the courses meeting the HCPC requirements but are

[15] Available at http://www.hpc-uk.org/apply/students/

not directly concerned with the academic standards of individual HEIs. In this respect academic attainment and professionalisation of students are measured differently.

The requirements for the education and training of OTs are derived from the standards of professional competence and behaviours which are split between generic and profession-specific standards. For OTs these standards are detailed in Standards of Proficiency (SOP) - Occupational Therapists (HCPC 2013). This document details what OTs need to be able to do in their practice to be registered with the HCPC. Structurally it is the cornerstone of the regulatory field and registration process which influences the structure of the OT habitus. In this respect it directs both practice and education and contributes to the shaping of professional identity. Individual and organisational agency is acknowledged in that it does not attempt to say how the SOP are met. The SOP can be seen as a form of generic and profession-specific professional capital by providing professional legitimacy. However, it does not go into depth about the complexity of manifold and different working environments or professional values other than to say "[a]s an autonomous professional, you need to make informed, reasoned decisions about your practice to ensure that you meet the standards that apply to you…" (HCPC 2013:5).

The HCPC has recently taken these standards further by combining them with Standards of Conduct, Performance and Ethics (HCPC 2016). These standards are brief and in a clear format that lists the professional and ethical behaviours expected of health and social care professionals. Similar to the SOP they are a type of professional capital gained through regulatory legitimacy which is accessible to the public and employers in generic form and are applicable to all professionals registered with the HCPC. Structurally this is the main document relating to ethical practice for health and social care professionals. The COT has provided ethical guidelines for many years with the most recent version at the time of writing published in 2015. Students tend to receive the COT ethical guidelines at the start of their training and education in both universities one and two and this is probably typical across all OT courses in the UK. This begins the process of embedding professional expectations and provides professional capital and legitimacy directly related to professional representation. To some extent the move on the part of the HCPC to produce ethical guidelines further encroaches on the role of the COT as the main repository and publisher of professional resources. However, some might argue, as Marion does, that the

standards produced by the HCPC are more accessible and relevant than those from the COT and thus promote professional agency. This tension between HCPC and the professional organisations it represents is highlighted in HCPC (2015:30). It states:

> Professional reactions to statutory regulation differ hugely. There are some who see it as a straightjacket, a block on innovation and professional freedom. Others see it as a positive influence on educational and professional standards and a way of ensuring that those who use a professional title can be legally held to account.

The HCPC (2015) does appear to value the contribution of the professions and acknowledges that the transition from the CPSM to the HCPC and the curtailing of the organisations representing the professions in setting educational standards was a difficult process. The HCPC (2015:6) says:

> Some of the professional bodies were unhappy about the shift of responsibility to the HCPC, and felt that the organisation simply did not have the education or professional expertise required to do the job. This was one of many contentious consequences of separating the role of professional body and regulator. A new role for the professional bodies, that of 'critical friend' emerged.

The value of the HCPC

Marion considers the HCPC guidelines and requirements as key to what OTs can and cannot do in practice. For her the HCPC standards offer a clear framework for newly qualified OTs when working in the third and private sectors, where experienced OTs will be fewer in number. Traditionally OTs work within a hierarchal structure with other OTs and health and social care professionals. Supervision and support will be part of the OT's development. Similarly, role expectation and support around professional identity is also accessible, as are opportunities for junior OTs to work with specialist OTs. In the third and private sectors this level of support might be more difficult to locate, the OT habitus might not be apparent and the development of a clear professional identity more challenging (Whitcombe 2013). As the main representational organisation, the COT arguably should be playing a strong role in providing support and guidance to its members working in all sectors and more so to those

within the third and private sectors, reflecting professional expectations and the profession's philosophical perspective. However, if the COT is struggling to make itself relevant and is therefore not able to fill the support gap for OTs working in the third and private sectors, then the practice criteria outlined by the HCPC might be considered sufficient. In this scenario the HCPC will increasingly be the first port of call for those in practice. Marion suggested that the licence to practice gave a form of professional agency to OTs to move their practice into many different arenas without having to engage with professional guidance from the COT when she commented:

> I think the HCPC is … better than the college of OT. In that it gives us clear guidelines in how we keep up to date; how we're competent to practice; what our boundaries are. Especially working in the third sector, you know, you are allowed to do this; you start to do that; and you could be struck off…And it also evidences… how we've kept up to date in our area and professionally and I think those guidelines… in terms of the audit and the four, five guidelines – for me it's really clear and it makes the bones of my supervision… Whereas sometimes I don't think the College of OT are as crystal clear as they could be… (Marion 1:2).

In contrast to Marion most interviewees saw the HCPC's role as only regulatory. Jean and Geoff were very clear that the role of the HCPC is that of statutory regulator and one which has no place in the representation of the profession, and cannot and should not represent deeper professional values and aspirations. To some extent it provides professional legitimacy, as suggested by Morrow et al (2011:6)[16], that "an occupational role is described as 'professional' may be in part determined by its legal status, such as whether it is subject to regulation." However, they also find that professionalism is a fluid concept made up of many complex and contextual factors including behaviours, skills, knowledge and values. For most of the interviewees the HCPC did not provide OTs with all of the professional attributes necessary to define the profession. Jean was clear on this when she commented on the perceived displacement of the COT by the HCPC.

[16] A qualitative research report commissioned by the HCPC carried out to understand what constitutes a professional and how professionalism is defined within health and social care.

> HCPC is a regulator... I was concerned about the future of the body of knowledge of our profession. Because obviously, when the Health Act came in, it established the regulator as the person who approved courses… I remember sitting in '05, in the first event, when they came back - when they had got that role, and seeing my professional body silenced. They were a guest at their own event, and were not asked to speak unless, they were invited to speak, they were invited to the event. It wasn't that they should be there. I see HCPC as the regulator. They operate the minimum core standards, if you like, of education and training. So there's no way that I see them as being a futures orientated organisation (Jean 2:1).

Geoff was also clear that the HCPC, although nominally independent of government, was part of the external control mechanisms of professionals and professionalism.

> You have to consider what the HCPC is about. Is the HCPC there to protect the profession or is it there to represent the government? Is it there to represent regulation? Well, really it's there to represent regulation (Geoff 2:2).

The value of the COT

Most interviewees felt supportive of the COT and appreciated some of its efforts to effectively represent the profession and provide some policy and curriculum guidance. However, they also suggested that the COT was struggling in its efforts to do this and that the guidance given was not always clear, sufficiently specific or relevant. The interviewees do recognise this as a problem for the profession and some suggested that at least the COT is attempting to address some aspects of this disconnect whilst others suggest that the COT's role is lost to those in practice. This frustration with a lack of clear direction from the COT was expressed by Beth and Roz when they said:

> …well it's a bit like when you look at the curriculum framework standards from College of OT and they're still vague. You could fit anything in them really… it is open to interpretation and I think it is purposefully so (Beth 4:1).

> I don't actually know what I think about it though, because I think the guidance from the COT is not very good. If that could be improved and made more coherent and more political and more challenging, then I would agree that we should definitely retain it and it should be what drives us all. But at the minute I don't think it does a lot really. I think what does - it's about how students are professionalised and if they have a good learning experience, that will happen anyway (Roz 3:2).

Jean relates this to the current political climate of change within health and social care and the COT's ability to respond to these changes effectively. Although Jean acknowledges some of the progress that the COT has made she also notes that it is not seen as leading the debate or challenging policy on the ways in which health and social care should be delivered.

> I think our professional body is struggling. I think that it's very reactive… Therefore, you've got a membership who can't afford time to feed things up. We've got a professional body who is constantly on the back foot, because of its lack of resources and its responsiveness (Jean 2:1).

Both Maxine and Nicky note the importance of the COT in providing, for example, curriculum guidance and the way this links in with some of the neoliberal changes occurring in the workplace. They do have some reservations about the praxis between guidance and practice but seem to appreciate some of the professional capital that comes from an association with the COT. They comment:

> I think they [the COT] try to [provide clear guidance], but it doesn't come out very loudly. I think they try to because they obviously give us guidance on the curriculum design in education and what they're expecting to be in there. They do talk about entrepreneurialism and making sure people are able to adapt to new working environments…The College of Occupational Therapists has shrunk and I suppose they're trying to do the key things about curriculum design and CPD side of things, that actually link out into people in the real world, what do jobs look like now - although obviously we have the conference and people do talk about those sorts of things, but I don't think there's a lot of guidance (Nicky 6:1).

> I think that there are no end of resources through the COT in terms of accessing knowledge that's out there and evidence that's out there. I think at times there's maybe a lot of talk but not as much action in terms of leadership about moving the profession forwards…They certainly give us curriculum guidance, don't they, that helps us on the road for moving towards entrepreneurial practice and everything… (Maxine 5:1).

Most narratives reflect the difficult position of the COT in maintaining its professional legitimacy when faced with a resurgent policy and neoliberal changes to ways of working, but some also note that the COT is, in part, responsible for this due to lack of innovation, relevance and representativeness. It was clear in the narratives of Marion, Geoff and Roz that they did not consider the COT to be relevant or representative and they mostly did not associate themselves with the organisation. For these lecturers the COT was seen as being out of touch and out of date in its use of language and in its relationship with its members. The emphasis of their narratives was on the COT falling into the use of patriarchal language, using terms such as 'chairman' within a female dominated profession; their perceived over-amenability towards government rhetoric and over-enthusiasm at any mention of OT outside of the profession especially by those in power; and in being reactive to government policy rather than proactive. For the professions generally this is a matter of professional legitimacy and credibility in the eyes of professionals and the public (Dingwall 2008; Sullivan 2000). For example, Marion, Geoff and Roz comment:

> College of OT… I think there're just very lost. I think there're really lost - because they're caught between a rock and a hard place. They're caught between the medical model and having to tick all the boxes (Marion 1:2).

> …in some way we as a profession we haven't got the same kind of profile where we're so glad if David Cameron says some stupid remark in an offhand way to one person, yes we'll look into that question for [AHPs] we have to report it all over the place. That's ridiculous and it looks stupid. It looks stupid and it looks naïve… I think there has to be a much more critical focus on all fronts about how we market occupational therapy, how we consider occupational therapy, how we present occupational therapy… (Geoff 2:2).

> I think as an organisation [the COT] it's a dinosaur actually and I refuse to have much to do with it, because I think it's a complete dinosaur…Because I think it's middle class, middle aged, white women, I'm ashamed to say, and the fact that they still have a chairman, they still talk about a chairman. Who else would have that in a predominantly female profession, to still use that out of date language (Roz 3:2).

Nicky, who was generally more positive in her thoughts on the COT, thought that the organisation itself needs a major overall and reinvention.

> We'd probably have to get together and come up with another body that would be like the College of Occupational Therapists, but I think they could do a better job. Maybe they need disbanding and we create a new body fit for the future…I think there's definitely a clear role, but it needs to adapt, to maybe relook at what its function is, because it's come from the regulatory side, hasn't it, and it's morphed and shrunk. So you could almost do with disbanding it and starting a new one. That's radical; get rid of it (Nicky 6:1).

The relevance of the COT

It would seem that the COT is not unaware of these perspectives and has attempted to respond to them and appear more effective and relevant. Julie Scott, the COT Chief Executive, commented recently that '[a]s an OT workforce, we are predominately white women from middle class backgrounds and we have tended to be polite and, and maybe we have to stop being so polite and start standing up. Why should anyone else speak for us OTs or AHPs? We've got to get more confident about it" (COT 2016b:16). Although there is an attempt here by Scott to be seen as relevant and to motivate the COT's members, not all of the members are white middle class women. Her statement has a general gender empowering context but does not identify and challenge hegemonic neoliberalism or the under-representation of those from other backgrounds which itself leads to a perception of a lack of relevance. More formally it has attempted to appear relevant through the publication of its Strategic Intentions 2013-2018 (COT 2013) which was in response to a members' survey in 2012. The COT reported its findings as: "serving members well; being the voice of the profession; ensuring that BAOT is an economically sustainable business."

(COT 2013:6-9). For Jane, however, answering this survey relied on having a detailed understanding of the COT, suggesting a lack of accessibility to the resources offered by the COT. Jane comments:

> Yes, I guess, I'm not sure how they connect for me. I filled out that survey [from the COT] and found some of those areas very difficult to answer. I didn't know the detail enough to be able to answer those questions. I could have sat with the documents open by the side, but that wasn't the point of it, they weren't there to hand. So what's that (Jane 3:1).

It is difficult to know whether Jane's experience was similar to that of other survey respondents, however there is similarity between what Jane and other interviewees say about the relevance or lack of clear guidance from the COT.

An example of the way in which the COT is attempting to be the main UK organisation to represent and internally define OT and therefore assert its professional legitimacy is the publication of Definitions of Occupational Therapy (COT 2015a) and Occupational Therapy Defined as a Complex Intervention (Creek 2003)[17]. COT (2015a) brings together a range of different definitions and Creek (2003) describes what it is to be an OT, the knowledge and skills this is based on and the ways in which values, knowledge and skills are applied to practice. The focus is wholly on clinical practice and does not describe practice in other areas such as higher education.

It is important to note that membership of the COT is voluntary and for OTs to want to join and for the COT to maintain its membership it must be seen as relevant within the field of representation, providing sufficient professional capital to its members to justify the expense. Without professional representative organisations such as the COT, professions would be externally defined and lose some of the key criteria for professional status (Dingwall 2008; Evetts 2013 and 2003; Fierdson 2001). Nicky makes this point when she says:

[17] The COT are looking to revise this publication and have asked for offers of interest from OTs to carry out this work (COT 2016).

> Yes, we're regulated by the HCPC, but we still need a professional body that is detached from that regulatory side to help us maintain our professional identity and the way our profession is developing (Nicky 6:1).

There were a couple of areas where the interviewees thought that the COT was making progress through the COT regional groups, and specialist sections were seen as providing a link between the COT and practitioners where there is a more effective and meaningful dialogue over and above that presented by the national organisation. Beth comments on this when she says:

> …so I think that link between the College of OT rep and the specialist sections is really quite an important one. So that they are understanding what members are doing on the ground and projects et cetera and how they might feed through to that (Beth 4:1).

For Jane, however, no matter how great the difficulties faced by COT at times and its struggle to make itself relevant, it remains an important part of her professional identity.

> But nonetheless I know I've got a loyalty to that professional body, I've absolutely got respect for it… (Jane 3:1).

Summary

This chapter has discussed the relationship between the HCPC and the COT and how this has developed in relation to the changes in legislation on the regulation of health and social care professionals. In both the interviewee narratives and the relevant documents it is clear that there is a tension between the COT and HCPC as to which organisation provides professional legitimacy and is therefore shaping OT lecturers' professional identity. Professional legitimacy is seen as deriving from status as registered health professionals, clear ethical guidelines and standards of proficiency, and a clear articulation of the profession's values. This tension relates to what Dingwall (2008) Evetts (2013 and 2003) and Fierdson (2001) say about the internal control of professions by those who make up the profession, related values as much as skills and knowledge and the State's desire to control and utilise the professions for its own ends.

The value of these organisations to the interviewees varied, with most seeing the HCPC solely as a regulator with no role in defining or representing the profession. However, one interviewee was adamant that what the HCPC offers is much more focused and clear on practice requirements than the COT. This was thought to be of particular relevance to those OTs working in the third and private sectors. All interviewees agreed that the COT was finding it difficult to respond to the changes within practice and regulation and is therefore at risk of becoming less relevant. However, high value was placed on the profession having a representative organisation. The narratives suggest that the relative value of the COT and the HCPC to lecturers and presumably the wider profession relates to their structuring of the OT habitus with a possible shift in favour of the HCPC. This shift relates to the authoritative discourse of the HCPC providing a professional legitimacy which translates more easily into professional capital. This initially plays out in HE within student education and training which is central to the way in which students engage with both their explicit and implicit understanding of their professional identity. When making this relevant to students, OT lecturers shift between the underpinning values-based discourse of the COT and the more competency based discourse of the HCPC. This is becoming more relevant due to the changes in working practices. The next chapter will discuss the lecturers' views on why this might be the case as OT moves from the certainty of statutory service employment to a more nebulous neoliberal market provision of health and social care.

Chapter 9: Moving into new ways of working – the selling of OT

Changes in language

It is clear from both the interviewee narratives and the documents that the changes to working practices across health and social care have had substantial and manifold pedagogical implications for the teaching and learning of OT students. These manifest themselves in approaches to teaching and learning influenced by the neoliberal discourse apparent in government policy and in regulation. This discourse prefigures EBP, cost effectiveness, efficiency, entrepreneurship and consumer 'choice' as rational responses to consumer demand (Eliason 2015; Paton 2014). This language has been a feature of government policy on health and social care services since the 1990s and more recently, in 2006, when the Labour government increased market competition in the NHS (Paton 2014; Pownall 2013; Cooper et al 2010). The Conservative led coalition government took these neoliberal changes further with the introduction of the Health and Social Care Act 2012. The Department of Health published a series of so called 'Factsheets' (DH 2012b:1) to qualify some of this legislation and these include the statement:

> We want the NHS to deliver high quality services for patients, and value for money for taxpayers. Choice and competition are powerful means to achieve this aim …We want patients to be able to choose the best services for their needs – whether this is from an NHS, third sector or independent sector provider and the Act [Health and Social Care Act 2012] strengthens patients' ability to do so.

There is some indication that, by some measures, increased competition has improved NHS services (Paton 2014; Cooper et al 2010). However, 'choice' and 'efficiency' are both seductive and ambiguous terms used as a justification for the fragmentation of health and social care services, lowest bidder provision and exploitation of more lucrative areas of the health and social care market. This has to be seen in the context of the current situation whereby the NHS is struggling to meet demand and staff are under greater pressure to deliver services, whilst the selling of those services is increasing job insecurity (Paton 2014; Pownall 2013 Mooney 2012; McGregor 2001; Copnell 2010).

Lecturer narratives suggest that the professional identity of OTs and educators is being shaped by these neoliberal policies and related discourse. These changes to OT and OT lecturer identity are resulting in a pedagogical shift from teaching mainly OT skills and theory to approaches which underpin these with professional development focused on EBP, entrepreneurship and marketing. Most interviewees acknowledge this change and some were keen to see opportunities and ways in which OT principles and values can thrive alongside these changes.[18]

These changes to the delivery of health and social care affect the ways in which OT's engage with clients and will require a different approach. Traditionally within the NHS, service users would be referred to OT by a health and social care professional within the Multi-Disciplinary Team (MDT). These referrals would be made within the limits of service level agreements based on what OTs offered. In this respect professional roles were delineated, even if poorly understood, within the MDT. OTs still needed to clarify and justify their role but this was, and mostly still is, internal to the NHS or social service organisation. However, these changes to the delivery of health and social care have resulted in less internal control around referral and treatment (BMA 2016).

In this consumer-focused model the associated shift in language reflects a change in perspective from the 'professional knows best' to the consumer (service user) deciding what is best from a range of services on offer. Some of the interviewees suggested that aspects of these changes, when viewed as empowered choice, can reflect the values of OT. For example, Beth and Maxine say:

[18] This was reflected by the COT 2008 version of the Pre-registration Education Standards which stated "…the need for programmes to address emerging issues – current examples being social inclusion, entrepreneurship, leadership, and public health – which would prepare students for contemporary practice in a dynamic environment" (2008:4). Interestingly this is not repeated in the 2014 version although the COT do say that OTs should "…acquire political astuteness and hone leadership skills to ensure that occupational therapy continues to be relevant and beneficial during changing service structures and design" (COT 2014:3).

> Equally I think also people are changing in their approaches to health in that you and I would be quite happy to go and buy a small bit of equipment for our parents or for ourselves… It's what you choose to buy. So I think we need to do some thinking around well how do you move those kind of consumer models into healthcare as well? About giving people information and advice and then we always talk about offering choice but at the end of the day it's a consumer choice about what they buy and what they choose to buy. Where our skills would lay would be in giving them information and helping them to choose what best suits their needs and how they might do that (Beth 4:1).

> I've been in services where they have service-level agreements and say with this particular nature of client we would offer this, that and that. With this client, we'd only do this. So I think they don't sit comfortably on the surface together being business minded and being an OT, because of the values. But then when you dig deeper, they do, because they are about being fair, being equal, providing [unclear] justice and autonomy and all of those sorts of things (Maxine 5:1).

However, this supposes that the consumer has a real choice; that this choice is based on equity of information, resources and service availability from which to make their choice; and that it allows for individual needs to be met within available resources.

These changes from the provision of services by the statutory sector to the increasing involvement of the third, independent and private sectors is a transition that has been ongoing for a long time but which is now taking on a new momentum. This reflects what Patten (2014) and Copnell (2010) say about the rise of neoliberalism and the effects this has on the role of professionals in the delivery of health and social care. This is also reflected in the shift in emphasis away from OTs working in acute hospital settings to working in more community-focused environments which also echoes the government's public health agenda (Health and Social Care Act 2012). This change in emphasis was discussed by the interviewees and was highlighted by Nicky and Beth:

> I think the landscape is changing out there anyway and commissioners and people who are developing and looking at the services that are needed within communities, I think they know that they need, the occupational therapy type skills and they want those types of skills, but they are talking a lot more about trying to break down those professional silos and having posts that are around a particular service group, or long term conditions… (Nicky 6:1).

> I think that has to be part of OT practice now in terms of the way that the social care in particular - we're reducing budgets and are reducing the resources that people have got to work with. So there's an element of business mindedness in there, I think, that very much needs to be there around cost efficiency and effectiveness and best use of resources (Beth 4:1).

Roz finds the change in approach and language difficult but like most she seems resigned to these changes occurring, and similarly to Maxine and Beth she attempts to see the opportunities for OTs to work more directly with communities.

> We have a lot of appropriate skills and knowledge, because as I say, it's about occupation, but our professional knowledge just comes from working in collaboration with people…it is about working with people, and it is about working with communities, and it is about empowering, and it is about participation. I think that we ought to be able to influence how those outcomes are set up and measured (Roz 3:2).

For Jean it is not so much about being challenged politically by these changes but rather it is about how OTs are able to define what they are and what they do within the neoliberal discourse. This is similar to what Maxine says above about finding ways of fitting OT values and concepts into the neoliberal model. Jean stated:

> So entrepreneurial, being business-minded, having that acumen to see an opportunity and grasp it, maybe we do, maybe we've got to measure our cost effectiveness, maybe we've got to get more clued up with these models. But I think you'd find a lot of people say I didn't come into the profession for that. So there's that mismatch or there's that stumbling over linguistics or semantics. So maybe we have to spend more time defining what we mean and defining our concepts (Jean 3:1).

Changes to practice - selling to the third and private sectors

A key area of development noted by most and in particular by Nicky was the development of marketing and selling skills to effectively communicate what OTs have to offer, which needs to be done in a professional way and supported by evidence. For Nicky, however, it is OTs' ability to demonstrate the effectiveness of their practice through being able to effectively and professionally sell what they do which will ultimately result in the commissioning and take up of OT services. She comments:

> …it's about you and you have to use your skills to sell - I think it's a lot about marketing - sell what you're doing with patients, clients, whatever, to the people who commission services…I know it sounds silly, but having lots of glossy information, lots of written down things, lots of presentations…It is, it's the advertisement, I think, but quality, done in a quality way, not a little bit of paper. I believe in professionally presenting what you're doing and yes, you need evidence, but there's no point even having the evidence that something's effective if you can't translate that into - it depends on what setting would be needed, but into something that people can understand and they can look at, or you can tell them about in a very simple way but in a very professional way and slick way (Nicky 6:1).

Most interviewees recognised this perceived need to be able to sell OT, however they also thought that OTs do not want or feel able to sell services in this way. Most interviewees suggested that the selling of the profession was a challenge because of the need to explain what is meant by occupation combined with a lack of confidence in selling themselves. This is also reflected in some of the lecturer narratives in Chapter 5 'The value of professional identity and artistry'. The differing opinions below reflect some of the uncertainty but also the perceived need to adhere to the new form of neoliberal 'arationalism' framed as 'economic realities' within which health services and HE operate (Paton 2014; Steger & Roy 2010). This was of particular concern for Jane and Maxine who comment:

> I think a lot of us come into the profession perhaps there's some sense of - I don't know, perhaps that's a generalisation, but it does feel we don't necessarily want to stand and project ourselves right at the forefront. From the people I've worked with, I think we're often not visible through what we do and we're not often visible through articulating that clearly, which has been a big frustration... (Jane 3:1).

> The problem with OTs in a way is that, because of our nature, we're facilitators and enablers. So we would put the benefits or the interests of the client and service user… first. That naturally makes us not the most - I don't know - bombastic, assertive, shout it from the rooftops, look how brilliant I am. But we can't be like that now…in curriculum development about how to market and how to target and sell your services and stand up for … our … capabilities and what the profession has to offer in order to make people want our services really (Maxine 5:1).

Maxine took this further by aligning what it is to be an OT with associated professional capital and professional identity which can be utilised as a unique selling point but also suggested that this has to come from a clear professional identity. She stated:

> I think the core values actually are our marketing strength, …core values, philosophy, threshold concepts, I think they're all linked in that we believe in the power of occupation to enable people to enrich their lives…So if you know what it is you do really well and you can start to do that, then you can take that to wherever you go, but then you need the other bit of, well, how am I going to take this into an arena where I'm the only OT? So those entrepreneurial and marketing and assertiveness and clarity, they come from your professional identity. You can't sell if you don't know what you are or who you are or what you can offer (Maxine 5:1).

Nicky is also clear that OTs need to obtain and use these types of marketing skills as a response to the changes and suggested that OTs do have the skills to effectively sell the profession when she says:

> I'm positive about occupational therapy because I know that we have skills and knowledge that is needed to work with people wherever, whatever setting they're in…So it will be more about us being able to fully explain that to people who want to buy our services (Nicky 6:1).

For Jean and Roz leadership was seen as a key skill for OTs to develop irrespective of changes to working practices driven by neoliberalist approaches to policy, and something that OTs should be willing to embrace. They considered it important for OT lecturers to develop leadership skills in order to be able to link up effectively with organisations and groups outside the universities and also to become leaders in research. There are clear links

here between what the interviewees have identified and the strategic aims of the COT (COT 2013). Jean and Roz comment:

> But I think what we must have is investment in leadership - in succession planning, if not leadership - to say that, okay, we're working in those outward facing or inward facing - because, like in here, I'd like to actually have all our staff out there, so we in-reach into the university. We're not sitting in here anymore (Jean 2:1).

> You see, I see leadership and management - well not so much management actually; leadership and - you could argue that research isn't a core skill of being an OT, but we certainly do that…I think entrepreneurship - well, I think there are subtle differences, aren't there, because we do - and I've been involved in that, …putting in a bid. Obviously you could argue that's a business skill, … we do all sorts of bids, research bids. So that is quite a useful skill (Roz 3:2).

For Beth it is about ensuring that people know that the skills she has to offer come from being an OT and similar to Maxine she suggests that clear professional identity is crucial in doing this. She says:

> So I think sometimes it's about the person and their attitude towards the profession as well. Do they want people to know that they're from an OT skill set? Does that help? … an OT background, does that help people in their voluntary, diverse and entrepreneurial type role? Or does it hinder them? .. For me it's about making sure people know that I'm an OT and that my skill set comes from an OT role. I don't know that everybody does that when they're in voluntary and third sector roles (Beth 4:1).

Professional and public contract

The selling of OT focused on marketisation of health and social care, even when presented as consumer choice and empowerment, could have adverse effects for the social contract between service user and OT (Dingwall 2008; Sullivan 2000). This is because the increasing fragmentation of statutory services and market opportunities offered to OTs might undermine the therapeutic relationship if this is perceived to be focused more on professional financial gain than treatment. However, for Beth the development and exploitation of business opportunities is central to the new ways of working. She sees

opportunities to develop partnerships with private business as a win-win situation for the private sector and for the profession. She states:

> …trying to signpost or create new - like Boots' partnerships - the COT in Boots on the high street. So that it's about building trust in the public that Boots have been endorsed by the College of OT… there is a rising market in private OTs and in private OT Consultants and lots of people … trying to look at doing individualised assessments then recommend a series of products that then you can go and buy yourself. That kind of thing. So there is that kind of using our skills in a consumer market is I think an interesting one (Beth 4:1).

Roz, however, notes that the discourse around consumer choice is misleading, and the language used to support this around empowering service users is another way for the government to place the availability and use of resources as the responsibility of the service users not the government. Some of this can be seen in the move towards direct payments (Health and Social Care Act 2012). Roz suggests that OTs will be held responsible when the availability of resources does not meet service users' needs when she says:

> …there aren't many sources which can enable people to really actively participate in meaningful occupations and communities. Then I think what happens is that it's a lot about people having to take responsibility then for their own health, having supposedly had all these wonderful choices of things that they can do, which means then that we get into a bit of blame culture when things go wrong and the services themselves get blamed, we as providers get blamed (Roz 3:2).

Although Roz, who does take a more critical line on these neoliberal approaches, ultimately offered a more pragmatic response when she said:

> Ethically for me, I think language is confusing, because at the end of the day … I don't like the word marketplace, but it is all about the marketplace, let's face it… …that sort of community participation and entrepreneurship, it's basically about the marketplace (Roz 3:2).

Changes to teaching and learning

As noted the prevailing neoliberalism and associated discourse appears to be structuring OT lecturers' thinking and, by extension, the OT habitus. This filters through to the development of students' professional identity through curriculum design and implementation of teaching and learning which reflects this neoliberal discourse. Some of the interviewees suggested that even if they do not agree with these approaches it was necessary to put them into practice so as not to put students and the profession at a disadvantage.

Maxine in particular noted that the practice areas in which OTs work are changing and that lecturers are at the centre of shifting OT practice on this through student education and training. She comments:

> I think it's happening now. We're driving it. Education are driving it with some reluctance from practice, but things like social enterprises that practitioners are developing. If you look at even where OTs are working under health or social care [auspices], they're not doing what you think they might be doing. They're at a little niche service offering this, because that's needed in that area. So it's about responding to local need. All right, you might be working with a housing group or a children's charity, but you're still taking occupational therapy into those settings to solve the problems, offer solutions to what the problems are (Maxine 5:1).

Although Roz was uncomfortable with these changes and the use of business focused language she did acknowledge that a shift in OT and OT lecturer practice was occurring and becoming a key narrative in approaches to teaching and learning. As noted earlier Roz takes a pragmatic approach when she says:

> I think I know where that comes from and there's been lots of debate in our team actually about teaching students marketing and business skills, which I personally have resisted actually, but I suspect it's going to come in …I know other OTs would argue completely the opposite. You talk about the marketplace, it's a term I'm very uncomfortable with. I don't see it as that, but I do see it as going out there and working with service users and allying with the people who might call on our services. So I see it as - it's about the purpose, isn't it, I think. But maybe in the marketplace is just where all the work is going to be, therefore it's not just about self-promotion, we're still offering a service there. I think it's the language, isn't it, I object to… It's nothing about being an OT, it's nothing about using occupation before, but it will be about how people get jobs… (Roz 3:2).

Maxine sees the importance of teaching entrepreneurship, management and leadership through a curriculum which continues the expansion of clinical placements within the third and private sectors. This, she acknowledges, will result in less traditional teaching of clinical skills, however she notes that this change in emphasis appears to be supported by the COT. This was also acknowledged by Maxine when she commented on the change in practice towards the third and private sectors and the opportunities students have to do practice placements in these areas. Maxine sees the development of these practice placements as meeting students' demands to develop more diverse expressions of what OTs do.

> I think that there are many settings that we traditionally have worked in where our students come back and say, that's not OT. That's not what I've been talking about. That's not what we've been discussing and learning about at uni. Coming back to us and saying, you're not preparing us for the real world. Whereas more community placements, more of the emerging placements that we go in allow students to be occupational therapists and be true to the philosophy, values, et cetera (Maxine 5:1).

However, Roz suggests OT courses are struggling to fit in teaching of new ways of working (which includes business focused skills) alongside traditional skills. She notes that students and those in clinical practice expect that students are taught traditional skills such as using adaptive equipment. Similar to Maxine she suggests that students' placements should be in new and emerging areas to introduce students to the third and private sectors. However, in

contrast to Maxine she notes that these are difficult to fit into the curriculum and don't always meet student expectations. She says:

> Apart from what we try and do here through our emerging placements, I think, that sort of role, those different roles, which is a really small, tiny, tiny bit, in fact the undergraduate program has only just started to introduce it, which hasn't got the infrastructure. I think we really are struggling, because I think that's where we should be, but there isn't an infrastructure for that. So the students get all the traditional stuff on placement and then they come back and they think - so that's what they want to learn. We then have to deliver what they want to learn, because they're consumers as well, and if we're not teaching them how to fit a bath board or whatever, then we get poor evaluations. But actually if you think about OT really, where it should be, is moving into that new territory (Roz 3:1).

Maxine also notes the challenges for curriculum design and teaching and learning priorities, some of which are picked up by the COT, when she comments:

> Then in second and third year, …If we're looking at entrepreneurial and marketing skills that are current and needed now, we can't do a year of anatomy. Curriculum cram is always a problem and it's a juggle, but we still do have challenges within that. I don't know if I'm answering your question now. But I heard one of the - I won't say who - a key speaker from the COT who challenged me personally and said, why are you still teaching so much anatomy and physiology? Where are OTs working now? This was somebody very high up in the COT (Maxine 5:1).

A further implication of this shift towards the third and private sectors will be a decrease in the number of students working within statutory services, further eroding the link between practice and the NHS. Changes to the funding of health professional course fees have been announced by the UK government (DH 2015; DH 2016). These changes will result in students on NHS funded courses in England no longer having their tuition fees or a bursary paid via Health Education England (HEE). This will place health professional students on the same or similar footing to Higher Education Funding Council (HEFC) students. The responsibility for these students will move from the Department of Health to the Department for Business, Innovation and Skills. In 2015 the Department of Health underlined its commitment to

ensuring the link between education and training and the NHS, ensuring that "education and training funding is predominantly provided to support the next generation of clinical and professional staff…" (DH 2015:34). However, this is a commitment which is questionable in the light of these proposed changes. The link between the NHS and student education and training was reflected in the expectation that working in the NHS was the main route of employment for most OTs. However, as this link diminishes students are aware of the need to be 'marketable' within the third and private sectors and a result of this might be that students become more demanding around the aspects of their course which reflect changes to working practices with a more 'business minded' focus. This change in funding and student expectations was highlighted by Maxine:

> I think what will make a big difference to the profession in the future is how they decide to fund training. At the moment, we're hopeful that the strategic health authorities move to the education training boards - or whatever they're called… - will be okay. But if it goes to GPs who don't know about us, will they fund it? Will they pull the plug altogether? In different countries around the world, OTs have to pay for their own training. That would impact on how many people are around to do the job, wouldn't it? So I don't know (Maxine 5:1).

It is still uncertain what the changes to student funding, due in 2017, will mean for the link between health professional related courses, the students, universities and the NHS. It would seem, however, that lecturers' approaches to teaching and learning are responding to these changes by moving more towards attracting the third and private sectors, as previously noted by Maxine. For Roz there is a fundamental shift in approaches to teaching and learning occurring within the marketisation of education and one which she accepts will change her approach to teaching. She comments:

> When you get into situations where students are paying for the course, which will come in, I do think for me that will have to be the point where I have to change my way of looking at it, to be honest (Roz 3:2).

Marion notes that the changes in teaching and learning required to train students for these new ways of working within the third and private sectors are not currently reflected within OT curricula and that students are not being sufficiently prepared. Marion states:

> So I think there's lots of things happening in the profession. I think OT will move towards the third sector. I really do believe that if we were to maintain where we are we will move towards the third sector and I think we will move towards… social enterprises and charities and because that is where real OT is…but what we're doing at university kind a doesn't match that. And so the university for me is out of kilter. It's not moving with what's happening now. I mean we're trying to in the undergraduate course, because they are introducing the third sector, but I don't think students are kind a ready for it because it's dammed hard in the third sector on your own (Marion 2:1).

In contrast Nicky suggested that OTs have the ability to respond well to these changes and that OT lecturers can and do prepare students for the new ways of working. She emphasised the flexibility of the profession to respond positively to these changes and believes that with the necessary skills students will be well prepared.

> Yes, were you looking for some words like flexible, creative, entrepreneurial spirit? Whatever that is. I see it as a little rucksack that they can take and a really good pair of shoes, that they can nimbly jump around, that's how I see it. They've got all the equipment, they're protected, they've got their hat and everything and they can go into the workplace and they can nimbly negotiate it as they can (Nicky 6:1).

As noted above many changes to working practices are occurring within health and education and these changes have an influence on OTs' and OT lecturers' professional identity. However, given what was said in the lecturer narratives and the documents, it does seem that the current changes are of greater significance although surprisingly Nicky suggests that these changes might not be happening yet. Maxine and Nicky note:

> But that's where they were seeing it going, but who knows? It could all change tomorrow. Things change all the time, don't they? But I think - I've been around a while. This feels like one of the biggest changes. There's a lot that's happened. I wonder whether this will go around again (Maxine 5:1).

> I think that's going to happen more, that will grow [the third and private sectors] and actually we're going to need a much more strong sense of our identity, aren't we, to be able to go and do those types of roles. So I think the need for occupational therapists in the way that they've been educated and trained now, I think it will change in the future but I don't think it's just around the corner, is my view (Nicky 6:1).

Summary

This chapter has discussed the neoliberal agenda and the language of consumer choice and empowerment alongside the perceived need for OTs and OT lecturers to be able to sell what they do in response to changes in working practices and approaches to teaching and learning. The fragmentation of NHS services and the increasing involvement of the third and private sectors in the delivery of those services is changing where and how OTs work and driving the perceived requirement to teach business focused skills with a market based discourse. This was noted as a challenge for OTs who do not tend to speak up about what they do. This is, in part, due to a lack of a clear professional identity.

One of the main challenges for lecturers when responding to these changes is within teaching and learning. It was thought that business focused language and skills should be taught although the way this fits in with the traditional OT curriculum was seen as problematic. This was because of limited time within the curriculum to teach so many different areas and to align the skills with OT values. This was expressed as the competing needs from students to have the opportunity to work and be taught about new ways of working whilst maintaining the learning of traditional skills. Feeding into this was the expectation from students on what the course should deliver. Students will become more consumer focussed due to recent proposed changes to the way health students' education and training will be funded. This might result in lecturers feeling compelled to respond to these expectations when designing course curricula.

Some of this focus and shift in teaching and learning is demonstrated in the increasing use of business language with the emphasis on the selling of services. There was some suggestion that these changes provided OTs with the opportunity to develop partnerships with business. However, it was noted that there are also risks to the profession's credibility

in terms of market exploitation and the contract with the public if OTs are seen as more focused on selling what they do than working for the benefit of their clients. Overall there was however a clear trend towards the acceptance of this and a recognition that OTs need to respond positively and effectively to the changing landscape. It was felt that OT lecturers and OTs in general have the skills and knowledge to deal with these changes to maintain their professional identity. Therefore, business focussed language and skills offer professional capital to OTs and are becoming part of the structuring process within the OT habitus, however it remains questionable whether this fits with the values and philosophy of the profession. The next and final chapter will bring together all of the above to form conclusions which will answer the research questions and in so doing highlight implications for practice.

Chapter 10: Conclusion

In this final chapter I will consider to what extent the findings answer the research questions (given at the end of Chapter 2) and therefore meet the aims of the study, and I will also highlight the implications of my findings. At the end of this chapter I will make recommendations on the way in which occupational therapy (OT) lecturers and the broader profession can meet some of the challenges to practice and identify potential areas for further research.

In this study I set out to identify some of the changes and shifts that are occurring in OT lecturers' practice which are directly influenced by the wider changes within the profession and health and social care in general. The broader perspectives on these contemporary factors were outlined in the literature review with discussions on the relevant areas of professionalism, professional identity, neoliberal policy, managerialism, Evidence Based Practice (EBP) and competing paradigms, emerging disciplinary knowledge discourses, language and professional values. The literature also identified firstly some of the ways in which other studies have attempted to understand the professional identity of OTs and secondly the theoretical bases from which to interpret my findings based on Bourdieuian approaches to structure and agency. The factors were understood within the three main fields of regulation, representation and higher education. Data was collected from OT lecturers and relevant documents. A narrative inquiry approach was used to gather the data which was interpreted within a constructionist epistemology. Thematic analysis was applied and the main themes identified – namely professional identity and artistry; the professional and philosophical body of knowledge; doing research, evidencing practice and the neoliberal agenda; the representation and regulation of the College of Occupational Therapists (COT) and the Health Care and Professions Council (HCPC); and moving into new ways of working – the selling of OT.

One of the key findings, and where I tentatively claim new knowledge is demonstrated in my thesis, is that neoliberalism and associated polices are influencing the structuring of the OT professional habitus and therefore shaping OT lecturer identity. This is mostly due to increased third and private sector involvement and the marketization and fragmentation of these services, and ways of evidencing practice through EBP. Professional and individual

agency is constrained by these structural changes which are shaping OT lecturer practice. However, mitigating factors are the profession's values, the emerging body of knowledge and, for lecturers, a combination of years of professional artistry and their sense of vocation, built up initially in clinical practice and then transferred into the field of higher education. Professional capital is also acquired from professional representation, although this was not always seen by the interviewees as effective or relevant. The fields of regulation, representation and higher education are where the macro influences of neoliberalist policy play out, shaping OT lecturer identity and practice. However, many of the interviewees seemed to suggest that the COT could be more proactive in the way it mediates between these structural influences and the way the profession is represented and internally defined. Although there were varied opinions from the interviewees on what these contemporary factors will mean for the future direction of the profession, there appears to be a pragmatic response to the teaching and learning of students and what they need to know about the contemporary factors, including business focused skills, so they are prepared for the workplace.

Similarly, most felt that the COT should be providing professional representation and capital that supports OTs training and working within these different areas, however interviewees decried a lack of clarity from the COT and the way in which it communicates to the profession, hindering their ability to obtain and transfer professional capital into the field of HE and wider areas of practice. One interviewee considered the HCPC to be best placed to provide professional capital for OTs when moving into the third and private sectors as it provides a license to practice and associated competencies which are unambiguous. The tension here is also represented within documents from the HCPC which suggest it is increasingly taking on an active role in representing professionalism. However, all other interviewees were clear that the HCPC is a regulator and should not take on any representational role and that the COT or a similar organization is required to sustain the profession.

However, there is a risk that some of the opportunities that come from neoliberalism will result in a structuring of the OT professional's habitus and therefore OT lecturers' dispositions towards approaches to teaching and learning which accept these neoliberalist changes as normative. This might be at the risk of re-structuring the OT professional habitus

in a way that does not reflect the vocation of OTs and the profession's values. There is a further risk that the public perceive the profession as using its status to exploit market opportunity rather than meeting public need. Neoliberalist policies and EBP are in contrast to OT professional values which prefigure holism, client-centeredness, equity and empowerment. The resulting tension and dissonance between the contemporary factors and the profession's values within the OT professional habitus have implications for the whole profession on the way in which OT lecturers and OTs in general can critique, challenge and, where necessary, pragmatically accommodate the differences between their professional values and these contemporary factors. EBP is one key factor with which OT lecturers engage in their day to day teaching and which reflects some of the tension noted above. The literature suggests that EBP segues a positivist rationalism with a neoliberalist drive for outcome measures and a managerialism which fragments and reduces professional autotomy. This was reflected by most interviewees, who viewed EBP as a prescribed 'tick box' approach which diminishes professional autonomy and client centeredness. Some interviewees suggested that this tension between EBP on the one hand and professional autonomy and values on the other could be resolved through a change in language from evidence based practice to evidence informed practice. However, it is uncertain whether this would address the fundamental structuring influence of neoliberalism on the OT professional habitus.

These tensions also play out in the way types of evidence are viewed by the interviewees. They were mostly in agreement that qualitative types of evidence are more ontologically congruent with the profession's values then positivist quantitative approaches. However, they also accepted the requirement to engage with and understand quantitative methodologies and that doing so can provide a form of professional capital which reflects the COT's drive to increase the impact factor of the British Journal of Occupational Therapists and third and private sector expectations of evidence. However, knowledge and the types of research methodologies used to obtain evidence on which this knowledge is formed need to be seen as congruent and relevant to OTs to avoid a theory into practice gap. Some of this tension is also reflected in documentation from the World Federation of Occupational Therapists (WFOT) and OT science literature in on-going attempts to produce knowledge and a discourse which places OT within social rather than medical models of health. Most interviewees expressed the belief that a knowledge base which supports a

grounding in occupational theory and language was central to developing a positive and confident professional identity which in turn will mean a more coherent professional identity.

A coherent professional identity was felt to be important by the interviewees to build confidence in OT's ability to promote the profession with a clear sense of professional agency within these changes to working practices brought about by the contemporary factors. Professional agency can be obtained through a critique of these contemporary factors within the field of HE but is also prompted through professional dialogues with the COT to promote a mediation between the competing influences of professional values and neoliberalism. However, for this to happen effectively the COT needs to be seen as more relevant and proactive in challenging State policies that are potentially to the detriment of the profession and the members of the public it aims to serve. Taking this critique forward is not just the responsibility of the COT but also of OTs in general and, crucially, of OT lecturers.

Therefore, OT lecturers' approaches to teaching and learning are key to moving the profession forward into this ever-changing landscape. The way in which the OT professional habitus is structured will shape OT lecturer professional identity and, although there is some distinction between an academic and a clinical practitioner identity and the types of professional capital acquired by each, they do reflect one profession. The shaping of OT lecturers' identity is important, however, as this will influence changes in language and pedagogical approaches to the way OT lecturers interpret these contemporary factors to prepare students to be members of the profession and for employment. As part of this interpretation there needs to be counterbalancing through OT lecturers' willingness and ability to critique and challenge these changes, based on the profession's values and knowledge base, which starts with and should form part of the OT curriculum. This is happening to some extent and noted in some of the literature and the interview data but this tends to be within a nebulous academic arena of publications and conferences rather than directly within teaching and learning. As OT lecturers are pivotal in designing and implementing OT curricula which reflect current work demands on the profession, whilst promoting and developing in students the profession's values, it is crucial that OT lecturers

engage with and critique the contemporary factors which are shaping their professional identity, that of their students and ultimately that of the profession.

Summary of main conclusions

- Contemporary factors derived from neoliberalism through marketization, managerialism, State control of professions and EBP are shaping OT lecturer identities through some restructuring of the OT professional habitus towards the market economy and positivist dispositions.
- This is in contrast to a professional artistry which was reflected in OT lecturer journeys, informing their approaches to teaching and learning and their shared values and vocation with others in the profession.
- It is also in contrast to an epistemology based on knowledge co-constructed from human experience strongly influenced by OT science which supports an OT professional habitus linked to its values and which influences key aspects of the OT curriculum.
- A shared identity and language derived from these values and OT knowledge base are central to OT professional habitus and therefore identity. However, there is tension and a dissonance between the two main structuring influences.
- There are opportunities and professional capital to be gained from the neoliberalist restructuring but at the expense of the profession's values and an emerging body of knowledge.
- There is a long standing and well documented gap between theory and practice within OT (and across similar professions). Therefore, research and the knowledge produced needs to be seen as relevant and accessible to those in practice and the profession with research outcomes supporting rather than supplanting practitioner knowledge.
- The COT promotes the profession’s values but is reactive and malleable to neoliberalist policies rather than critical. Therefore, most interviewees valued the COT but suggested that it is crucial that it makes additional effort to be more

relevant to its members so that they could obtain professional capital to support their professional identity and autonomy.

- Within the field of HE changes to teaching and learning are taking place (e.g., business focused language and skills, increasing use of positivism in research) as a necessary and pragmatic response but the structural influences from neoliberalism and EBP are not sufficiently critiqued within OT pedagogy. OT lecturers play a crucial role in taking this critique forward.

Limitations and suggestions for further research

As in all research there are limitations in both the scope and aims of this research and therefore in its focus and what is pragmatically feasible. One such limitation was the perspective on gender. Gender is an important feature of OT professional identity, therefore a different theoretical lens on, for example, the position of OT in relation to gender representations within a male hegemony, considering different ways of working that women might favour, could be an important area of further research.

The focus of this study was OT lecturer identity so student perspectives were not obtained, however how these changes are viewed by students in relation to the OT curriculum would make for another area of further research.

Both the COT and the HCPC were represented in my thesis through the documents they produce, however a response from representatives of these organisations might be obtained in further research on a similar topic and this would make for an interesting comparison.

There was some suggestion in my thesis of emerging academic OT identity as distinct from an OT identity associated with clinical practice. Further understanding of the differences between these identities and what this might mean for the profession could be developed further.

Implications for practice

The findings and conclusion from my thesis raise implications for occupational therapy as a profession and the role of OT lecturers in the teaching and learning of students. One

implication is the way in which OT lecturers are able to both acknowledge and teach all types of research methodologies as a form of EBP, and encourage students to be research active, whilst placing this teaching within a critique that is epistemologically congruent with the profession's values. One key aspect of this for OT lecturers is to emphasise the importance of co-constructed knowledge and the relationship between tacit knowledge and other types of evidence to share areas of best practice.

A further implication is that the COT is at risk of a diminishing relevance to the profession as the HCPC continues to develop its influence. To offset this the COT should be at the centre of the mediation between the structuring influences of the contemporary factors identified in this thesis and the wide range of OT practice. In doing so it should enhance its role as the key UK national organisation from which professional capital and agency is acquired. This will highlight a clear distinction between the fields of regulation and representation from which OT lecturers can add to their guidance to students on what both the COT and the HCPC have to offer.

Lastly it is important that the profession's drive to make itself seem relevant within the market place is not at the expense of the profession's values, knowledge base and, crucially, its relationship with the public. Therefore, careful consideration needs to be given by leaders within the profession and by those who are responsible for the training and education of students to ways in which market based principles and skills are included in professional guidance and OT course curricula. In this respect the COT should be more reactive and critical of policies that are not in the profession's and its clients' interests. OT lecturers should develop modules that seek to place the teaching of skills and ways of working associated to these contemporary factors within a critique of their implications for health and social care and for the profession.

Reflections on being a practitioner researcher

As a final note the process I have been through over the past six years leading to this point has been a very challenging one both intellectually and logistically through balancing a full time job with doctoral study. It has also been immensely rewarding, through the sense of achievement, through the people I have met and worked with and through the knowledge and skills I have acquired about research methodologies and methods and the theoretical

contexts from which we can understand and make sense of the world. In particular this process has given me a deeper insight into my abilities and the way in which I relate these to my profession and to my practice as an OT lecturer. It is this practice which, for me, is at the center of the process and where I see the professional knowledge produced in my thesis adding to the debates within my profession and the wider field and in my ability to take these debates forward. This has been most notable in the conferences and seminars at which it has been a privilege to present and where I have had interest shown in my work. This has given a sense of contributing to my profession from which I have started to develop collaborations and to which I aim to contribute further.

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Appendices

Appendix 1 - Document Summary

Title	Organisation / Author (Date of Publication)	Synopsis
Continuing Fitness to Practise - Towards an Evidence-Based Approach to Revalidation	HCPC / Guthrie (2009)	This document is a driver from the HCPC to reconsider how it ensures fitness to practice. It outlines how professionalism relates to competence and behaviours. It highlights an 'interlocking' process that involves the regulator, the professions, the government, the public and employers in fitness to practice regulations to ensure professional standards. This offers some professional capital in the way it projects the notion of professionalism, however, its emphasis is on the HCPC's own process of maintaining professional practice rather than on how professionalism is defined.
Standards of Education and Training	HCPC (2014)	Short statements of the criteria required by universities providing education and training. It has a strong structuring influence on the health professions.
Professionalism in Healthcare Professions	HCPC / Morrow et al (2011)	A qualitative research study carried out to understand what constitutes a professional and how professionalism is defined within health and social care. The study's participants were OTs, chiropodists / podiatrists and paramedics. They were either students, trainers (practice educators) or lecturers. The data was collected using focus groups. The study identified key factors which make up what is considered to be a professional, what professionalism is and how associated professional identity is developed. The report mainly concludes that professionalism and being a professional is not restricted to a fixed set of criteria (although they do include the caveat of 'at and above minimum competency' as determined by the HCPC) and that it is a fluid

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		construct dependent on context, the individual and the profession. It is therefore a complex interplay between behaviours, values, skills, knowledge and context. This research report acknowledges that professionalism and professional identity develop out of the relationship between the individual, the profession's skills, knowledge and values and regulatory demands. Individual agency within this process of professionalisation is shaped by these structures and expressed as professional capital.
Standards of Proficiency: Occupational Therapists	HCPC (2013)	This document details what OTs need to be able to do in their practice to be registered with the HCPC. Structurally it is the cornerstone of the regulatory field and registration process and forms a habitus of professional behaviours, knowledge and skills. In this respect it directs both practice and education and contributes to the shaping of professional identity. Individual and organisational agency is acknowledged in that it does attempt to say how the Standards of Proficiency (SOP) are met. It links in with professional capital by providing professional legitimacy and translates across to the representational field. However, it does not address the challenges for practitioners when applying the SOP as part of developing cohesive professional identity in changing working environments.
The Making of a Multi-Professional Regulator: the Health and Care Professions Council 2001–15	HCPC (2015)	White paper detailing the regulation of health professionals. Structurally significant in shaping how professionalism is defined within the context of regulation.
Education Annual Report 2014	HCPC (2015a)	Details the remit of the HCPC in approving registered courses. It gives reasons for visits to HEIs and data associated with recommendations. It requires HEIs to submit to review and to notify them of any changes to the validated programme.

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		Also covers the increasingly generic role of health and social care professionals and how it is now the responsibility of the HCPC to regulate Approved Mental Health Practitioners (AMHP) and Independent Prescribing (IP). OT is an eligible profession for an AMHP role but not currently for the IP role. The report clearly outlines the legal remit of the HCPC as the regulatory body for courses which aim to produce qualified health and social care professionals and who will be eligible to register with it. It therefore demands of these courses that its Standards for Education and Training be met. It is worth noting however that these standards and associated curricular demands relate to the course meeting the HCPC requirements but are not directly concerned with the academic standards of individual HEIs. In this respect the HCPC requires courses to meet the Minimum Competency to Practice requirements of the Standards of Proficiency (SOPs). The HCPC is a powerful structural driver and monitor of registered health and social care professionals in that it provides a licence to practice. It demands that courses for which it is responsible follow its stipulations and is sole accreditor of these courses. It might consult with those from the representational field (e.g. COT) but is not obliged to do so. In terms of practical application, this leads to a defining of what a health and social care professional is and does.
The Making of a Multi-Professional Regulator - the Health and Care Professions Council 2001–15	HCPC (2015)	This report provides a history of the HCPC. It outlines why it came to be formed, how this was done and its relationship with the professional organisations it represents. It gives reasons and justification for the role of the multi-professional regulator as opposed to a uni-professional regulator. It comments on the challenges faced in bringing together many different health and social care professions to agree on generic and uni-professional standards. It also highlights the difficulties faced in translating these standards across to education and training. It further outlines its relationship with

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		all stakeholders, these being the public, government, HEIs and professional organisations. Its emphasis is on protecting the public, however it suggests that it aims to do this in cooperation with the professions it regulates. It would seem that the HCPC is aware of the tension between its role and that of those who seek to represent the professionals and is attempting to narrow the gap between regulation and representation.
Standards of Conduct, Performance and Ethics	HCPC (2016)	This is a brief and clear document that bullet points the professional and ethical behaviours expected of health and social care professionals. It does this in generic terms and is applicable to all professionals registered with the HCPC. Structurally it is the main document relating to ethical practice for health and social care professionals. In this respect it supersedes ethical guidelines given by the COT although both organisations outline similar professional requirements.
Building Evidence 2011	COT (2011c)	An overview of the COT's research priorities which identifies areas of importance mainly drawn from government priorities but also via a survey of OTs. Its intention appears to be to recognise and give advice on the importance of research; to support practice and areas in which this should be carried out; and to 'play catch up' with other health and social care professions in research production to increase the profile of the profession. As it is a broad profession the areas noted as priorities are many but there is an attempt to align the profession's specialist sections with national research priority areas. There is some acknowledgment of research which focuses on the profession's development of a coherent body of knowledge on which general philosophical and conceptual principles are based but this is mostly as a side issue rather than a key priority. In terms of professional identity this positions COT as structuring the ways in which OTs perceive their profession in respect to practice and research.
Creek (2003) Occupational Therapy Defined as a Complex Intervention	COT (2003)	In this research-based document Creek is attempting to describe what it is to be an OT; the knowledge and skills it is based on and the ways in which values, knowledge and skills are applied to practice. The focus is wholly on clinical practice and does not

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		describe practice in other areas such as higher education. It offers a very clear description of what OTs do and why, within the structural contexts of being an OT, and the associated values and knowledge base; how practice is carried out with clients etc., and the broader influences of government policy. Although Creek goes into great depth around defining occupational therapy terms and some of their applications to practice, she only briefly sketches out the way in which the knowledge base is being constructed, namely that this is an evolving process with contested viewpoints. Similarly the role of policy is only briefly described and the role of the third and private sectors is not touched upon in any obvious way. This document can provide some professional capital which can help to support professional agency and identity. This translates to the educational field as a guide to some aspects of curriculum content.
Developing the OT Profession (full document)	COT (2006)	Provides advice to HEIs, potential role-emerging placement providers and to students on role-emerging placements. This is within the context of OT practice moving into non-traditional third and private sector areas. The COT has identified this advice as necessary but has not taken it further through re-publication to reflect the growing marketisation of health and social care. There is no obvious acknowledgment in this or any other document on the requirement for a critical discourse on the neoliberalist developments and influences and their implications for professionalism and professional identity.
College of Occupational Therapists' Learning and Development Standards for Pre-Registration Education - Accreditation Process	COT (2014)	This document outlines what OT courses need to do to be accredited with the COT. Through this document the COT is attempting to maintain some professional legitimacy.

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Education Standards 2014	COT (2014a)	Within these standards the COT outlines the values and core concepts of the profession and in doing so which offers some professional capital and agency, however, similar to the previous document, it has advisory application only and any authority this document carries is questionable.
Guidance on the Use of the International Classification of Functioning, Disability and Health (ICF) and the Ottawa Charter for Health Promotion in Occupational Therapy Services	COT (2004a)	Guidance to complement and underpin practice derived from an eclectic and international body of knowledge. The main difference with the ICF is that it comes from the WHO rather than directly from OT. Structurally there is an influence on OT practice, body of knowledge and identity drawn from the broader debates about the way in which health is defined.
Code of Ethics and Professional Conduct	COT (2015)	This document provides ethical guidelines and requirements for OTs (including students and support staff). It is compiled in line with both the values of the profession and SOP as given by the HCPC. However, the COT do not have the power to sanction an OT in breach of this code as that is the responsibility of the HCPC. As an organisation the COT is attempting to assert professional agency within the regulatory structure. It influences the professional habitus in that it attempts to define what professionalism and professional behaviours for OTs should look like and it is a form of professional capital which can be employed by OTs when attempting to understand their scope of practice. It suggests a requirement of those who teach OT to incorporate this document into the curriculum and to make it part of a student's professional development. It aims to support all of those in practice including those employed in HEI's, however the majority of the guidelines in the document are aimed at those engaged in clinical practice.

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The British Association and College of Occupational Therapists Strategic intentions 2013-2018	COT (2013)	A very brief document that bullet points what COT intends to do. It states what the COT represents. Structurally it is attempting to position the COT as the primary, if not the only, organisation which can represent OT's in the UK thus linking membership with professional identity.
Definitions of Occupational Therapy	COT (2015a)	This document brings together a range of definitions of OT from COT, various authors, HCPC and WFOT. By doing this COT is attempting to drive and own the discourse on the way in which OT is defined by those in the UK.
Rethinking Regulation	Professional Standards Authority (2015)	Details the approach of the PSA to the regulation of the health and social care regulatory organisations. It also outlines how it sees the process of regulation changing to meet the demands of public expectations and different ways of working.
Health Education England Mandate	Department of Health (2015)	Details the responsibilities HEE has for providing the education and training of current and prospective health staff.
Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century	UK Government (2007)	This document focuses on the health professions and public contract with respect to ensuring best and safe practice and the ways in which regulation can be effective across different work and professional contexts. It was produced by the Labour Government and forms the basis for legislation regarding the ways in which health professions are regulated with a main focus on medicine. Its key narrative is about building partnerships and ensuring fair and balanced regulation and representation. It suggests that the professions remain independent, although the author's intention is to provide rules for the ways in which professional practice is carried out. Although some of what is contained in this document has been superseded by the Enabling Excellence Autonomy and Accountability for Healthcare Workers, Social Workers and Social Care Workers (2011), Health and Social Care Act (2012) and the Regulation of Health Care Professionals and Regulation of Social Care Professionals England (2014), this document forms part of the continuing narrative on the process involved in ensuring professional competency through revalidation and the regulatory process. This to a large extent comes out of issues related to public concern regarding professional standards and

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		safety. It also provides information to those employing health professionals in a regulatory framework. This is possibly more important as the health and social care services are increasingly provided by the third sector where employers might not have experience of managing health and social care professionals.
Regulation of Health Care Professionals Regulation of Social Care Professionals England	UK Government (2014)	A very comprehensive document which seeks to draft legislation which is designed to bring about consistency in the regulatory organisation of health and social care professionals. It is a proposal for clear regulation of the regulators and brings their discretionary decisions more closely under government control. Set up under the NHS Reform and Health Care Professions Act 2002 and amended under The Health Act 2012 which set up the HCPC. Structurally it brings all professional regulators under a form of central government control via the Professional Standards Authority. It delineates the field of regulation and the 'bureaucratic habitus' within which the contact between the professions and the public is given sanction via an 'independent' process with the main aim of protecting the public. Within this context it outlines professional responsibilities within the precept of autonomous practice. This plays out in the field of education via the HCPC and course validation and subsequently in the way in which professionalism and professional behaviours are codified and aligned to professional knowledge within the health and social care professions' curricula.
Equity and Excellence: Liberating the NHS	Department of Health (2010)	White paper which outlines many of the changes to be implemented in the Health and Social Care Act 2012. The white paper uses the language of choice, empowerment, efficiency and accountability. Two main changes are the removal of the NHS as the preferred bidder and the instigation of GP commissioning of health services. Structurally this is key to the way in which health and social care is run and delivered. It is also key to the funding of services and opens up the NHS to outside competition. The

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		effects of this will be more OTs working outside the NHS and uncertainty as to the role of the NHS in student education. The challenge for OTs is reconciling where appropriate, and challenging where not, an ever increasing private sector involvement with the profession's values. In doing so to maintain a clear sense of professional identity in many different working environments with different priorities and thus translate values as 'OT habitus' to professional capital which is understood by manifold stakeholders.
Liberating the NHS: Greater Choice and Control	Department of Health (2012a)	One of the key additions in this white paper from the previous one is the change from 'any willing provider' to 'any qualified provider.'
Health and Social Care Act 2012	UK Government (2012)	This Act brings the two white papers above into law. It also brings into law changes to the way the health and social care regulators are themselves monitored by the Professional Standards Authority for Health and Social Care, changed from the Council for Healthcare Regulatory Excellence. It also brings social work under the HCPC.
Department of Health 'Factsheet' Choice and Competition – The Health and Social Care Act 2012	Department of Health (2012c)	An attempt by the Department of Health to help the public understand the changes in the Health and Social Care Act 2012
Liberating the NHS Developing the Healthcare Workforce	Department of Health (2012b)	This document details the transition of commissioning of health and social care education from the Strategic Health Authorities to Health Education England (HEE) devolved to the Local Education and Training Boards (LETBs). This policy comes out of legislation in the Health and Social Care Act 2012. Some key aspects of the responsibilities regarding funding will probably change due to the government's proposals for health students to pay tuition fees.
Enabling Excellence Autonomy and Accountability for Healthcare Workers, Social	UK Government (2011)	This document discusses the relationship between regulation and the professions. It also begins the process of bringing social work under the regulation of the HCPC.

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Workers and Social Care Workers		
Skills for Health - Modernising Allied Health Professions (AHP) Careers	Skills for Health / Department of Health (2008)	Currently Skills for Health host a web site as a resource for employers but does not specifically relate this to the NHS giving advice to all health and social care sectors and providers. In part, this advice is focused on competency based work force planning and on the way in which health care providers might develop "new standardised roles" through skills development and matching. It is interesting that although its focus is on identifying how, in some cases, professionally regulated staff can be utilised in different roles, it does not mention the role of the regulators of health and social care professionals in providing competency criteria or the advice provided by professional organisations.
Report to the National Allied Health Professional Advisory Board on the outcomes of the Modernising Allied Health Professional Careers Programme	Department for Health (2011)	This report details progress and gives advice on generic areas of practice and career development across AHPs and how this relates to health care delivery and the importance of patient/service user involvement.
Reform of Support for Healthcare Students in England. House of Commons Briefing Paper	Hubble Foster and Bolton (2015)	The document sets out to change the way most health professions' student fees and bursaries will be paid. This has implications for the link between health professions' training and education and the NHS.
NHS Bursary Reform - Policy paper	Department of Health 2016	This paper begins the process of drafting legislation on the changes to student fees following government consultation.
OT Professional Autonomy	WFOT (2007)	A brief general description of the ways in which OT practice is carried out, organised, represented and regulated as an international profession. It briefly describes WFOT's expectations of nationally recognised and affiliated organisations whether these be

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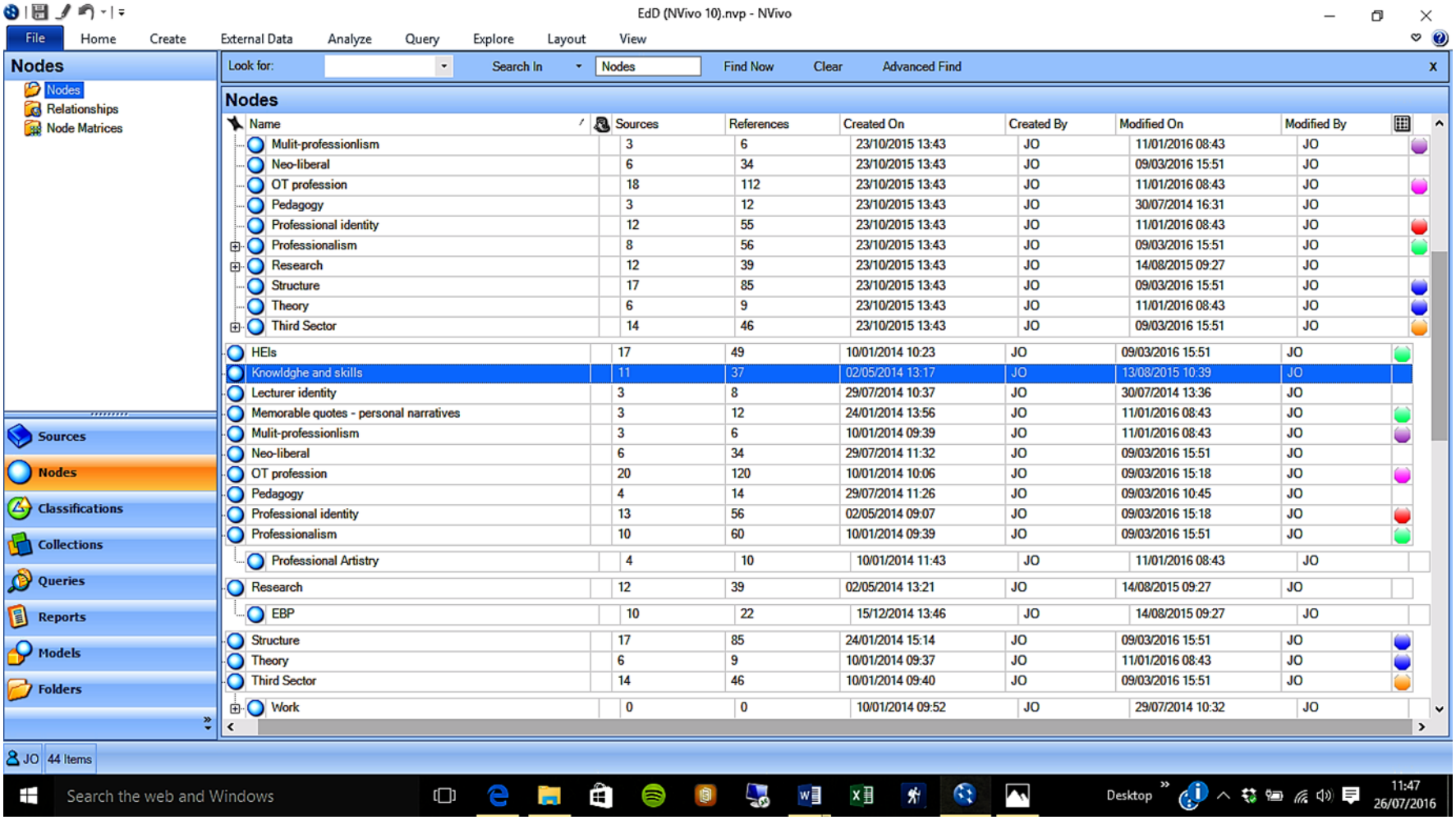
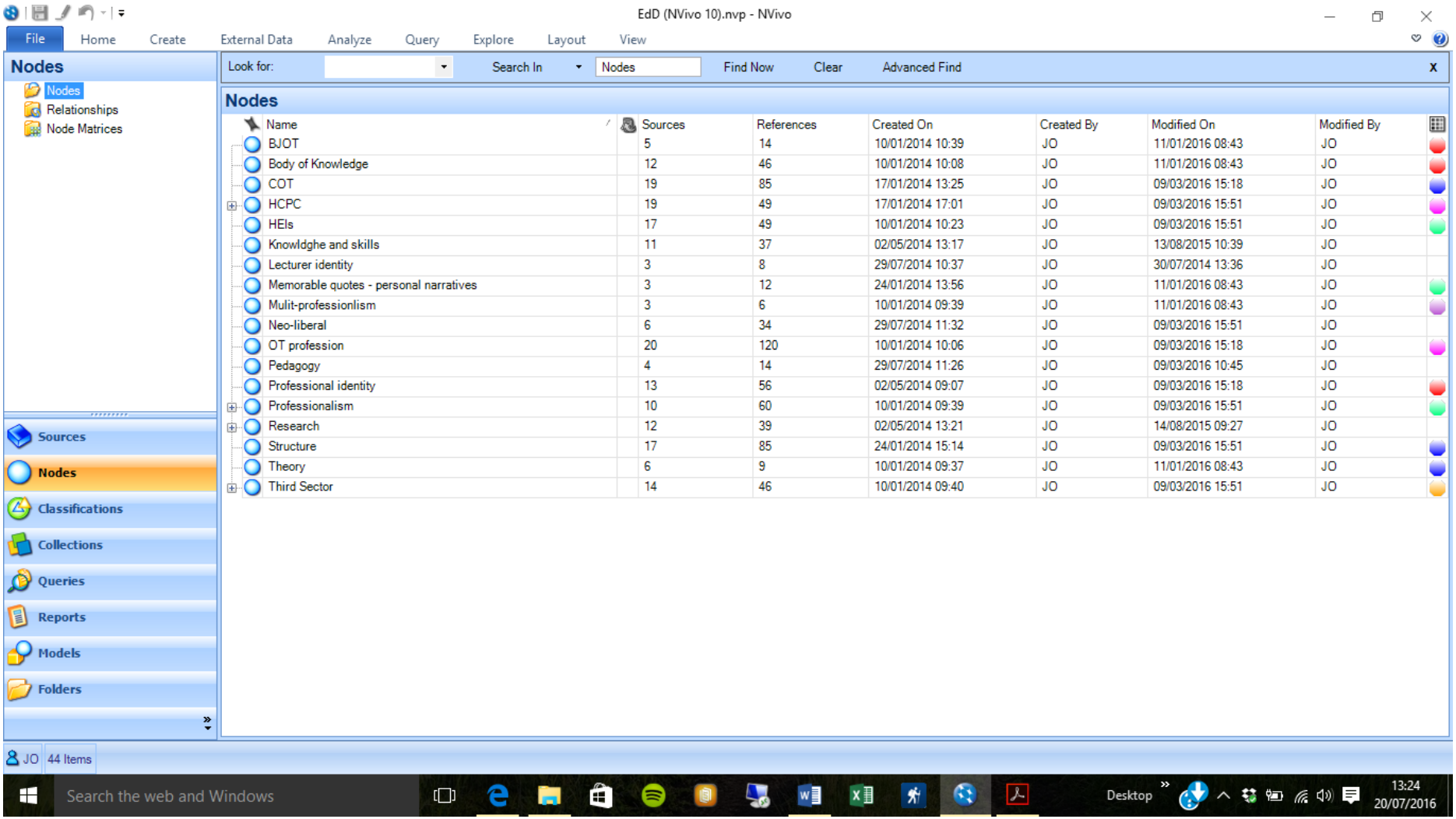
		representative or regulatory. Structurally WFOT carries international professional capital and directly influences OT practice via the COT.
Evidence-Based Practice Competency Standards for Occupational Therapists	WFOT (2006)	An overview of the knowledge and skills expected of OTs in the utilisation of EBP. It covers these as a set of competencies without critiquing what this might actually mean in practice and the ways in which different types of evidence are valued.
Process for the Approval of Educational Programmes and Advice to Establish a New Programme for the Education of Occupational Therapists	WFOT / Hocking and Ness (2004, 2004a and 2002)	Both these documents give brief criteria for the WFOT requirements for OT course approval. This is advice aimed at OT representative organisations such as the COT when approving courses.

Appendix 2 - Screenshot of Nvivo coding

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Body of Knowledge 12 46 10/01/2014 10:08 JO 11/01/2016 08:43 JO
COT 19 85 17/01/2014 13:25 JO 09/03/2016 15:18 JO
HCPC 19 49 17/01/2014 17:01 JO 09/03/2016 15:51 JO
HEIs 17 49 10/01/2014 10:23 JO 09/03/2016 15:51 JO
Knowldghe and skills 11 37 02/05/2014 13:17 JO 13/08/2015 10:39 JO
Lecturer identity 3 8 29/07/2014 10:37 JO 30/07/2014 13:36 JO
Memorable quotes - personal narratives 3 12 24/01/2014 13:56 JO 11/01/2016 08:43 JO
Mulit-professionlism 3 6 10/01/2014 09:39 JO 11/01/2016 08:43 JO
Neo-liberal 6 34 29/07/2014 11:32 JO 09/03/2016 15:51 JO
OT profession 20 120 10/01/2014 10:06 JO 09/03/2016 15:18 JO
Pedagogy 4 14 29/07/2014 11:26 JO 09/03/2016 10:45 JO
Professional identity 13 56 02/05/2014 09:07 JO 09/03/2016 15:18 JO
Professionalism 10 60 10/01/2014 09:39 JO 09/03/2016 15:51 JO
Research 12 39 02/05/2014 13:21 JO 14/08/2015 09:27 JO
Structure 17 85 24/01/2014 15:14 JO 09/03/2016 15:51 JO
Theory 6 9 10/01/2014 09:37 JO 11/01/2016 08:43 JO
Third Sector 14 46 10/01/2014 09:40 JO 09/03/2016 15:51 JO
Sources
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Appendix 3 - Interview Schedule

Participants were not asked precisely the same questions, instead they were asked questions under several themes and these questions were adapted as the interview progressed, in keeping with a narrative approach.

Examples of themes / topics under which questions were asked:

- Introductory questions asking about their journey into becoming an OT lecturer and their views on this journey in relation to how they see themselves as an OT and their professional identity.
- Questions asking their views on what constitutes the profession's values, its body of knowledge and how these are contested.
- Questions on their views of research and EBP and how these relate to OT and the influence they are having on practice in general, on their practice as lecturers and on teaching and learning and course curricula.
- Questions asking about different types of evidence and knowledge and how these relate or not to the OT body of knowledge and values.
- Questions on their thoughts about how types of evidence and knowledge relate to OT practice and the art of being an OT
- Question on what they thought are the changes to working practices of OTs and the involvement of the third and private sectors and how this is influencing their practice and approaches to teaching and learning
- Questions asking about how business minded discourse and language are influencing approaches to teaching and learning and whether this is congruent with the values of the profession; how they are responding to this and whether this changing the way the profession sees itself.
- Questions on their relationship with COT and about the role of regulation and representation of the profession
- Questions asking about the role of the COT in responding to the changes in working practices, and how effective it is in representing and internally defining what the profession should be doing.
- Questions on their thoughts about how the COT is responding to EBP and research, how this plays out in practice and in approaches to teaching and learning.
- Questions about the role of the HCPC as regulator and how it defines professionalism and what OTs do

- Questions asking their views on the relevance of COT in respect to the increasing role taken on by the HCPC and whether what the HCPC offers defines the profession more effectively to those in the third and private sectors.
- Questions on their views about how the above is influencing their practice and OT practice in general and how the OT professional identity is developing and their approaches, if any, to help students develop a cohesive professional identity.
- Closing questions asking their views on the future of the profession and anything else they would like to add.

Appendix 4 - Example of a coded transcript

In this example the initial general coding that was carried out in Nvivo is represented by the highlighted text. See **Stages of data analysis** for how the coding process was carried out in relation to all datasets. The sections of un-highlighted text not specifically coded in Nvivo were analysed as part of the complete narrative and represented as a vignette.

FILE DETAILS

Audio Length: 67 minutes

Number of Interviewees: One

START OF TRANSCRIPT

Facilitator: Okay, so thank you for agreeing to be interviewed. So my research is around challenges of professional identity and contemporary working and evidence base and the contested nature of that and so on. So they're the sort of questions I'm going to be asking you around those. But to start off with, can you just tell me something about your experience, your journey as an occupational therapist, as a lecturer and your view on the profession in general in relation to that journey?

Interviewee: Okay. Well, I was a late comer to occupational therapy and I didn't really hear about the profession until I was about 29, 30 and within a few months I'd applied for a course at Derby. Yeah, so before then - because I - what you find out later is that nothing you've ever done is really irrelevant in terms of occupational therapy, you can use everything that you've done, any kind of experience and it would probably drop in. So that's quite a good thing about it, it will probably drop in at some point. You'll be able to find some way of using the things[19].

But - so I'd done a degree in communication studies back in the '70s. I'd intended to be a radio journalist. I actually did a radio journalism training course and I came out at a time when the Independent News Service was - the Independent Radio News was - in effect all the standards were going out of radio, it was becoming much more commercial. They didn't need people in news rooms, couldn't get a job.

So I worked around office jobs and I'd already had a period of floundering around between the degree and the radio journalism because I got caught in student politics and did a lot of stuff that was supernumerary to the course. Very interesting, learnt a lot but got a third and I worked in odd jobs. I continued to work in odd jobs and then after about - I ended up on the dole for a year and trained as a teacher - that was a disaster, worked in YTS, that was the new training scheme in the 1980s.

I was - the thing that I was good at in that was dealing with a lot of adolescents with problems basically, getting thrown out of home, getting slapped about by mum and dad because they were too Western, all that sort of stuff. Just having crises. They would be having these crises in

[19] Coded to: professional Identity; OT profession.

the offices of the accountants and the insurance firms which we placed them in. So it was - we had to persuade them to take on these students in the first place when they were taking on older graduates.

But some aspects of that course were awful in terms of the way that those courses were [not available] [unclear] but some of them it was - some of the training that we had to deliver was just frankly piss poor. Then we started on taking on, on a similar basis, the employment training schemes which was an adult version of YTS which came in in about 1987. Got involved in that and of the people that we took on most of them had a mental health problem, that's why they'd been long term unemployed, and they were exploited by the employers that we put them on. It was just really [unclear]. I've always had very left wing opinions and this made me increasingly uncomfortable.

So I was looking to do something where I could be a public servant and not be doing something nasty and capitalist if you like. Not ripping people off and not getting involved in shenanigans, which there was a lot in the YTS industry. Some mate suggested that I went and looked at occupational therapy, and that was great, that was marvellous. I went and did a couple of day's mental health and physical unit and I thought I can do this. So that was how I got there.

So during that time I've also been involved in community publishing so - I tell you a lie I'm actually [unclear] that's been my big thing. So that was another really important thing in terms of occupation because for about 10 years I'd been working with - running a writer's workshop - sharing the running of a writer's workshop and getting involved in the running of an organisation of people that were doing community publishing. That was all around narratives of people doing stuff, what I did when I was a cleaner or something like that, or a chip shop owner or whatever and all the histories around community experiences, which were occupation narratives, I realised fairly soon into the course. But there was no place for that in occupational therapy.[20]

The thing that struck me when I was doing my diploma was okay, so what happens after you get outside the hospital gates? It all ends at the hospital gates. Nobody's thinking beyond that, it's all very clinical. We're talking about occupation, it's about human occupation, the model of human occupation model is very, very big, oh we've got the human occupation - it's so complicated, it's really wonderful [unclear] profession, which … at the time. Yet - but at the same time in 1990 occupational science was just coming out. I hadn't really heard of that at the time. I can remember seeing the papers and not being very clear what to make of it at the time. Well that stuck with me really.[21]

So when I became an occupational therapist and I was working in an asylum that was closing down - and that experience was like - if you read [unclear] [it's just] *One Day in the Life of Ivan Denisovich* and you've got all the behaviours there that can constitute the tone is, that sort of - everybody was doing those behaviours. So I read it very much in terms of that. It was oppressive and you were part of that system of oppression. Mistakenly, perhaps at the time, I did an MA in [psychiatry, philosophy] in society, which had a very strong antipsychiatry element in it and democratic psychiatry and all that kind of stuff.

So that - I was really sort of by this time questioning my practice. I became the manager of a - I went up through the ranks quite quickly because I was trying to build on my previous managerial

[20] Coded to OT Profession Knowledge & Skills
[21] Coded to: Professional Identity; OT Profession; Body of Knowledge

experience. I was 30-odd years old so I sort of - all this career path, need to be restoring the career status that I'd left behind in all the wilderness years. I did quite well in the [unclear] because it was all containable. You understood what was going on, you knew everybody in that network and even the people that maybe you didn't connect with too well and [unclear] you had to work together.

There were some interesting university [course], entrenched attitudes and stuff like that [unclear] it was a - but it was grim. Every day you came up the drive and you saw spectacles of extreme indignity shall we say, you were involved in that, trying to present a little island of that through what you were doing in occupational therapy. You'd get people in the minibus and take them down the drive, once you got outside the hospital gates everybody started to behave in a much more normative fashion, if you like and end up with - you'd get [unclear] bus and in two minutes we'd be back to all that sort of behavioural nonsense.

That in itself is very interesting. It was just prior to [unclear] coming in, so that was just on the cusp of that, because that was just - it was being put through the process of [unclear] antipsychotics. But yeah, working in the other unit - so it was - nobody really liked occupational therapy there apart from the occupational therapists. So what they tended to do was just dump everything in there. Anyhow, so I had a full blown hospital and I had people telling me I had to have people who were very, very [disordered] in there, fine, but then that meant that somebody had to take them to A&E when they were cutting themselves. That should be their responsibility but it isn't their responsibility when it's happening in front of other patients that they're disturbing.

So after a while I went off with anxiety and depression and I probably should have taken a longer period out before then - I was off for about four months, came back and thought bugger this I'm going to work as a community senior OT. A position had come up and I thought I'll do that and rebuilt my career. I finished my MA, completed that, but then I went back and did an MSc in occupational therapy. The person who stepped into my post had a number of places on this course offered for [various reasons] [unclear] why don't you do that. I thought that's [that's okay, that's certainly] what I needed to do. So that reaffirmed my faith in occupational therapy, but not entirely because I still had this anxiety about what occupation is.

I think from the MA, very strong, critical, [Foucaultdion] perspective. So I feel I've still retained - in fact if anything it's become deeper and darker if you like. [Currently MSc] reborn as an assertive outreach community OT and I'm having a great time. I got a part time post as a research and development worker which was chasing all the people who'd done their MAs or MScs and hadn't written their dissertations up as articles in order to beef up the profile of the trust. But nobody was being given the time because that's how it works, back in the old oppressive managerialist, corporatist stuff, we'd put the pressure on people.

Nobody wants to take the time - I'm prepared to do stuff in my own time because I'm very driven and I like study and I like engaging with ideas but other people don't have the time to do that because they've got families and they weren't being given the time to do it so they didn't want to do it. They saw it as work; they saw it as working for the NHS. So that left me with a load of time to do some writing in because nobody else was doing it. So that's what I decided to do. I would start engaging [unclear] so I systematically - well yeah, I thought I'll see what there is on the web and start fiddling around.

So I got in the model of human occupation checklist and there was a discussion going on there, I got into the international occupational science web list and there were discussions going on there. That's how I met Frank. So I met Frank through that. He was developing *Occupational Therapy*

Without Borders and they needed to have an English person to help them write it basically. I'd had experience of community publishing so I'd already written a [few previously].

So they invited me to join them on the board and that was it, I didn't look back. By the time I came here I already was entrained with writing *Occupational Therapy Without Borders*, we'd engaged a load of [South African] OTs … went down to South Africa to … I'm interviewing this Nick Pollard bloke and I said oh you're the bloke - because he's doing this book with Frank. So that kind of paved the way really for me to continue in this job to be engaged in writing stuff.

Actually in terms of a background just doing that exercise it was very, very fortunate to have arisen in that particular time. We had to deal with OTs all over the world, we had to tell people like [Gary Kielhofner] we didn't like that chapter, it wasn't critical enough. [Unclear]… I'm telling Gary Kielhofner I don't like his chapter can I do this … Can I [really do this]?

So the learning curve was very, very steep indeed because we were trying to justify ourselves to each other while we're actually doing this thing. We hadn't done this scale of a project before. We're having to engage with stuff and [read a lot of] stuff in order to be able to critically interpret the stuff that we're reading, so we're learning an awful lot. That has - once you're on that process you can't get off it, even if you wanted to. You can't get off it. So - sorry, [so that has made that]. I've since then been continually engaged in a critical discourse with people all over the place.

Facilitator: Obviously a very varied sort of a background coming into occupational therapy and it seems to me from what you're saying that a key area of your practice has been around actually the theoretical and critiquing of different perspectives in occupational therapy and whether you think they actually fit with what's going on maybe in practice and then maybe what the other people are saying, more internationally as well. So from your experience then what do you think is central to the occupational therapy body of knowledge and what do you think is maybe - is contested within that and maybe actually is not so central but is still there and prevalent?

Interviewee: There's two things, I haven't talked about practice very much and I should talk about practice before I get onto that. Let's go back to practice really. The key thing for me - the fact that I used to work [federation of writers] stuff is about people talking about the stuff that they like to do and the stuff that they've done in order to survive. They probably - most of the writing - at the end of their working lives in retirement they're writing a story for their grandkids about how life was.

You'd never believe it, we used to have horse drawn buses and all that sort of thing. I had to go down the road and ask for a pair of boots off my mate's parents because my mate was died and he was laid out on the table but there was a pair of boots there and boots were hard to come by. So very tough, raw survival. People forget that now. But my parents and my grandparents were from that generation. So the NHS and all that it stands for, it isn't a commodity you just piss against the wall or give away or something like that. It's a real bloody thing because people are going to die because they can't afford the doctor.

They're going to have things like diphtheria and all this stuff can come back, easy as wink, because we've used antibiotics in a stupid way or we haven't - you know. So it's really, really crucial to have this kind of thing. You have to decide if [we're having] a society then we want to run it on a neoliberal market principle. Why do we actually do this? How do we keep the thing functioning Do we sell everything else [that they might sell] in bloody China or do we have some things in place, like railways and the health system, that enable it all to function so we can actually have a bloody life.

So one essential thing then is having a life and those moments of enjoyment. I think in terms of practice what I felt was okay there's all the theory and there's all the research and we should be doing it. In mental health you're not so [unclear] to putting people on the bicycle fretsaw to make them do 20 minutes … exercise, it's about can I get this person to engage. Because most of the time I've worked in enduring mental health that's been very, very challenging.

It's a Zen process; you've got somebody who is [anhedonistic/anhedonic]. They don't want to do anything. They don't want to do anything because if they do anything they might reveal they've got these screaming voices inside their head and it's really, really bad in there and they don't want anybody to know. They want to just hold it in. Or if they do anything it's going to be so exciting that's where they're going to be pitched into, this kind of unfolding mess that one won't be able to get out of easily and other things like that.

So we're sometimes trying to find some way of actually getting that person to coax them along. Then you've got bums on seats, let's get them all in the art colouring group because art [unclear] activity. So you've got a bunch of adult people colouring in pictures out of the colouring book or [unclear] on the photocopier doing that all afternoon and they're saying yeah well what else could they be doing next week. Their potential is locked up in what the institution is prepared to give them in terms of very limited range of activities.

So I always - what I'm trying to do and - I've been working with other people, we've all being trying to do it - and not just OTs, nursing systems, nurses, social workers are wanting to push the boundaries out, let's do this. So by the time we got to [the assertive outreach team] we were playing this kind of game of being a subversive little [unclear] this is an idea, I wonder if we can get away with that, can we get away with it. Let's [run this] this idea past a very supportive manager. Can we put all this off? If we do this we'll write it up for *OTnews* or something, seeing how much we could get away with. People were willing to let us get away with it if we could support it well enough. So it's just a matter of laying these things.

All the time you're trying to do stuff that would actually give people just a different opportunity. You're like okay; it's hard to sustain these things. Then you've got things like [unclear] horticultural … they had a very good football [teams] it's still running actually in that … going on. So there are lots of different things like that. I wouldn't say what we were doing was unique or pretend it was but it's in that direction. It's saying okay there's a human value.

So a lot of the things that's now coming in, come into some of the sort of stuff from South Africa and from Chile [unclear] in the first place is … human scale development values. This is … in 2010 … So he's talking about before there is money there are people. Before you earn money you have needs that money is there to somehow translate. So let's look at the needs, because you can't actually quantify needs, you can't calibrate needs.

You can put them on a grid, you've got the matrix and you can say well the need for love, the need for space, the need for friendship, we have a need to go to parties, we have a need to be idle. But occupational therapy and occupational science has begun to do this [as an idea], these things have got to percolate through, hasn't really challenged that because there's never been any critical

examination of what occupation is. It's not a meaningful and purposeful doing, it's meaning and purposeful doing within the capitalist framework.[22]

So unless you have a critical perspective of capitalism, and then when you start to use words like productivity and use words like occupation, which are interpreted very narrowly now in terms of work and not occupation in a broader 19th century sense then that means making stuff that is about the value of labour in effect. [23]We get [unclear]… let's find a job for occupational therapists, we've all been thrown out of here, let's go and assess people for their capacity to work. It's just like bloody YTS again. I've escaped from YTS and come back into the fold.

Facilitator: [This has] a critical perspective that you're talking about…

Interviewee: That's missing at the clinician level because we're thinking about our pensions and the mortgage. It's understandable that it's missing.

Facilitator: What about evidence based practice then, that drive towards evidence based practice, does that fit with that or not?

Interviewee: It can't fit because what you're talking about, if you're talking about human scale development needs you're talking about individual bespoke assessments. Now there are ways to do this. [Rod Lambert] is doing this kind of thing. You get people to do stuff then they will form the neural pathways - so by getting people to do what they want to do they will form the neural pathways, they will make the neural connections and you can trace that back to a biomedical principle. That is the line that he's taking up. Yeah, that's right, that stands to reason. That means you can still scale these things up, you can still think about these things in terms of they know what your evidence base is about.

Is your evidence base about recovery or is your evidence base about cost? Well, cost matters much more than anything else these days, so okay, fair enough. But the sponsorship for the research that provides the evidence isn't about cost, it's about selling medication, it's about selling products, it's about selling [unclear]...

So you're not interested in the fact that if you gave somebody a tomato plant and it cost 50 pence and a grow bag and it cost £1.99 and they look at their tomato plant every day and they talk to their carer about it that actually gives some structure to their lives, just that. But you need to put something in motion and that might be just the thing that somebody starts to talk about - and somebody's actually said this [unclear] that made a difference to them, having a tomato plant. Having a tomato plant that costs total £2.50 per - I don't know, it grows to fruition over a period of three or four months, it's a hell of a lot cheaper than any medication pill that person has even if they're on bloody paracetamol.

So getting people to do what they want or would like to do, or if we can find what it is that they want to do - and okay it might take medication to stabilise it, should reduce the cost of care. The evidence base - we can only do horticultural therapy because there's so many pieces of literature saying that horticultural therapy is in some way good or beneficial for you, or some spurious uncontested notion of spirituality or some other stuff that we haven't really isolated down to any particular thing. I mean it's fine, it's right, but those notions have to be explored.

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[22] Coded to: Body of Knowledge; OT Profession; Structure
[23] Coded to: Body of Knowledge; OT Profession; Structure

If we're going to be holistic then we've got to - that's quite challenging to be holistic when you've got a case load of 40 or 50 patients in a community mental health team and you're going to see one of those every - see one person an hour for a day, seven patients a day, write them all up and so forth. How the bloody hell are you going to [really be holistic]? It's just a name on the label. It's just a name on a piece of crap from the COT. It's the name on some piece of policy. [24]

Facilitator: But in that respect how do you think that it plays out in terms of our teaching new students, pedagogical approaches and so on [unclear]…

Interviewee: We're in the midst of a crisis at the moment aren't we?

Facilitator: Yeah. There's a tension there, it seems to me between - from what you're saying between where maybe some of the OT evidence base should be as opposed to a sort of traditional sort of approach, i.e. medical approach and a [unclear] way of evidence [unclear]…

Interviewee: Talking about the history of the profession you might find that if you're interviewing somebody who did a degree as opposed to a diploma they might think about it differently I suppose. But when we had the diploma we went off and did things like [unclear] went onto the Derby railway works for an afternoon and I looked at people doing stuff in a noisy factory environment, because some of the people on the course had never been in a factory. We went to [Remploy], there were other places, I can't remember all the places we went to, we went to different - well, obviously. It was about looking at what people did in real environments.[25]

So the stuff that I was coming across in the work [unclear] and in fact I'd done some of this myself. So it was trying to inculcate some kind of idea. When we did woodwork for six weeks we had to look at our pieces of wood and understand where the wood was going and think about it before we actually started going into it. Now you would do let's make some nice pretty coloured craft things or this is some card and here we go, one hour later we've made a nice card. But what we haven't done is we've not looked at that card. We haven't thought well actually that card's 80 grams, that card is 100 grams and that card is 120 grams. That's nice.

Facilitator: You [unclear]…

Interviewee: There's no contemplation. There's no understanding - to understand how to translate the enthusiasm about that to somebody else you've got to be enthusiastic yourself. If it's just a modality of treatment - and it could be anything, it could be a bloody [kettle tipper], then you haven't got the passion about it, you haven't got the gut feeling about conveying this stuff across. So that's one thing.

So when we turned it into an academic course we lost all that and it becomes theory. But the theory is condensed. It's not - if you compare occupational therapy, education, occupational therapy education in some other countries where they have to have longer OT programs because they're working in a wider range of areas, you have to have the critical theory. Back in the days of the diploma when it was four days a week solid, nine to five, in there all the time more or less - Wednesday afternoons we were off [unclear]… some other stuff. We had some [of this critical] sociology, psychodynamic … stuff, engagement with theory in the course.[26]

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[24] Coded to: Professionalism; COT; Structure
[25] Coded to: OT Profession; Professional identity HEIs; Pedagogy; Knowledge and Skills
[26] Coded to: HEIs; Theory; Pedagogy

So you were expected to engage in that critical theory. All that stuff is gone. When they're over to an NSS driven more consumer led thing where students are paying £9000 a year and they're going to be £27,000 in debt over three years, they're buying a course, they want to have an easier life and they don't want to do the critical work because they want to just do what they had to do for the essay to get through the course. That is not going to make good clinicians. It's not going to make good, critical clinicians. It's not just about the critical theory, it's about relating the critical theory to the substance.[27] You can't have a [Frarian] [unclear] process in reflection if that's what we're going to have, unless you're reflecting on stuff like if you [unclear]… real stuff, [maize], bricks.

Facilitator: So in that sense then, in terms of what we're trying to get over to students in terms of [theory], (a) is that played out on the ground in terms of a knowledge then, tacit knowledge of the art of being an occupational therapist and secondly, are we actually sure about what we're actually saying they need in terms of the theoretical perspective in relation to [do that]?

Interviewee: The art of being an occupational therapist is something that we satisfy ourselves - it's a discussion that we have to satisfy ourselves. In a sense we are always talking about what we could be. Because occupation [Margret Riley] says is the greatest idea of the 20th century - it is the greatest idea of the century, it's a fundamentally revolutionary idea. We started to have a movement built around the [ways of] people having the right to do something that they actually like to do, which doesn't involve money but might involve money. But it doesn't necessarily have to involve money.[28]

It means something really fundamental, let's have some fun. Let's have some fun, it doesn't necessarily hurt anybody else, it's just a little thing that were going to have - a community as it were, we're going to have a bit of fun. That's what people are out on [Tahrir Square] about effectively. That's why Turkey's in bloody revolt over having a park.

Facilitator: Space, leisure, whatever.

Interviewee: Yeah, what a fundamental [need], a space in which to be. A space in which to be yourself. A space in which to express your identity as a person with other people. So that's a fundamental principle, that's what it's about. So yes, it's theory, but it's about actually doing stuff. One of the best things that - I spent 18 months working with one guy and I took ages to get to work with him in the end we went to buy his mother an ash bucket as a present for New year, because he was going to stay with her over New Year. Boxing Day you go into B&Q in the town centre, there was a two hour traffic jam - it took two hours to get to B&Q. We got to B&Q, of course, B&Q doesn't sell ash buckets - two hours back again.

It's taken 18 months to get this guy out of his flat [unclear] a total disaster. We've been talking all the time on the way back, chewing the fat and stuff and I thought this is dire. But three days later his key worker says to me oh so and so had a really good time [with you in the car on] Boxing Day. It's that - that is the essence of occupation.[29]

Facilitator: So what knowledge should we be imparting to students then?

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[27] Coded to: HEIs; Theory; Structure; Professionalism
[28] Coded to: Professional Artistry; Professional identity; Body of Knowledge
[29] Coded to: Knowledge and Skills; OT Profession

Interviewee: Well, the knowledge that we should be imparting - so what I'm trying to get round to is that that is not understood by all managers. A four hour disastrous trip in the car which is, as you…

Facilitator: [Unclear]…

Interviewee: Yeah, which is the culmination of an 18 month period of trying to engage a bloke who doesn't want to engage, which turns out to be successful, is going to look very bad on the report that I then tick off and tell you I spent four hours with this bloke in the car not actually achieving an objective. But I did achieve an objective, a key objective, which has then enabled me to work with that bloke for the rest of the time that I was in that service. I [unclear] a series of other things out of that doing stuff. So that was the turning point, but that doesn't fit in with the returns.

That's the problem with occupational therapy and the managerialism and corporatism [unclear]. Nobody understands what it is. We aren't successfully communicating what it is. There is no popular awareness of what occupational therapy is.[30] There are no popular occupational therapy programmes on the television; we don't have baskets, but resolving family disputes on Saturday evenings at eight o'clock instead of blues and twos or whatever it is. We haven't got any of that. We haven't taken over *Blue Peter*, we haven't taken over *Art Attack*, we're not telling it to kids.

There are in fact - there's a small sub-genre of Mills and Boon romance novels about occupational therapists who breach their ethical principles and cop off with the carers or the patients that they work for.

Facilitator: Okay, I didn't know about that.

Interviewee: No, they were written by nurses over in the States. But there isn't anything that captures the imagination, like *Holby City*, about occupational therapy. So we haven't won that battle yet. The COT is trying to do that, I think, in various ways, but not very effectively.

Facilitator: So what are the difficulties do you think there? I mean how are they trying to do that and why aren't they doing that very effectively?

Interviewee: I think it's very - it's very stuffy, it's very twin set and pearls. The membership are alienated from the COT, it's too bloody expensive to go to the conference.[31]

Facilitator: Why are they alienated?

Interviewee: Because it doesn't involve them, it hasn't involved them. What's the voting figures for anybody that stands for [unclear]? Nil, zilch. Not very many. The journals try to make itself more academic to get a higher impact factor but the consequence is that probably less people read it because it's more difficult to read.[32] People go to the COT conference - I mean the last time I went to a COT conference I couldn't move in Brighton for people shopping who were the COT delegates. So yeah, they all went to the COT, which cost a mint, but large parts of the time it was empty because they were out shopping.

They were there for the key events but that isn't good. We're not engaging people enough. That's about - when you're investing that kind of money and going to an event like that and it costs as much as it does to go to a foreign conference to going to one in Brighton or Glasgow and you're

[30] Coded to: Knowledge and Skills; Professional Artistry; Structure
[31] Coded to: COT
[32] Coded to BJOT; Research

going to get less networking done because everybody's in Debenhams and John Lewis, that is not a good thing.[33]

Facilitator: Are the COT trying to represent us or…

Interviewee: I don't think they are seriously - well, they should be there to represent us but I don't think that's - something needs to be done, some sort of basic footwork. On the other hand at the more regional level you've got very dedicated regional members, but the outward thing of [unclear] occupational therapy says in some way we as a profession we haven't got the same kind of profile where we're so glad if David Cameron says some stupid remark in an offhand way to one person, yes we'll look into that question for [AHPs] we have to report it all over the place. That's ridiculous and it looks stupid. It looks stupid and it looks naïve.

So I think there has to be a much more critical focus on all fronts about how we market occupational therapy, how we consider occupational therapy, how we present occupational therapy and the [doinigness] occupation.[34] But what's happened is that instead of being occupational therapists who do all of these amazing, crafty things and get people looking after chickens and stuff like that what we end up doing is we end up being told that we've got to assess somebody for a hip operation and [unclear] and all the rest of it over the telephone in a call centre in Lincoln. Or we end up with being told that we're going to discharge this patient this afternoon, can you see them? No. Oh well, we're discharging him anyway.

Facilitator: Yes, rings a bell with me.

Interviewee: Or we end up in a situation where can you go and follow up this equipment adaptation request for this person. They've had five locum occupational therapists in the last year, nobody's ever stayed long enough to actually process the application. Oh but your contract ends in two weeks. So that's not necessarily the profession's fault, it's how the profession has ended up getting used. On top of that you've also got - which I did - you've got the give us a job syndrome, so I can do that, I can do that, I'll take that patient on and work with them because I need a full case load otherwise somebody in the time might say well you've got an empty space.

So I'll take this person on who isn't necessarily [appropriate] occupational therapy but I'll try to work with them in an occupational way. Nine times out of 10 it will work, so that's okay. But then there's somebody else who might be more suitable - I've already started engaging with this bloke so I can't work with them. Because I need to fit in the team, [unclear]… all working generically and the manager is a nurse or a social worker and they want us to work generically [unclear] that means that the OT bit of what I do is lost, or I'm communicating to other people and they think they can do it. It's common sense really isn't it? We don't really need an OT.

All those people that you had in your - I got told all the people you had in the pottery workshop who were there for about 10 years weren't they, we got some of those as volunteers doing the pottery group now, so we don't need an OT. Why do we need to spend £40,000 [unclear] costs on employing a band six when we can have a couple of volunteers do a couple of mornings a week?

Facilitator: So that seems to be what you're saying there is quite a diffuse nature of OT in terms of where OTs work, how OTs work and then how OTs encapsulate their practice and actually

[33] Coded to COT

[34] Coded to: Body of Knowledge; OT Profession

delineate it really. There seems to be two things there, that (a) there's a problem in terms of professional identity and professional coherence which then is a problem when it comes to this increasing move towards a more generic nature of healthcare delivery and the more marketisation of healthcare delivery. What do OTs need to do, do you think, in terms of its body of knowledge, in terms of how it's represented, in order to try and ensure…

Interviewee: Well we can look at what's going on overseas. If you look at - I went to Chile earlier this year and in Chile the occupational therapy profession has matriculated since 2005 a 387 per cent increase in OT students. It's the fastest growing profession in Chile…

[Over speaking]

Interviewee: But it's starting from a low base but it's impressive. The other fastest growing professions are also nearly all health professions, physiotherapy, different branches of nursing, speech therapy. Occupational therapists there work in a wide range of systems. It's a neoliberal economy, growing [health] disparities, young population - they will have an aging population in time because in 30 years' time that aging demography is going to catch up with them. You've got particular issues like [long thon] country or … dispersed indigenous population, earth quakes. So you've got post-traumatic stress disorder, all that kind of stuff as well.

You've got less tax base to build the resources with. But there's a lot of new building going on, a lot of new university buildings, and that's phenomenal. It's absolutely phenomenal. It's just you can't walk around the place without seeing another university cropping up. Eight universities - satellite universities many of them in a town of 300,000 people at the conception. So that's pretty interesting because in the period between 2000 and 2007 the Labour Government sent a load of people off to South America to work out how it was going to implement all these things like social enterprise and stuff like that in the health service.

They looked at all the Latin American countries and some other ones. I'm just coming across this in various [unclear]. All these ideas get mistranslated back to the UK and we end up with [CICs] and occupational therapists … social enterprise … on the periphery of this there's Richard Branson rubbing his hands and saying I'm going to buy that out. Care UK, are they going to step in there and buy them out if it's profitable? Of course, in a place like a [a farm] in north-east rural Lincolnshire where there isn't anybody you can do that sort of thing and nobody's going to buy it anyway because nobody else is going to want to work there.

But in a place where there's a big city of course you can step in there and clean up because it would be economical to do that. So we've got to be very, very canny about what we do. Out there in Latin America they haven't got a massive evidence base, they've still got the same drivers; they've still got to produce the evidence. All the things that we've got they're having to bring in, in terms of audit and stuff and that's all happening because it's very cost driven, it's very - all the apparatus of accounting and that kind of stuff that goes with neoliberalism.

We've got big [style] because we're in the middle of cuts era; we've got all the austerities. We've spent more money on management and audit than we actually do on delivering a service. They're going to end up doing the same kind of thing. But in the interim they haven't got that. What they have got is they've got a Latin American continent which all speak Spanish and they've got a network of knowledge building going on. Because there aren't the number of journals and there aren't the number of - you can't generate enough - it's hard to publish a book because you're [on demand] publishing, you [can't get big enough orders]. You've got to find other ways of doing it.

So OTs and other health professionals are doing the same thing, they're creative. They're sending PDF documents off to each other. They've built a network of exchange. There's a conference happening every month somewhere in Latin America everybody goes to. It's affordable. There's the money in university because there's a lot of students are going and they're paying a third of the fees that our students are paying to support that kind of knowledge building. So not only that, it's a five year program for undergraduates. [35]

Facilitator: Oh okay.

Interviewee: Yeah. There's been a tradition since the 1990s, certainly since the 1980s in Brazil of a critical discourse, which is based on the realities of disparity that there are. Massive great slums, there are entrenched social problems in those slums and amongst the indigenous population and amongst other groups in society and recognising that they've got the same problems in the middle classes as much as they are in the working classes is another issue. There is a set of traditions which are about strong, patient led - or user led - organisations as well. So they are your allies.

So there are a lot of local [unclear] but we can learn from that because I think there are parallels with what's going on here. So if you want to actual deal with what's - if you want to take on the criticism of our society which is very much about actually holding things together and not [looking] too deeply. Look at the South African practice; look at South African perspectives to occupational science and occupational therapy. They've had to deal with the Apartheid regime. It's in their face. You can't have any credibility with going to work with the community if you can't [take] on board. So you've got to take it on board.

So that's where the critical discourse is and it's in English but it's in a South African journal. So we can learn from that. That's what is quite difficult here. [Unclear] talking about - I'm very interested in the political nature of occupational health … critical, it's bad conversational topics … don't want to talk about this kind of stuff because it means on one hand yes, it is macro politics. It is David Cameron and all that sort of nonsense, but it's not just David Cameron's nonsense, it's the whole bunch of them - a whole bunch of the establishment [unclear]. It's about the hegemonic order.

We have to tactically understand our position in the hegemonic order. That means every practitioner has to tactically understand the position in the hegemonic order, because in order to preserve the idea of occupation as a practice it has to be thought out over every little flower pot and bloody opportunity to stick a grow bag in a window. That's going to mess up my [unclear] I can't … You've got to fight the hegemonic order over every damn thing to get the risk assessment through, to be allowed to take that group out for a walk on a Monday afternoon.

Facilitator: So all these structures that are there then, the structures in terms of the wider political discourse and the general trend…

Interviewee: But they've played out very much…

Facilitator: On the ground…

Interviewee: On the ground in the individual practices. In can I do this, no you can't, you're not a proper qualified professional or you're not a nurse, or I'm not going to allow this patient to come out with you and do this, or I've already discharged them. Or who are you to talk to me like that. Or I'm

[35] OT Profession; Multi-professionalism; HEIs

not qualified; I don't have to do your job for you. Whoever it is, all these people are caught up in that system and so it's a very real problem that we have to understand at a very fundamental level of everyday practice.

Facilitator: So in terms of that - so in terms of here, in terms of teaching students and here there's a structure obviously within this university and there's various drivers going on here. The OT within this university is within the Department of Allied Health Professions and so on. So given what you're saying in your experiences and your understanding [unclear] and insights, what sort of agency do you feel then that yourself and the other lecturers have here in terms of developing that critical discourse whilst sitting within these particular structures? Is it supported within this university, is it not?

Interviewee: Well it is and it isn't. I think within the team it's supported but we've got to - the Department of Allied Health Professions, we're within the faculty of health and wellbeing which is nurse led. So the dynamics of the NHS are replicated in the faculty, with all the things that that means. There's a lot of things in the way that some of the other professions work, nursing in particular, very administrative, very used to using heavy handed tactics in managing things, and we've had a history of that in our own profession as well but that's always going to be the case.[36]

If you've got a female profession which is trying to - that's another aspect is the gender dynamics. A very largely female profession which is trying to compete in a male order - the medical order and the male order of management, and has to sometimes be more bullish than the men in order to be able to thrust its way into getting out into the relevant levels.[37] You can't do that by being nice. There are certain points at which you have to say well that's out of order. At the same time we're bound by professional constraints. So we can't tell people who don't pull their weight to bugger off, which you could do if you were Alan Sugar.

Facilitator: Yes. So we have a professional sort of view and in fact we're regulated even…

Interviewee: We're regulated, yes. If you compare the profession - I've trained as a journalist, if I had been a journalist then I would probably have been fired several times, I would have had several slanging matches with editors and colleagues which would have been blue and I would still be able to call myself a professional journalist but if I'd been a spare part at any point or - whether or not I'd been a spare part, if I'd been assumed to be a spare part I'd have been pulled out. I would [unclear] spare parts out in the same fashion, because that's how it is in that profession. Maybe that isn't the way to go on but it means that there's a certain lack of realism in terms of some of the delivery. So we've got that issue to deal with.

But despite the fact that there are the heavy handed tactics we've also got - you're in an industry where your people can be carried for years. So there's a lot of that as well. That means that other people can pick up the pieces. You're shackled to your mortgage, you're shackled to your professional reputation and you've got those things as well. I mean having a period of being depressed [unclear] one of the main concerns was would I ever claw my way back into the profession and what would that look like. I realised afterwards that actually it was probably an asset, but it didn't feel like that at the time.

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[36] Coded to Multi-professionalism; Structure; HEIs
[37] Coded to: OT Profession; Structure

So there are certain prices for learning certain things I suppose. At the same time you've got very young students who are coming out of school and they've got to find all that out for themselves, we can't tell it to them. They've got to find out experientially in order to have a resilience. You need a lot of resilience to be an OT. You've got a lot of competing factors and you've got to really fight a good fight. I think probably every professional group could say that. A physiotherapist could say that, physiotherapists and mental health can certainly say that, a nurse could say that.

[Unclear] a particular … that you want to deliver in nursing you've got to fight a good fight as well for your particular branch of nursing. How many nurses are unable to engage with the patients because they're stuck in the office having to deal with a load of other stuff?

Facilitator: Do you think the HCPC then in that sense in terms of professional constraints but also delineation of what the profession's about actually helps or hinders that process? That fight that you might need to take on?

Interviewee: You have to consider what the HCPC is about. Is the HCPC there to protect the profession or is it there to represent the government? Is it there to represent regulation? Well, really it's there to represent regulation.[38]

Facilitator: That's quite interesting, yeah.

Interviewee: It's there to represent [regulation]… We have to have standards and somebody has to regulate those standards and we need the HCPC to regulate those standards. But how it operates is inevitably it will operate as an instrument of government.[39] So you look at what happens with the HCPC, probably - I've known people who've gone through the mill in there and probably you have to be - there has to be a fairly clear case - but it isn't always a clear case - for you to actually end up being assessed by that group. They're not all evil people; they're people who are trying to do what they can for the profession.

There are different people in there - there are some people in there probably that like the power and there are other people in there who are trying to keep it sensible. I know there are people in there who are trying to keep it sensible because of the comments that people have told me about it. So it's a difficult thing. It's a service to the profession to be involved in the HCPC because we need it. But you can't go into anything and not question it. That's one of the - if [unclear] the assumption that I had when I was saying I want to do something that's actually honourable and helps people, the fact that's a very naïve idea.[40]

Facilitator: Is it a contradiction or do you think it actually works quite well [unclear]? We, let's say internally, we try to…

Interviewee: Sorry, that was a very naïve idea I had about occupational therapy back then in the 1980s and since then I've realised you have to question everything.

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[38] Coded to: HCPC; Structure
[39] Coded to: HCPC
[40] Coded to: HCPC; Professionalism; OT Profession

Facilitator: Yeah, sure. So in terms of then how we're attempting to internally construct let's say our professional identity and what we want to do and let's say for example we have some notions of social justice and so on and so forth…

Interviewee: Which we haven't contested.

Facilitator: Which we might not have contested, yeah, and how that relates to then - you're talking about the HCPC of being an arm of the government, how that external control actually is there to help OTs do that or actually is there something else going on there?

Interviewee: Well I think it could be progressive, it could be a progressive force, but I don't think it operates in that way, because I think it probably - I think one of the things that's going on at the moment is there is a lot of fear, [unclear] the profession. I certainly feel that there is an anxiety about the ability of the profession to survive at the moment in the current climate.[41] Occupational therapy is common sense dressed up in a load of occupational based language, the principal word of which is occupation. You can stick anything you like in front of - you can stick anything you like after the word occupation and make it into an occupational concept so in the end it becomes completely redundant.

We haven't really critically addressed that - the occupational science community hasn't really got to the bottom of that.[42] One of the things that we got, as a new profession and a new discipline is that we haven't - because we're very clinically focused on having to meet other criteria and do this in a - the first occupational therapist degree was in the 1950s, it's taken a long time to get a clutch of people together PhDs, the research, it's already hard to get [unclear] the funding, it's … the profile in the journals and the profile … so it doesn't get … they don't discuss it.

It gets passing mention in any nursing textbook, any critical book about medicine or something occupational therapy just gets a passing mention. It doesn't even turn up in disability studies literature, which is a pretty fundamental problem really since we've got a client centres base how come we don't turn up in the literature, how come we don't engage with that. So all those mountains to climb amount to invisibility, or negative visibility [unclear]… visibility. That is a real difficulty and it's a fear.

We could be going the same way as the society [unclear]… close up shop and disappeared. Not in other countries but we could seriously do that here, because loads of other people and reinventing the stuff that we're doing. We've got Peter Maxwell, I think it is, inventing nidotherapy, which is basically doing an occupational therapy. We've got some bloke in Essex saying let's have some volunteer befrienders who go out and engage people in their interests. That sounds very much like occupational therapy.[43]

So saying that occupation is a unique idea et cetera, et cetera is stupid. We keep instilling that nonsense in [our students]… We do keep trotting it out, the COT keeps trotting it out and we misinterpret occupational therapy as a complex intervention in that way as well. It's complex. We haven't read the bloody document.

Facilitator: Does that help that document? I mean…

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[41] Coded to: OT Profession; Structure
[42] Coded to: HCPC and OT Profession; Professional identity; Body of Knowledge
[43] Coded to: OT Profession; Third Sector; Neo-Liberal

Interviewee: It would help if we read the document.

Facilitator: Help if you read the document.

Interviewee: If you talk to Jennifer Creek what she's just saying is something much more fundamentally engaged about and critical about the nature of occupational therapy. She's - you know, but people just look at the title.

Facilitator: Yeah. This is [unclear]… answer as such but given what you've said, what do we need maybe to be doing in terms of actually trying to develop a quite more cohesive identity in our students and a more confident identity and how they can then take the profession forward to meet some of these very obvious challenges?

Interviewee: I think we need to look - so we've got the HCPC SOPs at the moment and we're devising a culture around the SOPs. But I think it's not just about the SOPs, it's about much more than that.[44] We need to think about the crucial positioning of occupational health, which we have all to do as professional responsibility, whether we're teaching in academia or whether we're a band five or whether we're a student. We've all got to do that. What the bloody hell are we doing here? How are we really engaging, we are we doing this? Why are we doing work rehabilitation, what's it for?

Why are we doing - yes, it's to get people back into work but fine, but getting to work in what kind of job and why? Why is that these people work in jobs and we're assuming that they're going to come back out in a few weeks' time because the job market is inflexible. Why aren't we challenging the nature of the job market? Why aren't we challenging the circumstances of which [unclear] people into occupational therapy departments? Why are we just looking at these things and not actually engaging enough with the disparities.

People are doing that within occupational therapy but our focus has been - our focus is very necessarily geared to the clinical stuff, it's not just the clinical stuff. So we've got to be super OTs. We've got to really think. When we bring people into the course we [unclear] this … we're upping our entry requirement then how are these people going to make this profession a challenging one? We need to address things like the gender imbalance, we need to address things like the fact that probably 90 per cent of OTs if they're not women are white. That doesn't reflect the population at large.

When we go to occupational therapy and we're [unclear] bloke we probably - I'm dreading the prospect of ending up in a care home in about 15 or 20 years' time because if I get an occupational therapist how can I guarantee it's not going to be sing along with Max Bygraves still? I'll bloody kill somebody [unclear] sign along with Max Bygraves, I'll tell you. Or dominos, chuff me, come in, that is not what I'm about thank you very much. If it's going to be let's all sit down and make Christmas cards I'm equally going to be pissed off.

Okay, I expect that there will be occupational therapists who will not meet that stereotype, but that is the stereotype. In the 1960s OTs were seriously cheesed off with the basket jokes and stuffed bunny jokes and they're sticking there still. So we haven't got rid of that stereotype, why not? Why

[44] Coded to: HCPC; OT Profession; Structure

haven't we challenged it sufficiently? We haven't been dynamic enough. To be dynamic enough we've got to be able to punch above our weight. [45]

We can't be complacent and we can't - if we're teaching our students to be complacent - if as practitioners we're offering fieldwork education to students which is delivered in a half arsed, complacent way - I'm not saying - a lot of people aren't engaging as practitioners in [unclear] process … people who've been hiding away not challenged [by us]. So one of the things that's … it could be a positive thing, I doubt it probably is, that's coming out of all the restructuring is that this is all being exposed. But if we're going to survive we've got to be much more assertive and strategic about what we do.

To do that - because the key thing with the strategy is we've got to actually employ a properly reflective practice to the nature of occupation. Properly reflective in terms of the way that we critique and position our understanding of why it is important to get people to do stuff that they value and purpose and is about them expressing their identity in the world around them.[46] If you want to fix broken Britain and have all that [unclear] participation and stuff like that then there's got to be some spaces created for those people to do that. If you've got people working three jobs a day in order to be able to pay the rent they haven't got the time to invest in that sort of nonsense. If they're on the dole they haven't got the resources because [unclear] changing your job all the time.

So they haven't got the time to enjoy the benefits of being human. So it's a book I recommend to the students but it's probably not wise to recommend to students because it's a bit heavy going and it's a bit mad, but Lafargue's *The Right To Be Lazy* it's one of these things. Working 14 hours a day in the French textile mill and that isn't what life's supposed to be for. Working in a textile mill should be incidental to your enjoyment.

Facilitator: Challenging some of these assumptions that we have I suppose.

Interviewee: Yeah, because a lot of occupation it's actually about consumption. So why? Why is it about consumption? Why are we consuming stuff instead of making and doing stuff? So we've got to have all these little gadgets in order to meet the needs of the digital generation in terms of their occupation. Fine, that is true, but at the same time it doesn't all have to be so oriented to serving those needs. Okay, fine, here's some wacky digital stuff and that's groovy, but this is an old style knitting, if we're going to get the basket jokes, let's go back to basket work and have a look at actually maybe there's some sense in making baskets. [Unclear] there's something useful there.[47]

Maybe it's not so quaint and fuddy-duddy and maybe there's - you can see that a lot of occupational therapists believe that kind of stuff. They got that kind of - if you put three occupational therapists in a room they'll probably do [craft] project and end up making … boxes, which is great. But a lot of that is nerdy and denigrated in some way. So another thing is popularising the activity … go off on our occupational therapy day … and wear our green shirts and wear our badges and stuff like that then that's all very engaging but it's only for a day and we've got to live that all the time. That's what we've got to instil within the navie.

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[45] Coded to: OT Profession; Professional Identity
[46] Coded to: OT Profession; Professional Identity; Knowledge and Skills
[47] OT Profession; Professional Identity

Facilitator: Thank you, very interesting. I don't know if there's any final comments you want to make at all in relation to…

Interviewee: I suppose I think - I am concerned about the future of occupational therapy, I don't think though it's a lost cause, I would not like to give that impression. I do think that we've got the capabilities to do something about it but we have to concentrate on something. I'm involved in the citizenship group in [ENOTHE} at the moment [for example]. That's one of the key things. But the notion of citizenship in relation to occupational therapy it is discussed, but it's not discussed in sufficient depth, what does it mean to be a citizen.

So all the time we're dealing with - it's another one of these things we're dealing with, the idea of occupational rights is dealt with at the surface level. The tool that we've got of occupation is a much sharper tool than we give it credit for.[48] Yeah, that's my final point.

Facilitator: Thank you. Thank you again.

END OF TRANSCRIPT

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[48] Coded to: OT Profession

Appendix 3 – Ethics Forms [49]

PARTICIPANT CONSENT FORM

Project title: How are occupational therapist professional identities developed by university education within contemporary practice. A case based narrative inquiry across two universities.

Researcher's name: John O'Shea

Supervisor's name: Professor Simon McGrath

- I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me. I understand and agree to take part.
- I understand the purpose of the research project and my involvement in it.
- I understand that I may withdraw from the research project at any stage and that this will not affect my status now or in the future.
- I understand that while information gained during the study may be published, I will not be identified and my personal results will remain confidential. I further understand that although the institution I work in will be kept confidential, it might be possible for those familiar with my place of work to recognise its identity from any publication that comes out of this research
- I understand that I will be audiotaped / videotaped during the interview.
- I understand that data will be stored electronically on the researcher's laptop and will be secured using encryption. Only the researcher and his research supervisors will have access to this data.
- I understand that I may contact the researcher or supervisor if I require further information about the research, and that I may contact the Research Ethics Coordinator of the School of Education, University of Nottingham, if I wish to make a complaint relating to my involvement in the research.

Signed …… (research participant)

Print name …… Date ……

Contact details

Researcher: Mr. John O'Shea, Post Graduate Research Office, School of Education, The Dearing Building, Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB,Email: ttxjo3@nottingham.ac.uk Tel:0732649562

Supervisor: Prof. Simon McGrath, Room C72 School of Education, The Dearing Building, Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB, Email: simon.mcgrath@nottingham.ac.uk Tel: 0115 951 4508

[49] Please note that with the agreement of my supervisors the title has changed and there have been some minor amendments to the aims of my project, however the overall aims and focus of the research, on which the research questions are based and to which the participants consented, remain the same.

School of Education, University of Nottingham - Participant Information Sheet

The aims of the project

You are invited to take part in a doctoral research project that aims:

To understand how occupational therapy (OT) is currently defined.

To understand the views of OT lecturers, clinicians and students on the effect of higher education, professional representation and health and social care policy on the development of their professional identity.

To identify changes in working practices and their effect on contemporary practice and OT professional identity.

To identify the disciplinary knowledge of OT education within two different universities.

To identify how, through understanding the above, students can be supported in the development of their professional identity.

What will this entail?

If you agree to take part in this research I will ask you to attend an interview. This interview will last for approximately one hour and will take place in a confidential and neutral environment at a time, date and place convenient to you. The interview will be recorded using a digital audio recorded. All data from these recordings will be stored electronically on the researcher's laptop and will be secured using encryption. Only the researcher and his research supervisors will have access to this data. During this interview I will ask you questions relating to the aims given above. The interviews will be carried out in a conversational style and I am interested in your thoughts, opinions and narratives. To begin this conversation I will ask you to bring an object, e.g., a photograph that is representative of the profession to you.

I also plan to obtain information from informal conversations that occur in the work place. Any information from informal conversations and interviews will only be used following agreement by you and you will have the opportunity to confirm what you have said. Your name and place of work will be kept confidential. Only my research supervisors and I will have access to your information, however, it might be possible for those familiar with your place of work to recognise its identity from any publication that comes out of this research. I do not envisage the possibility of any harm to you from participating in this research and I will attempt to address any concerns you have about it. Although there might not be any immediate benefits to you in participating I do see this research as benefiting the profession.

Do I have to participate?

No. Your participation is completely voluntary and you have the right to withdraw from the research at any time including during the interview.

Contact details:

Researcher: Mr. John O'Shea, Post Graduate Research Office, School of Education, The Dearing Building, Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB

Email: ttxjo3@nottingham.ac.uk Tel:0732649562

Supervisor: Prof. Simon McGrath, Room C72 School of Education, The Dearing Building, Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB, Email: simon.mcgrath@nottingham.ac.uk Tel: 0115 951 4508

School of Education Research Ethics Coordinator: educationresearchethics@nottingham.ac.uk