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The Impact of Clinical Governance on the Professional Autonomy and Self-Regulation of General Practitioners: Colonization or Appropriation?

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Introduction

The professional standing and autonomy of doctors has been a subject of much research and conjecture in recent years. Successive reforms of the NHS and government policies are said to have challenged the autonomy and self-regulation of the profession (Harrison 2002; Harrison and Dowswell 2002; Harrison and McDonald 2003) as part of a more general switch in the mode of public administration towards more managerialist approaches (Pollitt 1993; Ferlie et al 1996 Newman and Clarke 1994). The effects of such managerialist or bureaucratic organizing on professions have been theorized in a number of ways. Firstly, from a Marxist perspective, the impact has been framed as a process of deprofessionalization (Haug 1973; Haug and Lavin 1981; Betz and O’Connell 1983) and proletarianization (McKinlay and Arches 1985; McKinlay and Stoeckle 1988; Harrison and Smith 2003). This thesis sees the professions being sapped of power and autonomy due to a series of changes in social and structural conditions that take place as the system of advanced capitalism develops new modes of capital accumulation. Secondly, based on a Weberian analysis the process has been defined as one of re stratification (Friedson 1984, 1985, 1986; Mahmood 2001; Sheaff et al 2002). This
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action perspective places greater emphasis on the role of human agency in the ongoing shaping of professions.

In this paper we explore the explanatory potential of these competing theories in the context of changes in primary care organization in the UK with a focus on General Practice (GP), and specifically the implementation of Clinical Governance (CG) in this newly structured sector of the health service. Structural changes to the organization of primary care based on the establishment of Primary Care Trusts (PCG/Ts) which coordinate local healthcare organizations, including general practice medicine, were introduced in 1999 and concurrently work began to implement CG across the health service. Both changes had potential to alter the position and autonomy of the medical profession and in this paper we consider what the impact has been on GPs. We examine the evidence drawn from a longitudinal and detailed case study of a Primary Care Trust in the North West of England to assess the relative deprofessionalization / proletarianization or restratification of the professionals involved in the process of implementing CG. In so doing we also consider a new theorization of the process based on ideas of colonization and appropriation (Bhabha 1994; Chouliaraki and Fairclough 1999; Fairclough and Thomas 2004). Within this framework there is a focus on discourse, such as the ‘competing’ professional and managerialist discourses in our case. Whereas we might see managerialism as a colonizing discourse, moving into the professional domain and displacing professional discourse and social practices, instead the framework acknowledges the likelihood of professionals also appropriating managerialist discourse and developing new hybrid forms of discourse and practice (Nederveen Pieterse 1995). Such a framework may avoid the problem of seeing the changes as simply imposed on professionals due to structural changes, whilst acknowledging that human activity is constrained by the circumstances within which it takes place.

The paper begins with a brief review of the theories of deprofessionalization, proletarianization and restratification, and we review the evidence concerning the experiences of medical professions. There is a case to be made for each perspective but
we posit a further approach and we outline a thesis which rests on a theorization of the process as something characterized by ambiguity, drawing on the colonization / appropriation idea that Chouliaraki and Fairclough (1999) take from Bhabha (1994). From this perspective the process is neither one of change being imposed on professionals by abstract structural conditions, nor a voluntaristic response from a professional group, but a more ambiguous process within which hybrid discourses and practices emerge. Having laid out our framework we consider the evidence from the case, briefly outlining the methodology of the study and analysing and interpreting the resulting data to test the ‘fit’ of our idea. We conclude by discussing the relative merits of each theoretical standpoint and identifying how our framework might be deployed in further research.

Theorizing Professional Autonomy.

Early Functionalist and Trait theorists, with their roots in Durkheim’s sociology of consensus and order (1964), attempted to identify the key characteristics of the professions, differentiating them from other occupations (Parsons 1954; Millerson 1964; Goode 1957). The defining characteristics of a ‘true’ profession were perceived to be: orientation to community interest rather than self-interest; a system of monetary and honorary rewards that symbolize work achievement; and most importantly, the possession of a high degree of generalised and systematic knowledge leading to the ability to exercise autonomy in day-to-day work (Johnson 1972). Linked to this professional autonomy is the necessity for professional self-control of work without reference to others external to the profession. This is exercised through codes of ethics produced by independent professional bodies and internalized by individual professionals via their professional education, training and work socialisation.

Based on this early theoretical foundation, more critical contributions later focused on explaining how professions acquire, maintain and enhance their power base (Jamous and Peloille 1970; Johnson 1972; 1980; Parry and Parry 1976; Fielding and Portwood 1980; Larkin 1983; Halliday 1985; Macdonald 1985; Abbott 1988), with two broad perspectives emerging: the Marxist ‘Power’ perspective and the Weberian ‘Action’
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perspective. The power perspective stresses the impact of *macro structural and organisational change* and focuses on the political and social processes by which the professions secure and reproduce their privileged position in society. This influential body of literature deals with inter and intra-professional conflicts; professions and their relationship with Government; and professions and social stratification. The action perspective is more concerned with the impact of *human agency* in shaping and influencing the organisations and environments in which a profession operates (Friedson 1970a; 1970b Larson 1977). The suggestion is that professional status is actively pursued, and is the result of individual and collective action rather than the result of macro-structural influences.

Writers have also considered how autonomy and professional standing may challenged and even lost. As early as the 1950s, Mills (1956) warned of a loss of professional prerogatives and particularly professional autonomy. He argued that modern society was becoming progressively bureaucratized, with professions were being increasingly absorbed into administrative systems where professional work is standardized and more narrowly specialist. Further, assistants and sub-professionals would perform routine tasks while more senior professionals would become more managerial in approach. More recently these changes have been explored through the overlapping theories of deprofessionalization and proletarianization rooted in Marxist thinking.

*Deprofessionalization.*

Haug (1973; 1975) first posited the idea of ‘deprofessionalization’ as a means of understanding the changing role of doctors in the early Seventies, defining it as a loss of unique professional qualities, particularly monopoly over knowledge; public belief in the service ethic; and professional autonomy and authority over clients. Other proponents of the deprofessionalization thesis have subsequently emerged (Betz and O’Connell 1983; Rothman 1984) and Haug (1988) has revisited her initial thesis to assess its accuracy.
Haug (1973) argued that technological and ideological trends would render professions obsolete. Professions would lose control over knowledge as a result of computerization, the emergence of new occupations in the division of labour and increasing public sophistication. The result would be challenges to traditional professional autonomy and demands for increased accountability. Such deprofessionalization would strip away traditional claims of professional authority and deference. Haug (1973) noted that the academic knowledge underpinning professional medical expertise is largely codifiable and amenable to being held and accessed via computer. Even those parts of professional knowledge gained by experience and therefore not codifiable, could also be gained by less academically qualified but still well trained para-professionals, who would be cheaper to employ. Also, increased general educational levels would serve to demystify professional expertise. The public would become increasingly confident about their rights and would wish to take an assertive and active part in professional decision-making, encouraged by pressure and self-help groups.

Fifteen years later, in 1988, Haug re-visited the concept of deprofessionalization to assess its accuracy in relation to the medical profession. She noted that the medical profession had been only partially successful in preventing the spread of medical knowledge to less qualified para-professionals. Also, the media had popularized the increasing bank of medical knowledge, making it accessible to a more educated public, who appeared less willing to unquestioningly accept medical authority and more desirous of medics to talk in plain, understandable language free from obscure and mystifying terminology. It was also noted that changes to organization structures and governance had also served to erode medical professional autonomy. In general, Haug’s (1988) appraisal largely confirmed her thesis, painting a view of the profession as under threat from a gradual erosion of autonomy and standing.
Proletarianization.

Similarly based on Marxist analysis, the theory of proletarianization overlaps to some extent with the deprofessionalization thesis, being defined as:

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

(McKinlay and Arches 1985: 161)

McKinlay and Arches (1985) suggested that control is lost over: the criteria for entrance to an occupation; the content of training; autonomy in relation to the terms and content of work; the objects and tools of labour; the means of labour; and the amount and rate of reward for labour. McKinlay and Arches (1985) argued that whilst most occupations had been easily subjected to proletarianization, the medical profession had been able to delay or minimize the process. However, they argued that such resistance would be short-lived due to the bureaucratic consequences of capitalist expansion. The bureaucratization of healthcare that McKinlay and Arches (1985) observed was usually justified as a move towards rationality and improved service provision based on centralization, the accomplishment of economies of scale, the application of technological advancements and gains in efficiency. Also, bureaucracy was suggested to be the only way to deliver medical care to large numbers of people. McKinlay and Arches (1985) argued, however, that the move towards bureaucracy was an inevitable part of the process of continued capitalist accumulation, and was largely a means of controlling educated workers to that end. Bureaucracy maintains loyalty and allegiance by rewarding rules orientation, predictable and dependable behaviour and the internalization of an organisation’s goals and values, within a context characterized by hierarchical structures and regulatory processes that favour individualistic modes of evaluation.

McKinlay and Arches (1985) considered these processes of control in their analysis of the position of the medical profession in America. Doctors were observed to be working less in independent fee-for-service practice and more in large bureaucratic organisations.
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as salaried workers, ‘encouraged’ out of private practice partly by the need to avoid malpractice costs imposed on them by a profit-orientated health insurance industry. They also identified a growth in specialization, practiced in large bureaucratic settings, stemming from the continual increase in medical knowledge and rising levels of expectation and knowledge among the general public.

McKinlay and Arches (1985) also found that when professionals entered a bureaucratic setting they devoted themselves to climbing the managerial hierarchy and advancing their relative status. Doctors also tended to seek control in an organizational rather than professional sense; with increasing specialization on a ‘medical care production line’ leading to more a ‘manageable’ mode of service provision through codified rules and procedures. At the same time technological changes coupled with changes in organizational structures, and organisation structure were enabling medical work to be done by less qualified and therefore cheaper personnel.

McKinlay and Arches (1985) thus concluded that professionals were losing their monopoly control over strategic knowledge and were becoming de-skilled, thus cheapening their labour power and diminishing their privileged terms of employment. However, they argued that this seemed to be a slow process and going largely undetected by members due to their ‘false-consciousness’ of the significance of their daily activities, and their elitist concept of their role. However, seeing doctors as ‘dupes’ within a system of capital accumulation has not appealed to all researchers of the phenomenon and has lead to the emergence of a Weberian-based theory of restratification.

Restratification.

In ‘The Changing Nature of Professional Control’ (1984), Friedson took issue with the theories of deprofessionalization and proletarianization arguing that the idea that professions are losing their prestige and trust is unpersuasive. In spite of the narrowing knowledge gap between the medical profession and the general public, and higher standards of education generally, Friedson (1984) asserted that the medical profession
continued to possess a monopoly over important segments of formal knowledge, and that the use of technology to store codified knowledge was often overseen and controlled by those professionals.

With respect to the proletarianization thesis, Friedson (1986) argued that employment status is not a good direct measure of control or lack of control over work. Apart from lawyers and doctors, where an increase in salaried employment could be observed, professions had always tended to be in salaried employment anyway. With respect to increased bureaucracy there was evidence that professionals would resist the bureaucratization of their work rather than simply succumb to bureaucratic systems of working (Hall 1968; Scott 1966). Also organisations employing professionals are more likely to deviate from the bureaucratic type where employees are tightly controlled by rules and procedures with alternative hybrid structures emerging (Goss 1961; Smigel 1964; Scott 1965; Weick 1976; Minztberg 1983; Courpasson 2000). We shall return to this notion of hybridity a little later. Even were professionals to find themselves in a highly bureaucratic organization Friedson (1986) argues it would seem wrong to believe professionals would be placed in a situation directly analogous to industrial workers, lacking discretion in the performance of their work, being closely supervised and having their skills expropriated. Professionals are expected to exercise judgement and discretion in their every day tasks, and have different supervisory arrangements to other types of workers. Also the loss of autonomy by an individual professional cannot be read off as equating to a loss of control for the profession as a whole.

Friedson (1986) also suggests that there has always been competition within professions, and stratification of both intellectual power and economic power, but the degree of formalization of these relationships has changed. One elite group formulates standards, another directs and controls, and still others perform the work. He argues that, despite its internal division by stratification and specialization, the medical profession has maintained a degree of solidarity but this may be threatened by the formalization of professional controls. The profession could be split into distinct groups, the practitioners,
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the researchers and the administrators, each having its own professional association representing its own separate interests.

The restratification thesis has some merit in that it acknowledges the way in which changes in structural conditions are internalized within professional practice. Rather than change being something that is done to professions as is implied by the Marxist theories of deprofessionalization and proletarianization, the restratification view sees the professionals themselves as being agents in the changes. The view seems suggest that doctors are more heterogeneous group than is suggested by the literature on professions and that some become inculcated into the changes that we might expect them to resist. However, the restratification thesis doesn’t really give a clear account of this process, so whilst broadly adhering to this view we propose a theorization that acknowledges the hybridity of professional practices in new contexts and the heterogeneous nature of the profession.

Colonization or Appropriation?

The Marxist theses outlined above suggest a situation where forces beyond the control of professionals colonize the profession, leading to deprofessionalization and proletarianization. The discourses of bureaucracy and managerialism seem to be framed in almost imperialist terms, being imposed upon the professions who are unable to secure their borders. The restratification thesis on the other hand implies that change hinges on the appropriation of these discourses into professional practices and the contexts within which they operate. An alternative view is to see colonization and appropriation as two sides of the same process which gives rise to ambiguity and the development of new hybrid discourses and practices rather than the simple imposition of change or an entirely voluntaristic acceptance of external demands.

Chouliaraki and Fairclough (1999) examine the way in which discourses move between different settings deploying Bernstein’s (1996) concept of recontextualization. This thesis suggests that discourses are moved into different contexts in ways that are unpredictable
and not wholly controllable. They argue that attempts to impose discursive change tend to fail, as those upon whom it is being imposed tend to assimilate it into their existing practices in ways that the ‘colonizers’ would not favour. They draw on Bhabha’s (1994) idea of mimicry in colonial relationships which finds a middle ground between the attempted domination of colonizers and the counter-pressure of the colonized. Mimicry is a camouflage (Lacan 1977) in that some aspects of the coloniser’s discourse is appropriated and assimilated in the colonized community, in ways that satisfy the colonizing powers but leaves room for the subversive resistance of the discourse amongst the colonized. Bhabha (1994) describes the ambivalence of this situation, with mimicry being balanced between a resemblance of what is required of the colonized and its menace, that is, a strategic subversion of the attempt to colonize. He illustrates this with a quote from a missionary in Bengal who, in 1817, wrote of the ‘demand’ for the Bible amongst the colonized. He pointed out that the demand did not necessarily represent the success of proselytising and the assimilation of Christian faith amongst the community as many Bibles ended up being used as waste paper and for wrapping snuff.

For Chouliariaki and Fairclough (1999) this ambivalence manifests itself in many situations where discourses are imposed from outside. The imposition involves a hybridizing process, with the colonizing discourse being articulated alongside existing discourses to create a hybrid. Fairclough and Thomas (1994) explored this phenomenon in the case of a managerialist discourse, which is said to be colonizing more aspects of contemporary life. In a number of cases (Watson 1994; De Cock 1998; Salskov-Iversen et al 2000; Holden 2001) they found that the spread of managerialist discourse was often mitigated by local circumstances, with local actors appropriating the discourse in ways that meant they could turn the discourse to their advantage. The discourse was seen as a resource to be used selectively and thus its spread became variable and complex, rather than a totalizing and dominant force. This would seem to resemble the situation in relation to changes in the autonomy of medical professionals, with restratification being rooted in the variable, ambiguous and uncertain deployment of managerialist and bureaucratic discourses and practices. We now consider this theorization of the process in
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relation to a specific case, that is, general practitioners involved in the implementation of clinical governance.


Background

The position of general Practitioners in the NHS represents an interesting case in relation to professional autonomy, as the this group of clinicians has experienced a number of significant changes in recent years that can be judged to be examples of a managerialist project aimed at exerting increased control over their work. We focus on two: the establishment of Primary Care Trusts and the implementation of Clinical Governance.

The work of GPs has been restructured with the abolition of GP Fundholding and the establishment of the Primary Care Group/ Trust (PCG/T) system, responsible for co-ordinating local healthcare organisations, including general practice, in the provision of local primary healthcare services (Locock et al 2004). PCTs are statutory bodies controlling around 80% of expenditure on local hospital and community health services, and are required to control access to and develop secondary services, community nursing and care of the elderly. They can invest in premises, buy or construct community hospitals, purchase facilities and employ doctors.

Each PCT is led by a CEO who takes ultimate responsibility for budgets and performance. The CEO is statutorily accountable for the implementation of clinical governance in both the PCT itself and in associated independent practitioner businesses even though he/she can exert no direct authority over their management. The CEO leads a multi-disciplinary Executive Committee (PEC) that comprises no more than 15 members who must include the CEO, a Finance Director, one or two representatives from Social Services Dept, a lay representative, up to 7 medical practitioners (GPs, dentists and other primary care medics) and up to 7 nurses. Other managerial or professional members can be seconded onto this committee, but no one professional group is allowed
to hold the majority of the membership. The PEC is often chaired by a GP. The PEC makes key strategic decisions and its work is overseen by a local PCT Board that is led by a locally elected non-medical Chair with a further 5 lay representatives or non-executive directors from the local community and 5 representatives from the PEC.

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

A second change to impact on GPs is the implementation of a system of Clinical Governance which emerged against a backdrop of a series of highly publicised medical failures or cases of malpractice, including, the Bristol Heart Surgery Inquiry and the Shipman case. Clinical Governance aims to provide NHS organisations and individual health professionals with a framework within which to build a single coherent local programme for quality improvement, consistency and standardization of healthcare services (D of H 1998b). This is not an entirely new concept but combines a range of existing processes that include: multi-professional clinical audit, evidence-based practice, clinical supervision, management learning from complaints and adverse incidents, continuing professional development, patient/user feedback systems, clinical performance management and the collection and analysis of data for monitoring clinical care. The process involves: the setting of national standards of care through ‘National Service Frameworks’ (NSFs) via a new organisation, the National Institute for Clinical Excellence (NICE); continuous quality improvements based on clinical standards and evidence-based practice; monitoring of progress through another new organisation, the Commission for Healthcare, Audit and Inspection (CHAI); a new survey of patient and user experience; and a system of modernized professional self-regulation, involving performance appraisal, life-long learning and the periodic revalidation of medical practitioners.
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It has been argued that this system requires a complete change in organisation culture, systems and staff behaviour (Swage 2000) and as such it can be seen as having great implications for professional groups. Indeed, it has been described as the latest phase of managerialism in the National Health Service, and represents a potentially significant increase in managerial control of the medical profession and an attempt to regulate its work, thus presenting a direct challenge to professional autonomy (Flynn 2002). Clinical performance is to be monitored through performance indicators, benchmarking and league tables, and periodically inspected by CHAI. Alongside this, practitioners are subjected to performance appraisal and required to undertake continuous professional development in order to continue to be licensed to practice. These changes in organizational structure and governance processes would appear to be directly relevant to the issue of professional autonomy and has provoked a debate about whether the changes will result in deprofessionalization, proletarianization or restratification (Harrison and Lim 2000; Mahmood 2001; Salter 2002; Harrison and Dowswell 2002; Harrison and Smith 2003; North and Peckham 2001; Sheaff et al 2002; 2003; 2004; Flynn 2002). These studies present limited evidence of deprofessionalization, and more significant evidence of both proletarianization and restratification, while other studies indicate that the evidence is inconclusive (Armstrong 2002; and Locock et al 2004).

Against this backdrop Hewitt (2006) examined the impact of clinical governance on the professional autonomy and self-regulation of general practitioners (GPs) in a Primary Care Trust (PCT), hereafter referred to as Utopia PCT, in the Northwest of England. The research employed an in-depth exploratory case study methodology, and the data collection methods were semi-structured interviews, focus groups, non-participant observation at committee meetings and documentary analysis. In total there were fifty individual respondents in the study including thirteen PCT directors/managers, nine professional representatives at the PCT, twelve ‘rank and file’ GPs. In addition, eight practice managers participated in two focus groups, and eight practice nurses participated in two further focus groups. The field work took place in three phases. The managerial participants and the professional representatives at the PCT were interviewed first over a
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12 month period, February 2003 to February 2004. The GPs in the field were interviewed next and the focus groups were held over an eight month period, from March 2004 to November 2004. The data was analysed using a process of categorization based initially on concepts drawn from the literature. Transcripts were coded using these categories, and as the material was sifted new categories and codes were added that emerged from the data itself.

This paper draws selectively on data from the study to focus specifically on the effects of clinical governance on the professional autonomy of GPs. We divide the findings into four sections based on the themes of: the initiation of and rationale for CG; the bureaucratization of GP work; modernized self-regulation and the ambiguous role of GP Medical Advisors.

The Roots of Clinical Governance

Clinical Governance was often referred to in terms of quality assurance, a process which is difficult to question, as to question quality seems counterintuitive and irrational. However, the impetus for Clinical Governance stemmed in part not from a desire to improve quality but to avert disaster and to demonstrate political action in the face of a series of clinical failures. As one senior manager stated:

It (clinical governance) is seeking to improve quality of care and it is seeking to manage risk more effectively. Much of clinical governance has however found its roots in clinical disasters. As much as being a care imperative it is therefore a political imperative. The government could not afford the number of embarrassments. If you look at Bristol and Alder Hey, they are examples of breakdowns in the delivery of care and the management of the delivery of care. It’s about being responsible and accountable. (PCT Director)

From the outset it seems that a political expediency underpinned the process. This was not just a quality assurance process but a political stratagem. As one respondent noted,

The government has to be seen to be delivering on its promises, and all the people who work for it have to be seen to be doing what the government says they are doing. The only way you can do that is to check on people. (GP Medical Advisor).

Further, the rationale was not simply to improve service and care but to control professional practice to prevent abuses and malpractice. This is not in itself a bad thing
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but it does demonstrate that the system was rooted in an ambiguity based around promoting good practice and preventing bad practice. The system, like many quality systems, sought to prevent poor performance by increasing control, but it was often framed as a means of positively promoting good practice, though initiating such a governance system is not necessarily the best way to achieve good practice. Also, many respondents saw a need for preventing malpractice, but did not necessarily see Clinical Governance as the means by which this could be accomplished.

The whole system needs to be built on trust, and increasingly we don’t trust anybody else, so you have got to write it all down in triplicate. But writing things down doesn’t mean to say that you have done it! … Of course there are going to be shirkers, people who lie and cheat, but you get that whatever. I don’t think there is any managerial system, including clinical governance that is going to weed that out so that everybody is going to get 100% service all of the time. (GP Medical Advisor.)

Despite the doubts raised about the system’s capacity to facilitate control and prevent malpractice, several respondents made the point that control and the erosion of professional autonomy was the likely aim and outcome of the system. As one respondent said:

GP’s don’t like it (clinical governance) they feel threatened by it; they are self-employed and have always had their professional freedom. They have never had to answer to anybody before. They see themselves as professionals and they really don’t like it … Up until this point GP’s haven’t really been scrutinised, but now somebody is going to come in and see what they are doing. Before, they were very autonomous, quite detached; they could do what they wanted. Now clinical governance is bringing an outside body in, which has never happened before. It will show up all of the gaps in their practice. (Practice Managers: Focus Group 2)

And a GP opined:

I think its title tells you everything (clinical governance), it’s there to govern you, to bring you to heel. It is governing you, controlling you, saying, yes, you can do these things but within the confines that we set. At the moment it (NICE guidelines) is advisory, but that’s how it starts, it’s the thin end of the wedge. (GP).

So from the outset the system was perceived in rather ambiguous terms, being: a political reaction to serious but frankly rather rare problems in medical practice; a quality assurance process designed to prevent problems and, at the same time, promote best practice; and a control mechanism that would reduce professional autonomy.
The Bureaucratization of GP Work.

The development of bureaucratic structures and managerialist processes has been a focus of previous studies of changes in professional autonomy and standing. A key aspect of this in terms of CG was the development of National Service Frameworks (NSFs) that would help reduce variation in service provision by giving evidence-based clinical guidance on the best treatment for specific medical conditions. NSFs were recognised by managers and almost half of the GP participants as a valuable reference point and a useful means of staying up to date with recent developments in medicine, however, the GPs were alarmed about the quantity of the guidance and the associated time it took to read and absorb the content. The ambivalence of GPs was evidenced by the comments of one doctor:

Looking for evidence of treatments, what works and what doesn’t work is a really very recent concept, and it’s very difficult to stay up to date. The NICE frameworks are obviously evidence-based and are a useful means of keeping up to date, but they do potentially create a huge amount of extra work… (GP Chair PEC)

The value of NSFs, particularly as they were rooted in research-based evidence, was appreciated by GPs, with most seeing them as offering the opportunity to keep up to date with advances in clinical practice. However, the capacity to act upon the frameworks was cast into serious doubt. The volume of guidance was seen as a significant barrier to it being usefully employed:

GP Medical Advisor

Ironically, one GP even suggested that the process impeded his ability to stay up to date with medical practice:

I can’t read it all! I am far too busy trying to keep up to date with medicine. I mean, you tend to pick on the ones that you think perhaps you ought to look at, but then you get all these documents, and you think, where am I going to put them? I mean, where do I store them, so I know where it is? Will I ever refer to them? We are just overwhelmed with paper. (GP)
Despite concerns about the overly bureaucratic nature of the NSF system, some respondents saw the frameworks as benefiting GPs and suggested that, generally, they welcomed the guidelines:

… it means they have got a framework, whereas in the past, whether they did it one way, or issued a particular prescription, it was down to them and they got all of the backlash from that. The fact that there has been an agreement about which drugs to use avoids them suggesting the use of a drug and then the health authority saying, no we are not going to fund it, and then they are left in the middle with the patient saying, why can’t I have it. So it kind of takes the heat out of the situation … (PCT Director)

Here we have a positive view of the guideline role of the frameworks. Firstly, the frameworks act as guides to practice. The frameworks can help GPs make better clinical decisions based on what has worked in the past for other clinicians. In this sense they are interpreted as guidelines rather than the rules we would associate with bureaucratic organization. Secondly, the frameworks represent a degree of protection for GPs, from disgruntled patients who may question the clinical decisions their doctors have made, and even from legal proceedings being taken against them. However, this legal protection was seen as a double-edged sword, for if a doctor made a clinical judgement to ignore the frameworks in a particular case it could make them more susceptible to litigation. As one GP reported: ‘GP s worry about the provision of guidelines and protocols, that if you don’t follow something, you do lay yourself open to being sued.’

All GP participants shared one opinion, however, that the implementation of NSFs was an attempt to reduce their specialist knowledge into a set of bureaucratic guidelines that would replace the exercise of their knowledge, skills and experience in the diagnosis and treatment of patients. Whilst the application of NSFs was still optional, most thought that there would be little deviation from the guidance given the fear of litigation mentioned above. This, plus the fact that GPs must record and justify any deviation from national standards, undermined any claims that the system was entered into voluntarily and was generally perceived as an attack on their professional autonomy, a theme to which we now turn.
Modernised Self-Regulation or the Erosion of Autonomy?

The managerial participants and the GP Medical Advisers to the PCT suggested that ‘modernised self-regulation’ was an inevitable consequence of highly publicized medical failures and the General Medical Council’s (GMC) tolerance of unacceptably low standards of GP performance. There was a perception amongst these participants that many GPs had not kept up to date with advances in medicine and had merely pursued their key interests, in the context of Continuing Professional Development (CPD), rather than using the process to identify and overcome specific weaknesses. As the GP chair of the PEC remarked:

> I guess it has to happen doesn’t it? (Increased government attention in professional self-regulation), I mean, if we haven’t carried out that self-regulation ourselves, somebody has to take an interest in it. The general public won’t stand for any more laxity really. I think in days gone by, really appalling situations, and appalling standards have been allowed to exist. Patients have got very poor service from a minority of GPs. I don’t think it is the majority. I think there are a minority, for reasons of ill health or burnout, or in a very small number of cases, just sheer badness, who have not given their patients a decent service. If as a profession, we have not sorted them out, the government has to do something.

Another senior manager also made the point that continuous development was difficult for GPs given the breadth and volume of their workload: ‘I think appraisal will help them keep a focus, so they’ve got to keep up to date, and revalidation will help with this as well, it’s a prompt’.

The positive view of self regulation was not shared by GPs though:

> Self-regulation is getting to be a difficult concept. One of the issues with clinical governance seems to be that people no longer trust professionals to be professionals, and the degree to which they are self-regulated is to an extent offset by the desire of other people to control them. Without wishing to make too much of a political point, it seems that politicians, who are themselves probably the least regulated ones, actually want to control and regulate the others all the more. I think there are cultural and societal issues here, no longer is it enough to do the right thing, we have to prove that we are doing the right thing, almost the case of guilt until proved otherwise. And when something goes wrong, there always has to be some villain, somebody they can blame, be it the profession as a whole, be it the individual, or be it the regulatory mechanism. This, I think is colouring people’s attitudes to professional self-regulation. (*GP*)

All except three GP participants (trained GP appraisers themselves) strongly resented the new model of self-regulation suggesting that it sanctioned the probing of professionals to a degree they considered to be unacceptable. Indeed, as the above quoted suggests,
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doubts were voiced as to whether the system really was one of self-regulation. Although two PCT managers observed that modernised self-regulation continued to employ a model of peer assessment, that might be useful in overcoming the resistance of GPs to the new system, it may not be a very effective vehicle for performance management and for identifying under-performing GPs. The tenor of their comments is that the system should not be one of self regulation, and that it should be a performance management system rather than one of professional review.

It’s (the appraisal system) an interesting system but it is very much based on a professional model, it’s not managerial, and I have some problems with that. The question is, is it a performance management system or is it a professional review? Our system is very much the latter. The appraisers are GPs, peers. Do they have the skills to appraise? They certainly do not do it like a manager would, in the sense of managing performance. I suppose you have to start somewhere, but I would have to ask the question, if we had a doctor who is not performing, and we do have, would we pick this up? I’m not sure that we would, and I’m not sure that the system is contributing much to clinical governance! *(PCT Director)*

The idea that the system may be rather soft on performance was also hinted at by comments from practice nurses:

It’s (appraisal) going to be strange for them, because they have never had it before. It will be gentle appraisal though! They won’t rough each other up; GPs always support other GPs. But just the concept of it will be so alien to them. Doctors have always been gods they have never been questioned. I’m not saying they are arrogant, the public has done it, people admire them. They are the doctor, end of story! *(Practice Nurse: Focus Group)*

The contrast between GP and management opinions is quite stark, with GPs seeing the system as intrusive and an attempt for external groups to exert leverage over the profession, and managers seeing the process as being rather weak and unlikely to prevent lapses in performance. For GPs the system would weaken their professional autonomy but for managers the system did not seem to go far enough. The result seemed to be a system which pleased no one, and which was seen as burdensome:

I think that providing the evidence that you are doing these things is almost as much of a burden as actually doing it’ *(GP)*, and potentially punitive, ‘If these things are increasingly used as a stick to beat you with, rather than a carrot to help you then that will be an unfortunate development. This is yet another burden on an already over-burdened profession, at a time when recruitment needs to be improved. *(GP)*

The case provides evidence of managers explicitly expressing the wish to erode professional self-regulation and autonomy, but doubting that it would happen as they perceived that the system remained largely in the hands of clinicians themselves. It also
shows that clinicians harboured fears that autonomy would be lost and that their role would become increasingly regulated by those outside of the profession. Again, there is a basic ambiguity here, one which hinges on the differing standpoints of managers and GPs. The way in which this ambiguity became played out was through the role of GP Medical Advisors to whom we now turn our attention.

**GP Medical – Professional Representatives or PCT Managers?**

Throughout the study participants from both the managerial and the professional group, whether they were positive about clinical governance or not, stressed that if clinical governance was to be implemented effectively in general practice there needed to be trust, respect and good communication between the PCT and the GP practices. The directors and managers emphasised repeatedly the significant dual role the GP Professional Executive Committee representatives (GP Medical Advisers) play, firstly, as clinical advisers to the Professional Executive Committee (PEC) of the PCT, and secondly, as a conduit of information between the PCT and general practice in relation to the implementation of clinical governance. These individuals were perceived to play a bridging role and to be key change agents in the process of CG.

The GP PEC members are a kind of bridge between the practices and the PCT in terms of understanding what has gone on, what has worked well, or not so well and why, and what can be learnt from that experience. They are passing this on to other practices and back to us as managers to look at … They help to influence policy. If you have a PCT policy that is not working well, then we need their views to actually change that policy. We also need the clinicians view to actually develop that policy in the first place. *(PCT Director)*

The GP Medical Advisers were expected to take the lead in the cultural change programme for general practice. *'Undoubtedly general practice is changing and the GP PEC members have a key role in shaping the culture of general practice’* *(PCT Director).*

They were expected to ‘sell’ the clinical governance agenda to their professional colleagues in the field, being the main link between the PCT. At the same time they were seen as a channel of information from the medical profession to the PCT, representing their professional group in the managerial decision making at the PCT. Thus they played
an ambiguous role in the process, selling management changes whilst at the same time representing professional colleagues. As we have seen above, there seemed to be something of a gap between managers and clinicians on clinical governance so the Janus-faced role of GP Medical Advisors is one that warrants particular scrutiny.

These individuals played a key role in interpreting national guidelines on clinical governance at the PCT and in shaping the subsequent policies, procedures and systems for implementing clinical governance in general practice. The role was described as complex, broad and daunting but, in the view of managers, crucial to the successful implementation of change:

Their role is so important. If GPs appreciate that it is not the PCT telling them what they have to do, that it’s coming from their own professional colleagues I think it will be accepted more readily. (Chair PCT Board)

Their role here is framed as a political one and is rather unflattering, casting them as the means through which managerialist initiatives are communicated and made palatable to professional colleagues. For their part, GPs in the field were suspicious about why any GP would be willing to take on such a role. It was suggested that perhaps these individuals might be bored with general practice, not so good at dealing with patients, or just careerists, this being despite the fact that GPs believed it important that general practice should be fully represented on senior committees at the PCT. Generally, the GP perceptions of Medical Advisors were a mixture of scepticism tinged with suspicion, and a degree of grudging respect:

I think somebody has to do it because it is important that we (GPs) are represented at the PCT. I wouldn’t want to do it though. For those that do it, I think it is important they have their feet on the ground and that they spend most of their time in general practice rather than on committees, because otherwise they lose sight of the sheer pressure of it all going on five days a week! I would find it jolly easier sitting in a committee room than seeing patients. (GP)

The PCT needs advice from people who know the demands on general practice, but there are so many people involved with fancy titles doing non-jobs, and I think it is an enormous waste of money, when there isn’t the money for the basics. The other thing I always wonder, as well, is what sort of person is it who would want to do that job? The danger is they attract people who have got an axe to grind, or some zealot or some geek or whatever else! Are these people actually representatives of mainstream general practice? I’m not sure that they are. Another problem is that GPs are such a heterogeneous bunch, getting an overall view of general practice, all the different types of practices, big practices, single-handers, getting any kind of consensus view I think is almost impossible. I have my doubts about the usefulness of such things. (GP)
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…it’s vital that somebody does it, I’m very grateful to them … I’m desperate that GPs maintain a healthy, strong position on the PCT, and that their places are not filled by other people who aren’t GPs, because it’s about general practice and it’s the GPs who know what is going on in general practice. (GP)

So it seems that whilst managers saw Medical Advisors as giving voice to GPs, and being a means of selling the changes that were to be carried out, professionals were more ambivalent towards the people fulfilling the role. The representation role was seen as crucial but the ability of the advisors to fulfil this aspect of their work was doubted. It may well be argued that the representation role sits ill with the ‘selling’ role and may create a degree of role conflict for the advisors. This was not lost on the Medical Advisors that were interviewed. They recognised that the Government perceived them as change agents, and that GPs in the field often viewed them with suspicion, as facilitators of managerial control. They experienced a lack of clarity about their role and found this frustrating and stressful.

I think the government definitely sees us (GP Medical Advisers) as change agents in all of this (implementing clinical governance in general practice), and I suspect we probably are. I think GPs involved in management are seen by other GPs pretty much as, well, the thin end of the wedge. I mean its going to come anyway, (tighter control of GPs work), but yes, that’s how they see us I think......I didn’t want to do it really, I mean I did it because no one else would do it, I mean somebody had to do it, we need GP representation on the PEC, but I’m fairly sceptical about the whole process. I suspect there is still a lot of distrust, and the feeling that possibly we (GP Medical Advisers) don’t tell everybody the whole tale. (GP Medical Advisor)

Two key PCT senior managers stressed that these individuals are first and foremost representatives of their professional groups in managerial decision making at the PCT:

They (GP Medical Advisers) come from a clinical background, it doesn’t matter what managerial training or experience they have, the over-riding priority is always the clinical element. It’s about being able to look at systems and procedures and asking, what does that mean for the patient experience? (PCT Director)

A lot of the role is about clinical leadership. As a member of the PEC they have a clear responsibility to support the work of the PCT, perhaps to allay any fears that their colleagues may have, and to demonstrate, as clinical leaders, that they are at the forefront of delivering clinical governance. I think it is a difficult role for them, but I would expect them to perform it. (PCT Director)

However, another Director, whilst agreeing that these individuals are potential change agents with respect to getting clinical governance accepted in general practice, stressed
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the corporate responsibility of these individuals to participate fully in and then support the decisions of the PEC.

The hardest thing is understanding their corporate role. They are not there as a representative of GPs. They are there with their knowledge of being a GP to make informed corporate decisions. Around clinical governance, all of them, as are the managers, are there to develop and implement clinical governance. The fact that they are GPs is irrelevant. If you begin to use them as champions, you would then have to look at how the role impacted on other things. So, if you wanted to make changes to the way you dealt with secondary care, or to a commissioning function of a particular speciality, you couldn’t take their word because they are not representatives. So we have to think about how we use our GP Medical Advisers, they are there to give you clinical guidance. With respect to clinical governance, if they promote it as good thing, which they would because of their corporate responsibility, could they impose this across the whole of general practice? Very unlikely, it is a hearts and minds thing. (PCT Director)

A further Director, who had recently joined the PCT from a senior management role in a hospital believed that because PCTs are new organisations the role itself and the individuals undertaking it are still significantly under developed when compared to clinical directors, the parallel role in hospital trusts. Clinical Directors were perceived to be professionally more powerful and authoritative in their representation of their specialism than the GPs at the PCT. The problem was perceived to be that in hospital trusts clinical directorates are very cohesive groups. The consultants know each other well, they know each others strengths and weaknesses, they are able to clearly verbalise their various positions in relation to key issues. On the other hand, GPs are independent contractors, they operate in isolated practices; possibly don’t know each other or the individuals who are representing them at the PCT. It was suggested that it is difficult for just a few GPs to represent such a large, diverse and fragmented professional group. At the same time their managerial role was undermined by their lack of management knowledge:

I don’t think they (GP Medical Advisers) understand enough about management; they are very naive. On Hospital Trust Boards, the Clinical Directors might be asked by the Chair, what is the feeling of the medics, and they would be able to give a clear viewpoint. If the same was asked of the GP Medical Advisers, the answer might well depend on which practice you talk to, the reality is, they might not even see their colleagues. I fear that it is the government paying lip service to the professions, it may develop in time, but I don’t see it as effective at the moment. I don’t think that people outside see them as key influences, though they may be glad that they have a foot under the table. (PCT Director)

The role of medical advisors was generally poorly defined and made problematic by the dual management/representative nature of their position. It is clear from the data that
different groups had different but often quite fuzzy expectations of the medical advisors, and that they felt several roles were actually being played. The discomfort of the advisors in the study was, therefore, not unexpected, but it is clear that they were neither management ‘dupes’, who would simply sell ideas to GPs, nor were they just mouthpieces for clinicians. The ambiguity of the clinical governance was embodied in their role, and it is this ambiguity that is central to the effects of change on professional autonomy, as we will now discuss.

Discussion and Conclusion

The case study findings suggest that patterns of change are more in line with the theories of restratification rather than deprofessionalization or proletarianization. The case corresponds to the findings of Harrison and Dowswell (2002) and Sheaff et al (2002; 2003; 2004) finding only limited evidence of the deprofessionalization taking place. Patients may be better educated, more demanding and less deferential towards GPs, and may have access to authoritative information from books and the internet, but this is the result of general social trends not the result of the implementation of clinical governance in general practice. Also, Utopian GPs did not perceive a reducing ‘knowledge gap’ between themselves and their patients, and although there was potential for management surveillance through computer systems, GPs retained control of the data that was input and what was data was made available to managers. The transfer of skills to other para-professionals was evident but GPs, as medical professionals and employers of these staff, are still the dominant profession in general practice.

In line with the observations of Harrison and Ahmed (2000), Harrison and Dowswell (2002), Flynn (2002), Harrison and Smith (2003) Harrison and McDonald (2003) and Locock et al (2004), the study does demonstrate that clinical governance does serve to proletarianize GPs in some ways. Though the medical profession has so far not lost control many aspects of its professional work, clinical governance has impacted on the terms and content of the work of GPs. NSFs represent a challenge to the professional autonomy of GPs because they seek to direct a GP in the diagnosis, treatment and referral
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of patients. GPs are required to follow a set of centrally defined, pre-determined rules in relation to these functions, and to record their reasons for any deviation from these. GP appraisal and formalized CPD, although still based on peer assessment by professional colleague, is now a compulsory requirement for GPs to gain revalidation and remain licensed to practice. Whilst Utopian GPs perceive their professional autonomy and self-regulation has been significantly eroded by clinical governance, the GPs have by no means been reduced to the status of production line workers as suggested by the theory of proletarianization (McKinlay and Arches 1985; McKinlay and Stoeckle 1988). GPs still have high professional and social status; they remain highly paid and are considered a ‘significant force’ by PCT directors and managers. GPs in the study also found it desirable to resist aspects of clinical governance, justifying this resistance on the basis of their specialist knowledge and skills, and had not experienced any adverse consequences for their non-conformance (Sheaff et al 2002, 2003, 2004; Mahmood 2001; and Locock et al 2004. They were aware of the threat to their autonomy but this was an anticipated threat rather than an actual one; there was no sense in which members of the profession could be seen as unwitting dupes, nor as being powerless to resist a relentless change.

Friedson (1984; 1985; 1986; 1994) argued that bureaucratization, rather than causing a decline in the overall power and autonomy of the medical profession, results in a redistribution of power and autonomy within the profession. This restratifies the profession into distinct and separate groups: a ‘knowledge management’ group, such as medical professionals who serve on senior committees to produce protocols and guidelines; a ‘supervisory stratum’ of members who are drawn into management and supervise their fully qualified professional colleagues; and finally, ‘rank and file’ professionals in the field. ‘Rank and file’ professionals may lose power and autonomy, but it is not to managers but to elite groups of professional colleagues. In the case of Utopia PCT there is evidence of restratification but not in the pattern Friedson (1985, 1986, 1994) suggested. Instead, GP Medical Advisers seemed to take on all three functions within the same role as suggested by Sheaff et al (2004): acting in an advisory capacity at the PCT in relation to the interpretation of NHS policy and the development
of local procedures and systems; taking on a supervisory role in exercising ‘soft governance’ over GPs in the field; and retaining their own general medical practice.

In this context there is a clear image of the kind of colonization / appropriation process at work that we outlined earlier. The post of Medical Advisor may be one that is defined as part of the governance system, but the detail of the role has been more emergent and has been under the control of clinicians to some extent. Management may seek to colonize the medical profession, and the role of Advisors may be seen as a route for management to exert pressure on the doctors with the Advisors being seen as collaborators. However, our evidence does not support this, as the medical professionals saw the Advisor role as one which could be used to resist the excesses of managerialism. ‘Someone has to do it’ was a common response amongst the professionals, the hope being that those that did would prevent the erosion of the profession by helping to safeguard a degree of autonomy, and putting the professional case whenever possible. Whilst senior managers saw the role as one of change agent there is a sense that the Advisors appropriate those aspects of the managerialist agenda that they feel will be least harmful to the profession, and provide a buttress against those that are undesirable.

The Medical Advisors become ‘mimics’ of the colonizing management. They take on parts of the role and deploy the discourse selectively, but they are not ‘management’. Indeed, if they follow the development pattern of the equivalent role amongst hospital consultants, GP Medical Advisers will become very powerful individuals, as they are able to articulate together a specialist medical knowledge and discourse with a management one (Llewellyn 2001), creating a hybrid discourse (Chouliaraki and Fairclough 1999). They are not straightforwardly co-opted under the management agenda (Coburn 1992), as it is clear from the study that they remain wedded to the standards and goals of their profession. The idea that they are merely professional enforcers of management diktat is not an accurate view of their position. The role is complex because they balance managerialism against professionalism. Blending a management role with a professional one creates a hybrid role that, at the time of the fieldwork, seemed unlikely
to lead to straightforward co-option into management, nor to a conservative defence of professional status.

The case we have outlined may have more general relevance to changes where professional work is being changed by a managerialist or bureaucratic logic. The case suggests that in such a scenario the situation is likely to be one of ambiguity. It is clear that professions are not made up of homogeneous members and are not unquestioningly cohesive. Opinions within a profession about many aspects of professional work may be varied, and these differences may be played out through the re stratification process. However, professions will not be easily deprofessionalized, and neither will members be simply co-opted into managerialist modes of working. Rather a situation will emerge where the colonizing attempts of management will be met with appropriation strategies on the part of professionals. A mode of resistance based on this appropriation process will emerge, and instead of a blanket rejection of change the professionals will respond by taking on board some aspects of the change whilst rejecting others. This may take place through the establishment of professional roles (such as the GP Medical Advisors) that act as the both conduits for, and gatekeepers against, managerialism, and we would argue that further research on these ambiguous, boundary-spanning roles should be conducted to better understand the impact of managerialism on professional autonomy and status.

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