THE IMPACT OF SUCCESSIVE NEOLIBERAL POLICY REFORMS SINCE 1980 ON A CASE STUDY GROUP OF DOCTORS, NURSES AND MANAGERS IN PRIMARY CARE TRUSTS (PCTs) IN THE NATIONAL HEALTH SERVICE (NHS) IN ENGLAND

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Abstract

This study investigates the relations between doctors, nurses and managers in a primary care trust in South East England in an era of neoliberal reform since the 1980s. Using two concepts from the work of the cultural theorist Raymond Williams – 'epochal' analysis and 'structures of feeling' – the case study group is seen as an 'occupational tripartite' within a dynamic cultural totality. Using interpretive phenomenological analysis, interview data is examined and reveals aspects of tradition being used by both doctors and nurses in ways that tend towards organisational inertia and support existing dominant structures. Residual elements are employed by managers in an attempt to maintain their influence in the face of organisational change. The three groups are highly differentiated in their views and feelings, only agreeing on the difficulty of working together. The study suggests that any attempt to create more effective cooperation between the three groups needs to acknowledge and deal with the differences that exist between them rather than rely on the dominance of hybridized clinical and non-clinical roles.

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Abbreviations

AQP   Any Qualified Provider

AWP   Any Willing Provider

BFI   British Film Institute

BMA   British Medical Association

BMJ   British Medical Journal

BNIM   Biographic-Narrative-Interpretive Method

CCG   Clinical Commissioning Groups

CEO   Chief Executive Officer

CHAI   Commission for Healthcare Audit and Inspection

CQC   Care Quality Commission

CRQ   Central Research Question

DHA   District Health Authority

DMS   Diploma in Management Studies

DoH   Department of Health

EI   Empirical Indicator

EU   European Union

GLC   Greater London Council

GP   General Practitioner

GPwSI   GP with Special Interest

HCHS	Hospital and Community Health Service
IEA	Institute of Economic Affairs
II	Interview Intervention
IoD	Institute of Directors
IPA	Interpretive Phenomenological Analysis
IQ	Interview Question
JIT	Just in Time (manufacturing processes)
LHG	Local Health Group
LIFT	Local Improvement Finance Trust
MBA	Master of Business Administration
MiP	Managers in Partnership
MRP	Manufacturing Resource Planning
MUUC	Managerially-Led Unitary and Unique Culture
NDPB	Non-Departmental Public Body
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NPfIT	National Programme for IT
NPM	New Public Management
NUM	National Union of Mineworkers
OD	Organizational Development

OPEC	Organization of the Petroleum Exporting Countries
PBC	Practice Based Commissioning
PCG	Primary Care Group
PCT	Primary Care Trust
PFI	Private Finance Initiative
PHCT	Primary Healthcare Trust
RCGP	Royal College of General Practitioners
RGN	Registered General Nurse
RN	Registered Nurse
SE	South East
SHO	Senior House Officer (hospital doctor rank)
SQUIN	Single Question aimed at Inducing Narrative
SSDI	Semi-Structured Depth Interviews
TC	Theory Concept
TGWU	Transport and General Workers Union
TQ	Theory Question
TQM	Total Quality Management
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
UKIP	United Kingdom Independence Party

UNISON   Trades Union for public sector workers

WHO   World Health Organization

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The thesis that I am about to present to you is the result of intense effort over many months. Anyone who has ever produced a piece of work of this magnitude and to work full-time will recognise that much of the work is carried out alone and often whilst others sleep. However, behind this there is also a group of very generous and helpful people - in my case and in no particular order, Andrew Pike the Chief Executive at the local Primary Care Trust who was both generous and trusting allowing me unfettered access to his team at the Primary Care Trust to carry out my interviews. Dr Aslam who allowed me the use of his surgery as an interview site and for being a source of continuous support to me throughout the whole of this project. I am indebted to each participant who gave up their time to provide me with the rich seam of collective thoughts and observations concerning their experiences in the NHS.

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1. Introduction

This thesis concerns some of the voices of the changed and changing views of a single case study group of doctors, nurses and managers in the NHS regarding the impact of successive neoliberal policy-driven decisions in the NHS and the reported level of enmity that has developed between them as a result.

The focus of this research is on the NHS in England and not the NHS in Scotland, Northern Ireland and Wales and was carried out in a primary care setting between 2012 and 2013. The timeline for this research was after the most recent neoliberal policy changes in 2010 (Department of Health, 2010) and the wider reforms of the social care network (*Health and Social Care Act, 2012*).

The case study group in this research is representative of the core workforce in the NHS: the rationale being that managers will have either a clinical or non-clinical background, nurses encompass midwives and therapists, and the doctors and nurses in the case study will have worked in both the secondary and primary care sectors of the NHS.

1.1. Aims and objectives

Whilst there is already considerable research in the social sciences that explores occupational relationships and organisational behaviour in the NHS, this seems to focus on the traditional concentration of occupational relationships between professionals and management. This thesis aims to examine occupational relationships within the NHS from a different prospective and has the objective to further understand what the impact of neoliberal policy

reform has been on a case study group of doctors, nurses and managers in the NHS in relation to their defined occupational boundaries and how this transposes to an assessment of the group as an 'occupational tripartite' from the perspective of occupational cultural totality viewed as a more balanced set of influences.

1.2.   Theoretical framework

Underpinning this research is a theoretical framework based on two concepts of the cultural theorist and neo-Marxist Raymond Williams: 'epochal' analysis and 'structures of feeling', applied to the empirical data as a deductive a priori coding system. This research uses Williams' two concepts as an analytical tool to establish connections and polarised themes in an array of historically varied and variable viewpoints ranging from those within the 'dominant' culture, as well as aspects of oppositional emergence, through the 'residual' elements of past culture which may still exert influence. Through 'structures of feeling' the consideration of embryonic thoughts and feelings which may either assimilate into the 'dominant' culture or alternatively form differentiated structures feeling against the dominant culture, are all considered in the assessment of cultural behaviour from the point of Williams' attention to an analysis of the 'whole cultural process rather than only to the selected and abstracted dominant system' (Williams, 1977, p. 121).

1.3.   Research question and methodology

The research question has been constructed using the interview techniques of Tom Wengraf (2001); adapting his methodology of one-to-one semi-structured interviews based on a SQUIN or 'single question aimed at inducing narrative' Wengraf (2001, p. 69). A 'pyramid model', also by Wengraf (2001, p. 63) serves

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to separate the 'interview Question' (IQ) designed to be 'indicative-material-seeking', and a theory question (TQ), formulated in the theory-language of 'the research community', and is discussed in detail in Chapter 5.

The TQ:

> What has been the impact of successive neoliberal policy reforms in the NHS since 1980 on the views of a case study group of doctors, nurses and managers in a Primary Care Trust (PCT) in the South East of England concerning their occupation in relation to those of the others they work with?

The IQ:

> How has successive strategic policy implementation in the NHS since the introduction of the internal market in the 1980s, and more recently the introduction of integrated working in the 1990s, impacted on inter-occupational behaviour between doctors, nurses and professional managers and also service performance delivery in the NHS?

The notions by Wengraf are used with Williams' two concepts adapted as an a priori deductive coding system, together with an inductive phenomenological analysis, based on Interpretative Phenomenological Analysis IPA (Smith, Flowers and Larkin 2009), as a methodological hybrid thematic research framework, based on Fereday and Muir-Cochrane (2006, as cited in Willig, 2013, p. 63).

1.4.   Contribution

It is argued in this thesis that its contribution lies in its approach. The research focus is explored and analysed from a range of perspectives wider than the current 'dominant' approaches in the social sciences, which essentially address the customary binary lens dynamic of relationships between doctors and nurses or doctors and managers. Conversely, this research focuses conjointly on

doctors, nurses and managers as an 'occupational tripartite', through a lens which facilitates a range of diverse 'historically varied and variable cultural perspectives, other than that of the 'abstracted dominant system' (Williams, 1977, p. 121). Furthermore, I am unaware of any example to date which examines the occupational dynamic of doctors, nurses and managers in the NHS in this way, and I suggest this is a new contribution.

1.5.   Background to the researcher

My own working life has been spent in both the private and public sectors and I have experienced organisational change spanning across the entire epoch of neoliberalism to date. I witnessed a huge amount of change through the 1980s, at first in the private sector, in the printing industry. This was a period during which emerging global markets changed the socio-economic and political shape of Britain irrevocably. It was a period in time when the Conservatives and Margaret Thatcher strived to overturn the 'dominant' influence held by the print unions, and when the diminishment of control through demarcation practices protected by the then-'closed shop' printing and allied trades unions led to erosion of longstanding pay agreements, and formed part of what was a much wider post-industrial upheaval in the early 1980s in Britain and elsewhere.

Similarly, working for a London borough council in the 1990s I witnessed an emergence of changing working practices as tranches of staff redundancies driven by political economic rationalism, in a series of market-driven changes in the emerging neoliberal public sector.

For the past 16 years I have worked in the NHS. I have witnessed unrelenting cycles of change as the NHS has attempted to maintain stability in the face of change shaped by successive neoliberal change reforms. The most notable of

which was the National Programme for IT (NPfIT), famously disbanded for its inability to deliver any real change, and estimated cost to the UK taxpayer – exceeding £9.8 billion by 2013, (House of Commons Committee of Public Accounts, 2013). The change programmes I have witnessed in the NHS are too numerous to recall them all; many following a similar format, but one was memorable in that it was led by a former hostage negotiator!

1.6. Structure

In Chapter 2, I discuss two concepts from the cultural theorist Raymond Williams: 'epochal' analysis and 'structures of feeling', which form the theoretical orientation of the thesis. I explain each concept in turn and also address those who have critiqued Williams' two concepts, and I suggest where these two concepts may be used as an analytical tool to assess the impact on neoliberalism on the NHS for the case study group.

In Chapter 3, I consider secondary sources – the literature which explains the origins of neoliberal policy and New Public Management (NPM) in the NHS. I consider the role successive neoliberal governments have played in the forging of new NHS policy, beginning with how the Conservatives under Margaret Thatcher ushered in the Griffiths Report in 1983 and the introduction of general management, the introduction of the internal market and competition and other neoliberal reforms which formed the conjuncture of nursing and management into 'emergent' roles which challenged the dominant hegemony of the medical profession. Then how 'New Labour' in 1997 under Blair appeared to remove the internal market in place of integrated working and multidisciplinary teams. The chapter then shifts focus to the Conservative-Liberal Democrat coalition in 2010 and Andrew Lansley's policy reforms of the NHS in 2010 and how this rekindled

the traditional hegemonic position held by the medical profession in the NHS and the impact this has had on the doctors, nurses and managers in this study.

In Chapter 4, secondary source literature that historically contextualises each of the three groups in the case study (doctors, nurses and managers) is considered alongside literature which discusses these groups' current occupational standing in the NHS. The focus is on the hegemonic dominance of the medical profession from its professionalization in the mid-nineteenth century, its relationship with the state at the inception of the NHS in 1948, and since the Griffiths report in 1983, and how this and other neoliberal policy reforms have sought to change this dynamic.

In Chapter 4 the focus then moves to nursing practices and the advantages neoliberal reform in the NHS has had for nursing with new and more autonomous roles away from the dominance of the medical profession. This chapter also considers the key ramifications this caused in terms of inter-occupational tension between doctors and nurses and intra-occupational relations within the ranks of nursing itself. The final discussion in Chapter 4 concerns management, discussing its neoliberal origins, what this has meant for the development of the managerial role in the NHS and the contrasting views about managers concerning their contribution. Furthermore, the question of whether management can be considered a profession, or if its generalised function excludes it from the expert status of the professions, is addressed.

Chapter 5 addresses the research methodology, strategy, research instruments and processes. The chapter discusses the rationale for the design of a hybrid methodology based on Wengraf (2001) and a SQUIN, together with a 'Pyramid model' incorporating a Central Research Question (CRQ), in this study

synonymous with a TQ beneath it and an IQ, and Interview Interventions (IIs) beneath this. This, together with a deductive a priori deductive coding system and an inductive phenomenological methodology based on IPA (Smith, Flowers and Larkin, 2009), in line with a study by Fereday and Muir-Cochrane (2006), is discussed. This chapter concludes with a reflection on the limitations of the chosen methodological approach.

Chapter 6 describes and analyses the findings, ensuring that the identities of the participant are kept anonymous and that abstracted phenomena are compared to the secondary source literature (where connected, or polarised themes are argued). I then consider how these compare and contrast to one of Williams' two concepts, 'epochal' analysis or 'structures of feeling' – whichever coding the phenomena is interpreted as aligning to, against the superordinate and subordinate theme structures adapted from IPA. At the end of both superordinate categories there is a summary of the main findings.

Chapter 7 closes the thesis. The key findings are revisited and related to the conclusions. There is a discussion concerning the limitations of this research and an autobiographical reflection, and what its key contribution is. Finally, recommendations to NHS organisations and policymakers regarding future reform of the NHS are made, together with suggestions of future avenues to explore in light of the findings of this research.

2. Theoretical framework

This chapter builds a theoretical framework with which to further understand the impact of successive neoliberal policy reforms in the NHS since 1980 on doctors, nurses and managers in a PCT in the South East of England.

Underpinning the theoretical framework are two concepts of the cultural theorist Raymond Williams: those of 'epochal' analysis and 'structures of feeling' (1977). This, together with a methodology based on the adaption of IPA provide the means by which the research question is addressed. The chapter begins with an explanation of Williams' ideas as used in the research, and seeks to justify their relevance to the research question, before examining alternative theoretical approaches and explaining why this path was chosen over the alternatives.

2.1.   Towards developing a theoretical framework

Whilst the decision to use two of Raymond Williams' concepts came late in this research, his approach seemed useful in the seeking of a further understanding of the complex nature of the organisational and occupational culture in the NHS following neoliberal policy reforms in the 1980s. As this study deploys neo-Marxian theory through the concepts of Raymond Williams, the focus is not necessarily concerned with class hierarchy, but is certainly concerned with occupational hierarchy within the NHS. This is examined in detail in this theoretical framework.

Williams' work is not widely employed in the arena of organisational studies in general or in health service organisation in particular; I am aware of only one

other example, that of Bryson (2008), discussed later. However, this chapter sets out the rationale for using Williams' work. According to Williams:

> For it certainly seems necessary to look for meanings and values, the record of creative human activity, not only in art and intellectual work, but also in institutions and forms of behaviour (2011, p. 62).

Williams adopts a revisionist neo-Marxist response to orthodox Marxist theory and its array of limitations within what he termed Marxist 'material fixed forms' (Williams 1977, p. 129). His alternative structure is 'cultural materialism' (Williams 1977, p. 5), extending orthodox Marxist class-based discourse beyond that of 'Marxian historical materialism', culminating in a hegemonic shift towards the proletariat and away from the bourgeoisie (Lukács *Et al.*, 1968).

For Williams, orthodox Marxist thought did not counter 'the problem of the mobility of the category of totality between an ideal (non-alienated) state and an empirical (but then also differentiated) social whole' (Williams, 1977, p. 182). Furthermore, Grossberg (2010, p. 19) suggests 'Williams implicitly foregrounded the problematic of totality as a question and challenge of modernity'. Grossberg observes Williams' 'commitment to totality is crucial to his project as an effort to find a different position on modernity' one which understood the necessity of the 'reification of the categories resulting from the modern fragmentation of the social formation' (Grossberg, 2010, p. 19).

The economic neoliberal ethos which became entrenched globally as a response to the 'crisis of organised capitalism during the 1970s' (McGuigan, 2016, p. 157), as a result of the OPEC oil crisis in 1973, (Harvey *Et al.,* 2005). This resulted in a shift from the traditional dominant rational organising model of Fayol (King and Lawley 2016, p. 31), and the Taylorist/Fordist methods of scientific management and systemised mass production, to a post-Fordist age

and methods of 'flexible specialisation (Piore and Sabel, 1984)' (King and Lawley, 2016, p. 105).

Both the private and public sectors alike have been restructured as a direct result of neoliberalism, in the public sector this has been through New Public Management (NPM) a method of organising public services in line with that of private sector enterprise, (Hood *Et al.,* 1991). I argue that Williams' theory of culture represents an approach to the study of cultural complexity, and importantly cultural totality. Few would doubt that the NHS is now culturally complex as a large organisation with many subcultures, and Brooks (2009) reminds us that 'in most healthcare sectors throughout the world, a series of subcultural groups work alongside one another' (p. 261). In this study, two of Williams' concepts are deployed in the examination of three subcultural groups, the doctors, nurses and managers in the NHS.

Williams is principally recognised for his contribution to 'cultural studies in England' and was part of an academic movement converging on the 'transformation of modernity around the world' (Grossberg, 2010, p 19). Furthermore, Bourne Taylor (2010) observes Williams had drawn on 'Althusser's theory of Ideology, Gramsci's conception of Hegemony, and Foucault's definition of power' (Bourne Taylor, 2010, p. 162).

However, it is West (1992, p. 8) who makes an audacious move in defining Williams' concepts as tools for analysis, claiming 'Williams provides indispensable analytical tools'. I argue this marks a fundamental step change for Williams' concepts when used as pragmatic theoretical tools, and one which Bryson demonstrates in her application of Williams' concept of 'selective tradition' in a workplace study, where she suggests Williams' concept be used

as a 'lens' or 'as a tool for analysis in both academic research and practitioner change processes' (Bryson, 2008, p. 744).

2.1.1. 'Epochal' analysis and its relationship to this study

The Griffith Report in 1983 formed a vanguard move by the Conservatives under Thatcher, and Learmonth (2001; 2005 as cited in Gorsky, 2008, p. 446) suggests, 'the discursive shift from "administrator" to "manager"' followed, where the general manager was viewed 'as a belligerent, heroic leader facing down consultant intransigence'.

Williams' concept 'epochal' analysis might help us to understand whether the ramifications of Griffiths and the neoliberal reforms in the NHS that followed constituted an 'epochal' shift and if so, what has been the impact. Applied essentially as an identification and classification system, Williams' concepts here is used to assess the multiplicity of cultural behaviour within any given epoch, and / or the fluidity of cultural behaviour through shifting epochs, with some remnants being carried through to the next. This is in contrast to Marxist materialism, which sees only the finished products of solidified systems with no further analysis beyond this, (Pavlac, 2011).

Williams' 'epochal' analysis, Bourne Taylor (2010, p 201) reminds us, 'can be traced back to *Culture and Society* (1958)'. However it is in *Marxism and Literature* (1977) that Williams charts, in a systematic way, the three dynamic cultural elements: the 'dominant', the 'residual' and the 'emergent'. The objective was to demonstrate how a cultural system may be identified within the interrelated social factors, often uneven, both macro and micro, in institutions, traditions and formations and through other heteronomous factors. As Williams suggests, 'it is necessary to examine how these [elements] relate to the whole

cultural process rather than only to the selected and abstracted dominant system' (Williams, 1977, p. 121). This is indicative of Williams' preoccupation with the understanding of the 'totality' of culture (Williams, 1977, p. 183) which, Bourne Taylor observes, '… represents a shift away from more monumental 'epochal' analyses of history in the manner of Hegel and Lukács, where periods or stages of history succeed one another and each epoch is characterized by a dominant mode or spirit of the times'. (Bourne Taylor, 2010, p. 201). Furthermore, this is evident in *The Country and the City* (1973) where Williams' focus is on the transition from a rural to an urban mode of society and where an array of paradoxes are in tension, bringing forth newly formed complex interrelations and varied perspectives between past and present.

Williams' theorising in this respect is criticised by Roman, who suggests, 'cultural holism erroneously presumes that cultural practices, formations, and experiences are unmediated by very different and often asymmetrical structures and interest of determination' (2013, p 176). However, I would argue this is the logic of Williams' 'epochal' analysis and may prove useful in further understanding complexity arising from change. This also highlights the potential generalizability of Williams' concept of 'epochal' analysis and, I would suggest, can be overlaid onto situations as diverse, on the one hand, as the cultural differentiation emerging from a knitting circle which meets regularly at a tearoom in a suburban town, right through to major world conflict situations – the basic approach would remain the same.

Williams' 'epochal' analysis, as applied in this research, may prove useful in the identification of 'dominant' behaviour and complex 'emergent' movements, and the 'residual' cultural tendencies from previous epochs that influence occupational culture in the NHS. This applies whether this is the 'dominant',

demonstrated through group or individual 'dominant' behaviour, or the 'residual' where past cultural practice is carried through into the present, belief systems, formed in the past, yet of influence in contemporary day-to-day cultural behaviour (Williams, 1977). Alternatively, the 'emergent' is wholly oppositional and contests the 'dominant' status quo. Williams describes the topography of the concept, the complexity found within social behaviour and social structures and how these variables react and interact with each other, which is defined as 'epochal' analysis:

> The complexity of a culture is to be found not only in its variable processes and their social definitions- traditions, institutions, and formations-but also in the dynamic interrelations, at every point in the process, of historically varied and variable elements. In what I have called 'epochal' analysis, a cultural process is seized as a cultural system, with determinate dominant features…or a transition from one [epoch] to the other…in which a sense of movement within what is ordinarily abstracted as a system is crucially necessary, especially if it is to connect with the future as well as with the past (Williams, 1977, p. 121).

As Williams suggests, it is the 'historically varied and variable elements' that contribute to the the changing dynamic of the analysis, and therefore close attention must be paid to the ways in which these elements react and interrelate to each other, with the 'dominant' culture, but also outside of this on the peripheries, and it is this cultural activity outside of the direct gaze of the 'dominant' culture that Williams suggests is the fluidity of 'the complex interrelations between movements and tendencies both within and beyond a specific and effective dominance' (Williams, 1977, p. 121).

Therefore in this study, it is argued that Williams' analysis may be helpful in the further understanding of organisational complexity in relation to occupational

behaviour following neoliberal reform in the NHS. Firstly, once identified and used as a framework, this may be used to then question how the three elements in Williams' 'epochal' analysis have originated, what they represent in the present and also what they are representative of in the past, whether past elements are carried through to the present, how variable these elements are and how they interrelate to each other in the totality of a 'whole cultural process' (Williams, 1977, p. 121).

The 'dominant'

In Williams' first element, the 'dominant', he chooses to define this in relation to the other two elements in his 'epochal'' analysis: the 'residual' and the 'emergent', which he suggests 'are significant both in themselves and in what they reveal of the characteristics of the dominant' (Williams, 1977, p. 125).

In referring to the 'dominant' element, Williams draws on Gramsci's hegemony (Bourne Taylor, 2010). As a mechanism which he suggests deliberately avoids 'consciousness', or any structuring as typical of an 'ideology', nor does hegemony transact towards 'manipulation' or 'indoctrination', (Williams, 1977, p. 110).

Williams suggests that whilst there are areas of social activity that obviously sit outside of the 'dominant' hegemony, and are incongruous to it, they are representative in his theorising as the 'residual' and 'emergent' elements in his 'epochal' analysis. However, in an attempt to control these, he reminds us:

> On the contrary it is a fact about the modes of domination, that they select from and consequently exclude the full range of human practice. What they exclude may often be seen as the personal or the private, or as the natural or even the metaphysical. Indeed it is usually in one or other of these terms that the excluded area is expressed, since what the

dominant has effectively seized is indeed the ruling definition of the social (Williams, 1977, p. 125).

Williams' theorising, here extends to the notion of 'advanced capitalism' (Williams, 1977, p. 125), which he later extended to the clandestine term, 'Plan X', to describe the more sinister elements of hegemony where state control becomes such that it is 'determined solely by player advantage' (Williams, 1983, p. 246). Moreover, he describes how hegemonic processes become so entwined in the normal fabric of society:

> The gross mutual flattery of military professionalism, financial professionalism, media professionalism and advertising professionalism indicates very clearly how far this has gone. Thus both social and cultural conditions of the adoption of Plan X, as the only possible strategy for the future, are very powerful indeed (Williams, 1983, p. 247).

Williams explaining the nature of the 'dominant' element draws heavily on Gramsci's theory of hegemony, which contrary to any form of ideology becomes part of the normal structure and practice of society, to the point where it is undetectable in normalised terms, (Williams, 1977, p. 110).

This is echoed by West (1992) in his observations on Williams' theory, 'by highlighting how, in relatively cold moments in human societies, class conflict is mediated through social, cultural or educational changes that insure the muting of class struggle' (West, 1992, p. 2). In contemporary writing this is recognised by Alvesson and Deetz (2006) who suggest contemporary workplace critiquing had 'gradually … become less concerned with coercion and class and economic explanations [and] became involved in systemic processes which produced active consent … (for example Gramsci, 1971; Burawoy, 1979; Willmott, 1990)' (Alvesson and Deetz, 2006, p. 83).

Within the notion of the 'dominant' Williams embeds what he terms 'selective tradition', which he suggests is a mechanism used by the 'dominant' culture to incorporate any 'residual' elements that the 'dominant' culture can recognise as such, and that may prove oppositional to it. The 'dominant' culture dilutes, represses, includes or excludes any belief system or practice which chooses to resist incorporation, and he describes this process in the following way:

> Moreover, at certain points the dominant culture cannot allow too much residual experience and practice outside itself at least without risk it is in the incorporation of the actively residual - by reinterpretation, dilution, projection, discriminating inclusion and exclusion - that the work of the selective tradition is especially evident (Williams, 1977, p. 123).

However, Williams is careful to point out that to make the assumption that all of society is totally subsumed by the 'dominant' hegemonic culture and the covert tools of incorporation is unfounded – in doing so, the nuanced cultural activity of the 'emergent' may be overlooked. He suggests:

> The specific functions of 'the hegemonic', 'the dominant', have always to be stressed, but not in ways which suggest any *a priori* totality. The most interesting and difficult part of any cultural analysis, in complex societies, is that which seeks to grasp the hegemonic in its active and formative but also its transformational processes (Williams, 1977, p. 113).

Applied to the NHS, Williams' notion of the 'dominant' could symbolise, at one level, the conventional 'dominant' structure held by the medical profession and the traditional method of social closure (Weber, 1978). It might also relate to less overt structures of dominance as a result of the changing dynamics in the NHS, and elsewhere as part of the post-Fordist structure of specialization in what Heydebrand (1989; as cited in Dent, 1995, p. 878) suggests are '[t]he

newer, more flexible, forms of organization identified as flexible specialization or post-bureaucratic'.

This substantiates what Williams suggests about the role tradition plays in Williams' notion of the 'dominant' – that the role of tradition is powerful. In Williams' view the power of tradition is grossly underestimated in orthodox Marxist theory, suggesting:

> Tradition is in practice the most evident expression of the dominant and hegemonic pressures and limits. It is always more than an inert historicised segment; indeed it is the most powerful practical means of incorporation (Williams, 1977, p. 115).

This concurs with Shils (1981, p. 25 as quoted in Jacobs, 2007, p. 143), who suggests tradition is 'this "normativeness of transmission", as "the inertial force which holds society in a given form over time"'. This concurs with Williams' suggestion that tradition resides as part of the apparatus of the 'dominant' (Williams, 1977, p. 115).

However, Williams (1977), suggests the 'dominant' can only ever be fully appreciated through an understanding of its dynamic relationship with both the 'residual' and the 'emergent', and he suggests these two elements say more about the 'dominant' than any analysis of the 'dominant' in isolation could ever say alone.

The 'residual'

This brings us to the second of Williams' notions within 'epochal' analysis, the 'residual'. Firstly, Williams makes a distinction between the 'residual' and the 'archaic', because 'the 'archaic'…is wholly recognized as an element of the

past', (Williams, 1977, p. 122). However, there are exceptions, and Williams uses the example of the monarchy to explain this:

> In the monarchy, there is virtually nothing that is actively residual (alternative or oppositional), but, with a heavy and deliberate additional use of the archaic, a residual function has been wholly incorporated as a specific political and cultural function - marking the limits as well as the methods - of a form of capitalist democracy (Williams, 1977, p. 122).

Williams suggests that the 'residual', has effectively been formed in the past, but is still active in present cultural practice – but unlike the 'archaic' it is not brought forward in any specialised way. (Williams, 1977, p. 122). Williams observes that while much of 'residual' culture is assimilated into 'dominant' culture, the truly 'residual' will remain distinct in its definition, in 'limited respects alternative or oppositional' (Williams, 1977, p. 122). However, Williams maintains the 'residual' will rail 'against the pressures of incorporation, [where] actively 'residual' meanings and values are sustained' (Williams, 1977, p. 123).

In this research Williams' notion of the 'residual' may represent nostalgic reminiscing of past epochs. It may be partly representative of a 'dominant' or subordinate relationship between the medical profession and nursing, maintaining traditional values even though the contemporary nature of these roles and their relationships has transitioned. In other words, by applying the use of Williams' element – the 'residual' – this may help to identify the ways occupations rely on aspects from the past to make sense of the present and their own role and relationships with others. It may also help to explain way certain values and meanings are persistently carried forward into new epochs and are difficult to change.

The 'emergent'

This now leads to the final element of Williams' 'epochal' analysis: the 'emergent'. Williams, suggests that 'new meanings and values, new practices, new relationships and kinds of relationships are continually being created' (Williams, 1977, p. 123). However, as Williams also observes, there is '…the (often uneven) emergence of elements of a new cultural formation' (Williams, 1977, p. 124).

The 'emergent' typifies areas of cultural behaviour where practical consciousness begins to manifest a distinct oppositional form to the 'dominant' hegemony. However, whilst oppositional emergence is in process it is difficult to identify, but the specific quality of the 'emergent' is as Williams suggests:

> '[b]y 'emergent' I mean, first, that new meanings and values, new practices, new relationships and kinds of relationship are continually being created. But it is exceptionally difficult to distinguish between those which are really elements of some new phase of the dominant culture (and in this sense 'species specific') and those which are substantially alternative or oppositional to it: emergent in the strict sense, rather than merely novel (Williams, 1977, p. 123).

One example Williams provides is the emergence of the working class in nineteenth-century England, (Williams, 1977, p. 125). However, Williams recognises that alternatives which emerge may become assimilated. As Williams explains, '[t]he alternative, especially in areas that impinge on significant areas of the dominant is often seen as oppositional and, by pressure, often converted into it' (Williams, 1977, p. 126). However, Williams observes, once there is no possibility assimilation into the 'dominant' culture, 'real oppositions…are felt and fought out' (Williams, 1980, p. 39).

However, the 'emergent' has become more nuanced in advanced capitalism, where the homogeneous nature of society is such that it has been increasingly less easy to detect oppositional emergence, and he suggests:

> …it is true of the society that has come into existence since the last war, that progressively, because of developments in the social character of labour…of communications, and…of decision, it extends much further than ever before in capitalist society…. Thus the effective decision, as to whether a practice is alternative or oppositional, is often now made within a very much narrower scope (Williams, 1980, p. 41).

The question this raises for this thesis is whether there has been a substantial redrawing of the traditional hegemonic boundaries in the NHS as new entrants – for example, nurses through state meditated opportunities (Department of Health 1987) – developed an 'emergent' culture. Or do the actions following the Griffiths Report alter the hegemonic power of the medical profession with the introduction of a 'new managerial class' (Dopson *Et al.*, 1997)?

2.1.2. 'Structures of feeling' and their relationship to this study

I argued 'epochal' analysis may be used as an analytical tool in relation to the groups in this study, seeking to identify and understand the dynamics of some of the elements of cultural behaviour as a result of neoliberal policy reform in the NHS.

However, Williams' 'epochal' analysis is only one facet of cultural theory beyond that of Marxist 'fixed forms' (Williams, 1977, p. 129). In Williams' view it is only when the developmental process of cultural behaviour can be demonstrated from inception through personal thoughts and feelings, to the culmination of social action that the objectives of any cultural analysis undertaken be met:

> In most description and analysis, culture and society are expressed in an habitual past tense. The strongest barrier to the recognition of human cultural activity is this immediate and regular conversion of experience in to finished products (Williams, 1977, p. 128).

This is where Williams' concept of 'structures of feeling' comes into play. Bourne Taylor (2010) observes that:

> Williams first used this concept to characterize the lived experience of the quality of life at a particular time and place (Taylor, 2010, p. 670).

Through 'structures of feeling', Williams shifts the focus of the analysis on the whole spectrum of cultural activity outside of explicit social 'fixed forms' (Williams, 1977). This concept is related to 'epochal' analysis, and all three elements, the 'dominant', the 'residual' and the 'emergent', as part of Williams overarching preoccupation with the necessity to understand individual actions and traits in the context of cultural 'totality'. As Grossberg (2010) observes '[t]he structure of feeling makes the cultural text into a microcosm of the whole – to see the world in a grain of sand – through a notion of homology or correspondence'….[where the] politics of any cultural practice…placed into the social totality, into the context as it were' (Grossberg 2010, p. 20). Through 'structures of feeling' Williams is 'defining a social experience which is still *in process'* (Williams, 1977, p. 132). Furthermore, he proposes:

> …then if the social is the fixed and explicit – the known relationships, institutions formations, positions - all that is present and moving, all that escapes or seems to escape from the fixed and the explicit and the known, is grasped and defined as the personal: this, here, now alive, active, 'subjective' (Williams, 1977, p. 128).

Furthermore, Grossberg (2010, p. 24) suggests 'structures of feeling' is Williams' notion of 'a space between presence and emergence'. Grossberg

(2010, p. 25) also suggests that it is in fact 'Williams' absent theory of modernity' (p. 25). Grossberg, extending this hypothesis, says:

> Williams…negotiates a constitutive relationship between the two chronotopes that constitute the centre of most Western theories of modernity – a more common sociological view and a more avant-gardist aesthetic view, but also, in bringing these together in the structure of feeling, which is not to say reconciling them, Williams opens the possibility of seeing modernity as a continually dynamic, emerging and even multiple possibility', (Grossberg, 2010, p. 25).

Another articulation of the usefulness of 'structures of feeling' which has been somewhat overlooked in contemporary cultural analysis, is observed by Sharma and Dygstrup (2015) who suggest that whilst Williams' notion was widely acknowledged in the field of literary and cultural theory at the time of its introduction, its potential as a contemporary source of analysis, although relatively unchartered at present, is borne out in his 'effort to look for the emergent and fluid states of affective presence without subsuming them into more tangible cultural expressions, and the attempt to gauge the relational configurations of the affects that reverberate in our surroundings'. (Sharma and Tygstrup, 2015, p. 6).

In this study, it is envisaged that the application of 'structures of feeling' may help to identify specific indicators which provide further insight into the potency of present thoughts and feelings manifesting in the case study group, which have yet to be fully articulated. This in turn will assist the greater understanding of how this impacts on the present culture in the NHS, and how this shapes and governs the behaviours of those in this study and therefore have the potential to provide speculative parameters concerning the reception of those in the case study group to future change initiatives in the NHS.

However, the subtle nature of 'structures of feeling' is such that it can be difficult to detect, which Williams himself admits:

> *Structures of feeling.* The term is difficult but 'feeling' is chosen to emphasize a distinction from more formal concepts of 'world-view' or 'ideology' (Williams, 1977, p, 132).

However, Williams suggests it has a structure which, because of its nuanced character, is hard to identify – even once it has developed:

> It is a structured formation which, because it is at the very edge of semantic availability, has many of the characteristics of a pre-formation until specific articulations-new semantic figures- are discovered in material practice: often as it happens, in relatively isolated ways, which are only later seen to compose a significant (often in fact minority) generation; this often, in turn, the generation that substantially connects to its successors (Williams, 1977, p. 134).

Moreover, it could also be argued that Williams is responsible for some of the misperception surrounding 'structures of feeling' in his own explanations:

> Structures of feeling can be defined as social experiences in solution, as distinct from other social semantic formations which have been *precipitated* and are more evidently and more immediately available (Williams, 1977, p. 133–34).

Using a metaphor, it arguably propels the notion of 'structures of feeling' into the sphere of the sciences and positivism, rather than the subtle nuanced character of cultural phenomenology. Although viewed from a different perspective it does express the fluidity of the notion. Perhaps this points to the reasons for Williams' concepts and notions not being more widely applied. Furthermore, 'structures of feeling' has been lambasted by some as having no real philosophical worth. For example, Pfeil (1980) comments '"Structures of

feeling"… [t]his is not theoretical definition, but a kind of rapture served up as one', (Pfeil, 1980; as cited in Christopher, 2005).

Yet despite the arguably justifiable criticism, there are those who have defended the use of the term. Bourne Taylor (2010, p. 670) suggests, that 'Williams wished to avoid idealist notions of a "spirit of the age"'. McGuigan concurs, suggesting '[s]tructures of feeling is Williams' alternative to the idealist notion of zeitgeist the spirit of the times. He [Williams] says 'it is as firm and definite as "structure" suggests, yet it operates in the most delicate and less tangible parts of our activity', (McGuigan, 2014, p. 27).

Matthews argues that 'it [structures of feeling] enables Williams to access an area of uncertainty, interest and inarticulacy…[yet the] vague quality of the formulation is in fact therefore its virtue' (Matthews, 2001, p. 191). This sentiment is reflected in Grossberg (2010), who attempts to allay some of the criticisms over the concept's validity, suggesting:

> If I may then be allowed, the structure of feeling is the endless construction and deconstruction of the difference between the known and the knowable, between culture and experience, between history and an ontological presence…but also of transcendence or possibility (Grossberg, 2010, p. 24)

Arguably then 'structures of feeling', when used in any analysis, have the potential to act as an analytical tool to expose obscure thoughts and feelings and therefore provide new and differentiated insights and views. This is in keeping with Williams' pursuit of a structure of totality regarding the analysis of a culture.

'Changes of presence'

Within the discussion of 'structures of feeling', Williams uses the term 'changes of presence'. I argue in this thesis that 'changes of presence' represents an incremental step in the development of a 'structure of feeling' and serves as an indicator to the identification of a structure forming. This is not to suggest that 'changes of presences' denotes any substantive conversion to an explicit form, it is more akin to the gathering of momentum as individual thoughts form a structural presence. This is the mechanism of 'structures of feeling' and Williams describes this in the following way:

> [C]hanges of presence (while they are being lived this is obvious; when they have been lived it is still their substantial characteristic); second, in that although they are emergent or pre-emergent, they do not have to await definition, classification, or rationalization before they exert palpable pressures and set effective limits on experience and on action (Williams, 1977, p. 132).

Grossberg (2010) questions '[h]ow do we make sense of this complex concept [structures of feeling] in which a notion of presence plays a crucial role in the relation of the known and the knowable, between the epistemological and the ontological (the lived)?'. He suggests this may be found in the two senses of the 'modern…historical time' and 'eternal contemporaneity' where the sense of the 'moment' dominates until there is a conversion to the 'consciousness and [the] "now"' (Williams, 1989, p. 76)' (Grossberg, p. 23).

In this study the notion of 'changes of presence' is used to identify the thoughts and feelings which are being lived and identified as influx, uncertainly held, apparent but existing possibly in isolation, until as Williams suggests 'which are only later seen to compose a significant (often in fact minority) generation; this

often, in turn, the generation that substantially connects to its successors'. (Williams, 1977, p. 134).

'Differentiated structures of feeling to differentiated classes'

The last notion of Williams' I have used in this research study is also discussed in relation to 'structures of feeling': 'differentiated structures of feeling to differentiated classes'. 'Classes' is the term used in Williams' writing, however, in this research 'classes' could be interpreted as occupational groups.

In this research I have emphasised 'changes of presence' and 'differentiated structures of feeling to differentiated classes' as two components of 'structures of feeling'. This is to illustrate the transitional aspect where a change in a 'structure of feeling' between individuals or groups occurs, which may then result in differentiated feelings between individuals or groups.

Williams (1977, p. 134) admits that this is a complex area that requires some explanation, and provides various examples from history of 'differentiated structures of feeling to differentiated classes'. He looks at the historical period of 1700–60, when in 1714, the established Stuart dynasty, of which Queen Anne was the last, was replaced by the German Hanoverian dynasty, and King George I. Williams suggests this set a 'differentiated structure of feeling to differentiated classes' in motion where a period of subdued resentment followed between those still loyal to the House of Stuart and those from the incoming Hanoverian court and those loyal to it. The whole purpose of this is to demonstrate how transitioning epochs consist of a number of diverse cultural practices and beliefs, some of which he suggests:

> [w]hen a formation appears to break away from its class norms, though it retains its substantial affiliation, and the tension is at once lived and

articulated in radically new semantic figures…and semantic formations by its articulation of presence (Williams, 1977, p. 134–5).

A contemporary example of new semantic articulations of presence and altered cultural behaviour evoked by change would arguably be the withdrawal from the European Union by Britain or 'Brexit', on 23rd June 2016. The 'differentiated structures of feeling to differentiated classes' is between the 'Brexiteers' who wanted to leave the EU and those who have become known as the 'Remainers', those who wished to stay in the EU. And even more recently, the election of Donald Trump as the 45th President of the United States on 8th November 2016, can also be compared – that a 'differentiated structure of feeling to differentiated classes' has emerged between those loyal to Trump and who voted him into office, and those who dislike his polices and did not vote for him. Both of these constitutional events have galvanised a raft of polarised views within the respective communities involved.

It seems that 'differentiated structures of feeling to differentiated classes' represents the end of a cycle of 'structures of feeling' where conflicting values have surfaced as a result of changed meanings and values, where different cultures are forced to coexist and retain residual value and belief structures. There is tension and a resistance to any form of assimilation into dominant values and beliefs, yet there is coexistence.

In this study 'differentiated structures of feeling to differentiated classes' may be useful in the examination and assessment of the impact of neoliberal policy change in relation to the three coexisting groups in this study, to identify where the differences that lay within the case study group and how intense any feelings of difference are. My interpretation of 'structures of feeling' is that represents not the experiences that are obviously social, the 'known', but

instead the slowly accruing personal thoughts and feelings that individuals and groups carry with them as their system of meaning but are kept repressed due to circumstances beyond their immediate control. As Grossberg (2010, p. 24) suggests, 'structures of feeling' are the potential 'knowable', which may later prove to be the substantial 'known', and the future social effects of change, but equally in present circumstances may still have an effect in on society through undiagnosed forms.

Finally, I would argue, 'structures of feeling' is not so much complex as subtle, and this is its strength, for subtle messages and signals warrant a subtle analysis, to be able to detect them. I argue therefore that this is what Williams provides us with, in his concept 'structures of feeling' (Williams, 1977), it is a subtle response to.

In this chapter, so far I have discussed Williams' work, which I have attempted to show has the potential to be applied to the analysis of occupational relations in the NHS as part of wider cultural change. In the remaining sections of this chapter, I will discuss some alternative theoretical approaches and compare and contrast to Williams' interactionist stance towards the assessment of a culture, before going on to discuss the work of researchers who have used Williams' theories in their organisational studies, and others that identify some of the limitations of Williams' concepts.

2.2.   Williams' theory in comparison with others

It is Peter Sedgwick (1964) in an article for the *New Left* who captures the nuanced value of Williams and articulates the possible intended outcomes that his theory aimed to achieve:

What Williams finally offered was the replacement of a conflict model of society (of the sort which has been traditional among socialists and even radical reformers) with a communications model, in which the unity of human-kind is primordially broken, not by the clash of rival social interests, but by blockages and faulty linkages in moral perception (Sedgwick, 1964, p. 15).

That said, there are other theorists who compare and contrast with that of Williams' two concepts used in this research. Strauss *Et al.* (1963; as cited in Hannigan, 2013), looks at a healthcare study in the US, and ways of analysing the complexities of the occupational aspects of healthcare culture through the concept of a 'negotiated order'. Maines (1977; cited in Hannigan, 2013) observes, this is '… a means to understand how social order is maintained during periods of inevitable change …in which Strauss and his colleagues investigated the organisation of services and the complex relationships between members of the hospitals' staff (Strauss *Et al.*, 1964)' (Hannigan, 2013, p. 33).

Negotiated order is a response to 'complexity…of ideological differences within occupational groups … a process which Strauss referred to as segmentation' (Hannigan, 2013, p. 34). Maines (1982, p. 268) suggests 'negotiated order' formed a sharp contrast to 'the then dominant Weberian and functionalist theories'. Furthermore, Maines (1982) observes that Strauss devised three central concepts of negotiated order: 'negotiation' – the negotiations themselves; 'negotiated context' – the contextual elements which may affect the direction the negotiations take, and 'structural contexts' – the wider macro elements which may exceed more localised contexts in negotiations (Strauss, 1979; as cited in Maines, 1982, p. 270). The extent of the effectiveness of the negotiations is governed by 'shifting patterns of constraints and resources…[in

the] settings where participants are involved' (Kling and Gerson, 1978; as cited in Maines, 1982, p. 271).

Furthermore, Maines (1982) reminds us negotiated order has been extended by a number of cultural theorists, including Thomas (1981) who emphasises the 'dialectical activity in which the human subject constitutes and in turn is constituted by a social object' (Maines, 1982, p. 276). In other words, negotiated order acts as a continuous response mechanism, in as much as a negotiation contributes to the passage of social order, which in turn generates further negotiation and modifications to the social order, and so on. In what Maines (1982) observes 'Geertz (1973) suggests is 'the domain of subject-object unity is the domain of mesostructure', resulting in 'meaningful patterns of participation' (Maines, 1982, p. 275).

This raises the question: what is the difference between Strauss *Et al.* and Williams? Strauss *Et al.* arguably provide a bridge between the subjective and objective divide through the meso-structure. However, Williams accepts the dynamic dialectic of social interrelations as part of a potentially unresolved divide, rather than any form of solution or 'negotiation' where settlements are made. In Williams' theorising the unresolved differences are part of the solution in the understanding of 'totality'; whereas Strauss *Et al.* are interested in the question of 'order' coming out of change, Williams is interested in change emerging out of the existing 'order'.

Again this appears in Bryson (2008), who suggests aspects of Williams' 'epochal' analysis are 'the constant negotiation between dominant, emergent and residual cultures' (Bryson, 2008, p. 747). However, in Williams' theory, as we have seen there seems to be as much attention given to the long view as

any short-term negotiation. Moreover, Williams reminds us, '[t]he strongest barrier to the recognition of human cultural activity is this immediate and regular conversion of experience into finished products' (Williams, 1977, p. 128). Instead it seems Williams' concern is with the dynamic of unresolved conflict, tension and opposition and how this impacts with the dominant order. His notion of 'differentiated structures of feeling to differentiated classes' (Williams, 1977, p. 134), and he articulates this as a paradigm where settlements are not sought and the terrain is left unsettled where differentiated views are acknowledged not through any negotiation but through maintained restraint which in turn maintains the strength of the differentiation. In other words as Williams suggests the preoccupation with differentiated elements of a culture is 'the important mixed experiences, where the available meaning would convert part to all, or all to part' (Williams, 1977, p. 130).

More recently, Alvesson (2002) has introduced 'multiple cultural configuration theory'. A bespoke approach to the management and control of organisational cultures, he suggests they should not be viewed as 'unitary wholes' but sets of 'subcultures', suggesting that 'cultural traffic'; which represents individual views, ideas and meanings of members of the organisation and which may have an impact on organisational culture, should be managed by selected groups employed to emphasise and encourage certain 'meanings and values' while discouraging others in the '[e]veryday reframing…seen as managing cultural traffic' (Alvesson, 2002, p. 193). Whilst this is in one sense a solution, this proposition assumes that the hegemonic control mechanisms in place are sophisticated enough to convince all the members of the organisation to value certain ideas and devalue others, and that no one will attempt to circumvent the

system by appearing to conform, yet still retain notions of resistance to the 'reframing' espoused.

How would Williams approach be different to Alvesson? As discussed in 'differentiated structures of feeling to differentiated classes', within his concept 'structures of feeling' (Williams, 1977) he suggests that differentiated meanings and values will not necessarily be reordered. As Grossberg (2010) also observes, what emanates from 'structures of feeling', is that it is 'located as a way of being in the irreconcilable difference – it need not always be a negativity, a conflict…' Grossberg (2010, p. 30). Grossberg links this to the question of modernity and suggests this is Williams' recognition and accommodation of the complexities of modern society, which are subject to such dilemmas and exist as differentiated meanings and values rather than fashioned into any uniform solution to appease a particular regime. Williams' notion of 'differentiated structures of feeling to differentiated classes' concerns the identification of cultural behaviour that does not conform to specified themes, arguably therefore it surpasses Alvesson's notion of 'cultural traffic' in that it does not assume that there will be the eventual conversion of universal compliance of all members involved and is therefore perhaps more of a pragmatic approach to real world situations.

Another organisational culture theory – that of Edgar Schein – also bears some superficial similarity to that of Williams. Schein comparably recognises that culture acts independently of leadership, or the 'dominant' in Williams' case. Also, there is a tendency for dominant hierarchies to develop a sense of myopathy towards the emergence of a new culture, and that all cultural behaviour works at a number of levels. Schein separates his theoretical reasoning into three key areas of cultural activity, 'Artefacts', 'Espoused values'

and 'Basic underlying assumptions', (Schein, 2003). Schein's theory assumes that the 'underlying assumptions', are the taken-for-granted beliefs, perceptions, thoughts and feelings. These can be compared to Williams' 'structures of feeling' (1977). They have similar characteristics as representations of unmediated cultural behaviour. However, the key difference is that Schein suggests that 'underlying assumptions' will be replaced as different groups assimilate and develop their own 'shared history' (Schein, 2003, p. 35). Therefore, Schein's theory assumes that group behaviour will assimilate, and prior cultural differentials will be subsumed and replaced by group 'shared history'. In Williams' 'structures of feeling' (Williams, 1977, p 128) cultural behaviour can remain differentiated as part of the totality of a culture.

Both Schein and Williams make an assessment of the dynamics of the whole process of a culture. However, I argue that the separation between Schein's and Williams' theories manifests in several ways. Williams, unlike Schein suggests that there will not necessarily be any cultivation of 'shared history' (Schein, 2003, p. 34). Through 'epochal' analysis Williams states that assimilation may not occur and that 'real oppositions…are felt and fought out' (Williams, 1980, p. 39). I also argue that Williams reinforces this with an additional layer of analysis, to that of Schein with his notion 'differentiated structures of feeling to differentiated classes' (Williams, 1977, p. 134). Here Williams maintains there is no guaranteed assimilation of difference into 'shared history', (Schein, 2003, p. 34). Conversely, (Williams, 1977) recognises that different cultures may well remain oppositional, existing alongside the dominant cultural structure, avoiding any process of assimilation or solution other than to remain differentiated and in tension.

2.3. Other researchers who have deployed Williams' theory of culture

Having introduced Williams' two concepts earlier in this chapter, and compared other organisational culture theorists in comparison, in this section I consider how other researchers have deployed Williams' concepts, both explicitly and implicitly in their research. To achieve this I accessed and interrogated the social sciences databases at my university, and at my local hospital library, both 'multiple publication bias' databases as well as 'grey literature' databases, reference lists and citation indexes (Heyvaert *Et al.*, 2017). I also drew on literature from NHS management and leadership courses and seminars I attended whilst completing this study. From a thorough search of the literature I could only find two pieces of original organisational research that uses Williams explicitly or implicitly. Therefore, whilst it is not possible to confirm that the discussion below forms an exhaustive list of Williams' theories in the work of others, it does form a review of those who have used Williams' notions that I have encountered.

From a cultural theory development prospective, McGuigan (2016) refers to a study by Brian Winston (1990) who deploys 'Williams' ideas concerning the development of communication technologies into a sophisticated model of 'how media are born'', McGuigan (2016, p. 98). In his study, Winston applies Williams' notions concerning advancements in technology and cultural emergence recognized throughout history in different epochs as a form of 'technological determinism', (Winston, 1990, p. 55).

Moreover, Bryson (2008) positions Williams' concept of 'selective tradition' as 'a practical conceptual tool' in a study concerning the dynamic forces of cultural

change in an Information Technology organisation in New Zealand (Bryson, 2008, p. 743), acknowledging that 'it affords us a different perspective of organizational culture…Williams forces us to think of the present, the past and the future [a] more complex and meaningful view of an organization and cultural change', (Bryson, 2008, p. 755).

However, Bryson is critical of Williams, suggesting 'Williams' ideas, while useful as a lens through which to question and explain, do not provide a research method or a full blown analysis method' (Bryson, 2008, p. 755). I would argue against Bryson (2008) and suggest that Williams' attention to totality, his deconstruction of cultural behaviour traits and tendencies, how culture operates and at what levels, the reassembling of this into a 'social whole' (Williams, 1977, p. 182), provides the 'indispensable analytical tools' observed by West (1992, p. 8).

O'Reilly and Reed (2011) take inspiration from Williams' concept of 'epochal' analysis in their research study entitled: 'The Grit in the Oyster: Professionalism, Managerialism and Leaderism as Discourses of UK Public Services Modernization' (2011). O'Reilly and Reed in their examination of what forms resistance have developed in the process of public service modernisation through NPM. O'Reilly and Reed draw heavily on Williams' notions the 'dominant', 'residual' and the 'emergent' in the further understanding of the complexities and contrasting nature of what they identify as 'quasi-pluralist stakeholder networks, which have the potential to resist the 'unitarist' nature of 'managerialism, and its relationship with 'leaderism' (O'Reilly and Reed, 2011, p. 1079). However, they do not explicitly cite or reference Williams' work, yet rely on a framework based on his concept but which has no contextual foundation or origins to base their reasoning on. This arguably poses serious

limitations to the depth of analysis O'Reilly and Reed can offer in this case in relation to Williams' notions of the 'dominant', the 'residual' and the 'emergent' applied in the context of organisational theory.

That said, O'Reilly and Reed (2011) is drawn on in a later section of this thesis (4.14) and their discourse concerning the synthesis of professionalism and manageralism, to create 'leaderism' in the attempt to incorporate 'quasi-pluralist stakeholder' outlier behaviour as 'innovative modes of action that will shape the long-term prospects for public service modernization,' (O'Reilly and Reed, 2011, p. 1096).

2.4.   Summary

The theoretical framework has been discussed in this chapter, and will be revisited in the remainder of this thesis and used in the following ways. Firstly, this chapter will underpin Chapters 3 and 4 by aligning the selected literature to Williams' two concepts. In Chapter 5, their relationship to the methodology and research question is discussed, explaining how this has influenced the research design. In Chapter 6, the theoretical framework forms the analytical structure by which the findings of this research are interpreted and analysed. In Chapter 7, Williams' two concepts are drawn upon to support the final conclusions and recommendations of this study.

3. Neoliberalism and its impact on the NHS – a review of secondary sources

Whilst this research has its core objective set as providing a 'snapshot' of the NHS at a particular moment in time, the next two chapters are secondary source reviews of the literature, drawing on the historical impact of neoliberalism on the case study group in this research – the doctors, nurses and managers in the NHS – and how this relates to Williams' two concepts used in this research, 'epochal' analysis and 'structures of feeling' (1977).

3.1.   Neoliberalism

A search exposed a wealth of literature concerning neoliberalism, and this seemed somewhat formidable at first. The danger being that the review would be far broader than is required, something Silverman (2013, p. 348) warns against. However, a definition and a short history is useful to gain a greater understanding of how neoliberalism originated and what it represents in the NHS.

David Harvey suggests the principles of '[t]he founding figures of neoliberal thought took political ideals of human dignity and individual freedom as fundamental, as "'he central values of civilization'" (Harvey, 2005, p. 5), going on to say that '[n]eoliberal doctrine was therefore deeply opposed to government interventionist theories, such as these of John Maynard Keynes, which rose to prominence in the 1930s in response to the Great Depression' (Harvey, 2005, p. 20)[1].

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[1] Neoliberalism first came to prominence at the culmination of the Second World War but resulted in something of a nexus emerging in the form of two opposite economic philosophies of the social democracy-inspired John Maynard Keynes, and neoliberal Frederick von Hayek (Wapshott, 2012, p. 211).

However, it was not until the 1970s drew to a close that what could be seen as an epochal shift towards neoliberalism occurred in Britain and elsewhere.

The Labour administration under Callaghan, 1974–1979, was by the late 1970s perceived as weak and unable to stand up to the intractable powers of the unions. Margaret Thatcher and the Conservatives took power in May 1979. Observed through the lens of Williams' concept of 'epochal' analysis, an epochal shift occurred.

By 1979, the newly formed Conservative government under Margaret Thatcher had laid down the foundations of the neoliberal age, leading Collette and Laybourn (2003, p. 7) to observe that '[t]he basic philosophy was one of rolling back the state'. This was seen as the remedy to the 'stagflation' which dogged the British economy after the OPEC oil crisis in 1973. (Harvey, 2005, p. 22).

However, as Harvey claims, '[f]aced with social movements that seek collective interventions…the neoliberal state is itself forced to intervene, sometimes repressively, thus denying the very freedoms it is supposed to uphold' (Harvey, 2005, p. 69).

Reading this, a relationship appears between social democracy and neoliberalism, viewed through the lens of Williams' 'epochal' analysis. Social democracy and neoliberalism are a variation on a theme of hegemonic control. However, the literature informs us that from a socialist perceptive the intention and design of neoliberalism is to embed within society a cultural reassignment towards competitiveness as a positive signifier, however, there is little emphasis on risks involved in competition. This sets neoliberalism apart from social democracy and the properties of collectivism. The nature of neoliberalism:

…involves the promotion of a mode of social life according to which people are encouraged to identify themselves and to relate to others purely as individuals, rather than as members of groups or collectives of any kind, and in which competitive market relations are treated as the normal model for all types of social interaction (Bauman, 2001; Curtis, 2013; as cited in Gilbert, 2014, p. 30).

As any form of unity is replaced with neoliberalism as an ideology to effectively reassign the culture of a nation towards competitiveness and self-interest, as Gilbert (2014) observes:

A key mechanism for neoliberalism's project [was] to re-engineer the subjectivities of citizens…as competitors rather than collaborators (Papadopoulos, Stephenson and Tsianos 2008; as cited in Gilbert, 2014, p. 45).

This chimes with the sociologist S. Kirson Weinberg (1962) who said 'Social Darwinism' is '[t]he individualistic *laissez-faire* doctrine…People were appraised by their economic roles, whether as utilities or commodities, and were analyzed from a biogenetic perspective. The successful people were considered the fit people; the poor, as failures, were the unfit' (Weinberg, 1962, p. 409).

These views are contrasted by neoliberal literature, for example the views of Milton Friedman. In his view, in his book *Capitalism and Freedom*, which became a Bible for neoliberals, and which espoused the logic of neoliberalism as a guard against what Friedman saw as the pitfalls of government inspired intervention by the well-meaning politicians' and bureaucrats, which often led, as he suggests to 'precisely the opposite of these intended by the men of good will who support it' (Friedman, 1962, p. 180). Reading Friedman's *Capitalism and Freedom,* it does seem evident that whilst unarguably a 'man of his time',

his accounts form a logical point regarding savings and efficiencies in the workplace.

But literature in relation to management thinking from as far back as the 1920s tells us that the impact of scientific management techniques at the turn of the twentieth century had far-reaching ramifications:

> The advance of science and the cult of efficiency have tended to obscure the fundamental humanity of industry. We have paid in largely to our account of applied industrial science, but we are bankrupt of human understanding (Sheldon, 1923, p. 27; as cited in Witzel, 2012 p. 115).

Drucker (1994, p. 157) refers to 'the vanishing plant community' – alluding to the breakup of the industrial heartlands of the West. The OPEC oil crisis in 1973 (Harvey, 2005) provided a platform for both 'Reganomics' and 'Thatcherism' (Steger and Roy, 2010). Both the US and the UK adapted forms of neoliberalism to address the economic pressures that were dogging a post-Fordist West by the late 1970s. (Pollitt, 1990, p. 44). The literature tells us that what came out of this were the management techniques of the 1980s and 1990s. In reaction to Toyotaism and TQM Deming (1986) (Needle, 2015, p. 415), techniques of manufacture embraced by a post-World War II Japan resulted in the West becoming increasingly challenged by its global competitors. However, Needle (2015, p. 229 cited Hitt and Ireland 1987) also observes Peters and Waterman, and their book *In Search of Excellence: Lessons from America's Best Run Companies* (1982); contrived to exaggerate the successfulness of their vision and those who followed their philosophy, however, it was established that these groups performed no better than organisations who did not.

3.1.1. New Public Management (NPM)

The literature informs us what this ultimately meant for public sector organisations such as the NHS. As Harvey (2005) suggests, '[t]he corporatization, commodification, and privatization of hitherto public assets has been a signal feature of the neoliberal project', (Harvey, 2005, p. 160). Hood (1991, p. 5) distinguishes between two branches of NPM. Hood uses the illustration of a 'marriage of opposites': the first marriage partner was the post-war development of 'public choice' and 'transactions cost theory and principal agent theory' through the work of Black (1958), Arrow (1963) and Niskanen (1971). The second marriage partner is 'managerialism', achieved through organisational culture change, as in Peters and Waterman *et al.* (1982) to facilitate improved 'organisational outputs' (Hood, 1991, pp. 5–6). As Du Gay (2000) elaborates:

> This variant of bureau critique derives from two distinct discursive locales –public choice theory and contemporary managerialism (Campbell, 1993; du Gay, 1995; Self, 1993). There are obvious differences between the two – with public choice casting the problem of the public bureau as one of 'control' seeking measures through which elected representatives might tame the autonomy of the bureau by putting it under tighter political control, and managerialists problematizing the defects of the public bureau in terms of its failure to work more like a commercial enterprise... (p. 5).

Arguably, out of the mélange of NPM approaches that surfaced in the NHS as the result of various UK government interventionist management regimes from 1979 onwards, the one that has dominated is the controversial Griffith Report from 1983.

3.1.2. The Griffiths Report, 1983

Whilst the literature tells us that the initial effectiveness of the Griffiths Report was questionable, '[e]arly evaluations found the Griffiths reform to have been only partially effective, with no infusion of new personnel, and little evidence that clinical autonomy was restrained' (Harrison and Lim, 2003; as cited in Gorsky 2008, p. 446).

Nevertheless, '[a] defining moment was the Griffiths Management Inquiry of 1983, which led to the appointment of an NHS chief executive, and the ending of "consensus management", whereby health authority decisions required approval by a multidisciplinary team'. (Harrison, 1988, p. 16; as cited in Gorsky 2008, p. 446). Furthermore, Harrison and Ahmad (2000, p. 134; as cited in Gorsky 2008, p. 446) assert 'that the legitimacy of general management was established, heralding a more assertive period in the reform era that followed'. One thesis (1994), and the subsequent book by Dopson (1997), provides a comprehensive account of the Griffiths enquiry and its various long-term ramifications. The detailed analysis discusses the impact of the intended and unintended ramifications of the Griffith Report in 1983. Dopson says this was 'more than previous reorganizations of the NHS in 1974 and 1982…a conscious attempt to move away from a "boxes and charts" approach to organizational change, to one which sought to disturb organizational processes and ultimately to change beliefs and values of NHS personnel' (Dopson, 1997, p. 3) – concurring with Learmonth (2001, 2005; as cited in Gorsky, 2008, p. 446) as mentioned earlier. Furthermore, Dopson says of the outcome of the Griffiths Report, '[i]t was not assumed that these managers would necessarily have NHS backgrounds and they were seen as critical agents in moving the NHS away

from an administrative culture to a general management culture' (Dopson, 1997, p. 3).

Dopson (1997) focuses on the overt arrogance of the Griffiths Report's approach to what was effectively stakeholder engagement, which can be garnered in the account by Davidman (1984, p. 3; as cited in Dopson, 1997, p. 58) who observed how the Griffiths enquiry team alienated a variety of key stakeholders, including the medical profession and other clinical personnel, as well as patients. In the somewhat patronising attitude taken by the government in its justification for its approach in selecting the membership of the working party for enquiry, Barton (1984, as cited in Dopson 1997, p. 58) suggests, 'member[s who] had relevant expertise in meeting the needs of the public in very different ways'. This concurs with Pollitt (1990) who observes, '[t]he actual implementation of neo-Taylorian reforms…charged ahead in a manner likely to provoke the maximum defensiveness on the part of those whose support, however conditional, needed to be wooed' (Pollitt, 1990, p. 131).

Through the lens of Williams' 'epochal' analysis (1977) it seems that it is possible to discern that the 'dominant' hegemony – that of the medical profession – was being challenged by an 'emergent' hegemonic counter-culture in the form of state mediated general management via the Griffiths recommendations. As we have already seen, the literature informs us that Griffiths was an agent of change which made the first real challenge to a hitherto static dominant hegemonic culture in the NHS.

The neoliberal transformation programme of the NHS, through NPM, sought to raise the level of commercialised practice in the organisation through the introduction of competition – at first between departments, and later between

the NHS and external providers (the private sector). The internal market was introduced to encourage competition with the intention to raise the standard of service. (*National Health Service and Community Care Act*, 1990).

3.2.   The marketization of the NHS

However, the literature tells us that marketization of the NHS was more controversial in NHS hospitals than for GPs, who historically, due to their lack of professional homogeneity, were not as preoccupied with the collegiate practice by doctors in the acute sector. Lapping (1970) reminds us that '[the] general practitioner was treated as a private contractor independently selling his services to the National Health Service' (p. 155). A key milestone in the marketization process of the NHS is described by Ham (2009) who observes a series of White Papers culminated in the (*NHS and Community Care Act 1990*), which formed the purchaser/provider split and the encouragement of competition and move saw District Health Authorities (DHAs) once in charge of hospitals and holding the community health care budget ring-fenced to the purchasing services for the populations health needs, newly formed NHS Trusts to deliver the services and GPs for the first time directly commissioning a range of services for their patients (p. 41). Ham also notes Le Grand *Et al.*, observed the less '*measurable* change' as being 'some evidence of cultural change' and Ham also suggests this concurred with Ferlie *Et al.*, who also observed that the earlier white paper '*Working for Patients* [(Department of Health 1989)] did have an impact on roles and relationships within the NHS (Ferlie et al., 1996)' (Ham, 2009, p. 45). As well has his own observations '(Ham 1996, 1997a)' (Ham, 2009, p. 45).

GPs consistently delivered a level of self-interest during the period known as GP fundholding in the 1990s, and as Palmer (2005) suggests, this period in

NHS history led to the potential destabilising of the acute hospital sector altogether, through the encouragement of GPs to seek competitive pricing: 'The prospect emerged of whole hospitals suddenly being closed because of their lack of price competitiveness' (p. 380). However, Flynn (1999) suggests for the medical profession this may be considered a process of 'uneven 'reprofessionalization'' (p. 31).

The literature also informs us that by the 1980s the turn was towards neoliberal global markets, as Underhill (1997, p. 3; as cited in Burnham, 2001, p. 134) suggests, creating '*desegmentations*, involving a blurring of the line'. Clarke and Newman (1997) also observe this suggesting, 'blurring the boundaries between public and private. In part, these are the result of introducing marketising or pseudo-competitive relationships into service provision, [and partly] the consequence of isomorphic injunctions that public sector organisations should learn to 'become businesslike' in more general terms (Cutler and Waine, 1994; Pollitt, 1993)' (Clarke and Newman, 1997, p. 28). Literature from a socialist left perspective suggests the ramifications for the NHS of its marketization was, as Whitfield (2006), observes, the 'facilitation of marketization…there have been a series of attempts…In particular, it extends control by transitional companies, creating new forms of accumulation in profit maximisation, and increases exploitation of labour' (p. 8). Other negative effects of change, were observed by Pettigrew, Ferlie and McKee (1992) from an organisational culture theory perspective. They suggest 'research in the US and UK private sectors by Kanter (1985) and Pettigrew and Whipp (1991; 1992) has clearly linked segmentation and incoherence to organizational inertia, and integration and coherence to change capability' (Pettigrew, Ferlie and McKee, 1992, p. 291).

Interestingly, Williams reminds us as part of 'advanced capitalism…the dominant culture reaches much further than ever before in capitalist society [and]…narrows the gap between alternative and oppositional elements'. (Williams, 1977, p. 125). This echoes what transpired in the NHS after neoliberalism, the difference between state-run and private enterprise became less obvious as repeated cycles of change occurred.

3.3.   The politicisation of the NHS and attempts at de-politicisation

The literature informs us that prior to the creation of the NHS, healthcare provision was organised through private practice and self-funded by patients or through various insurance schemes. However, in 1948, the culmination of years of cross-party planning resulted in the replacement of this system with a national service for all, funded through general taxation. (Kynaston, 2007, p. 145).

However, Whitfield (2006) from a left wing stance claims the neoliberal government policy in Britain after 1979 sought to introduce to the NHS a sense of competition, rather than raise quality standards, as was akin to the 'facilitation of marketization…profit maximisation, and increase[d] exploitation of labour' (p. 8). The literature also tells us that those in commerce and industry waded into the de-politicisation for the NHS debate. At the time of the Labour administration under Blair, Ruth Lea, then the Head of the Institute of Directors (IoD) Policy Unit, her suggestions included ridding the NHS of its status of 'triple nationalisation': of funding, of decision-making about resource allocation, and of provision'', and through the depoliticisation of the NHS, Lea believed this would 'redefine the NHS' as 'facilitator of taxpayer-funded 'core services'' and would

therefore no longer be 'politically driven' (Moorcroft, 2000, p. 30). Furthermore, the literature informs us that later cross party discussions Hawkes (2007) reported on how the Labour administration under Brown also examined the notion of the de-politicisation of the NHS, Hawkes noting those in favour included David Cameron and Andrew Lansley, (then in opposition). Those against included Tony Blair and the then Health Secretary Alan Milburn, whilst no consensus was agreed, two major viewpoints emerged, those who were against any form of independence for the NHS and those who believed political interference was damaging the prospect of organisational improvement. (Hawkes, 2007, pp. 1136-38).

3.4. Staying 'on message'

The literature tells us the original neoliberal objectives set out by the Conservative government were designed to gain control of the NHS, to then be able to reform it (Thatcher 1993, p. 6). The government stayed on message as it were, when New Labour came to power under Blair in 1997 –, the only distinct change was that the government rhetoric was different (Fairclough, 2000). The internal or quasi- market was to be replaced by collaborative working: 'a buzzword of the 1990s, the term "collaboration"'. (Coombs, 2000, p. 15). The 1997 Health White Paper, *Modern and Dependable*, states in the second paragraph of the foreword (written by Tony Blair himself): 'This paper marks a turning point for the NHS. It replaces the internal market with integrated care' (Department of Health, 1997, p. 3). This complimented New Labour's health policy mantra at the time, which was an impassioned plea to save the NHS: 'On the day before the vote [the general election 1 May 1997], Labour put out a message that voters had "24 hours to save the NHS"' (*The Economist*, 27 July 2000).

While that appeared to be an electoral promise honoured, the literature informs us otherwise. In a complete break with tradition, Blair had, as leader of the opposition prior to New Labour's election victory in 1997, sought to amend Clause Four, removing the Marxian based 'traditional' class struggle rhetoric in favour of more neoliberal values. The focus of New Labour was what became known as the 'Third Way', of which Mellbye (2003, p. 1) reminds us: '[d]eveloped by the sociologist and director of the London School of Economics, Prof Anthony Giddens, the third way stated that the old class-based divisions of left and right are now redundant'. Furthermore, the homogeneous nature of third way politics left little distinction between the politics of the left and the right, (Fairclough 2000, p viii). As part of the ethos of the 'Third Way' New Labour under Blair offered 'communitarianism', as a fusion of socialist democratic and neoliberal values, (Driver and Martell, 1997, p. 27). However, '[t]he key drivers for this relate to the perceived need to rationalise services and the provision of a more effective, integrated service, for users and professions (Ovretveit *Et al.*, 1997)' (Coombs, 2004, p. 15).

Through the lens of Williams, discussed earlier, this is arguably an illustration of the complex mechanism of 'advanced capitalism' (Williams, 1977 p. 125). The 'Third Way' seems to have attempted to bridge social divides created during the Thatcher administration – an oppositional 'emergent' culture. Alternatively it may also, through Williams' 'epochal' analysis, have been yet another form of assimilation by the 'dominant hegemony' to dilute oppositional elements that pose a threat to the 'dominant' culture, (Williams, 1977, p. 121). The overarching theme is hegemonic assimilation, to prevent any opposition from forming.

However, what is consistent in the literature is New Labour's approach to the NHS as one of financial pump-priming, and there was a considerable reduction of waiting lists between 1999 and 2001, with the core objective to recruit and retain clinical staff increasing numbers of key staff by 2008 (Seldon and Kavanagh, 2005, pp. 294–5).

Furthermore, under Blair and then Brown substantial differences to the NHS of a positive kind were made and while working in the NHS at the time there was a sense of growth and optimism. As Glennerster observes, the nation's resources spent on healthcare had gone from one of the lowest in 'advanced economies to near parity' (Glennerster, 2015, p. 290).

However, there is a conflict amongst authors writing about this concerning the motives of New Labour. For example, Exworthy and Greener (2008, p. 48) said of Labour's health policy: 'their approach to decentralization has also waned, then waxed', suggesting Labour's policy on health from 1997 to 2001 (the first term) was designed to move control of the NHS back to the centre, away from the Conservative decentralization mantra of previous decades. However, by this stage the NHS had been embroiled in endless rounds of change – the impact of which is discussed in detail in the second part of the literature review.

What happened to the NHS when Labour was removed from office in 2010 by a coalition government? The literature tells us the impact of this on the NHS followed a number of dramatic forms. The coalition, which was in effect two conflicting ideologies, engaged in a series of trade-offs with each other, as the Conservatives struggled to appease their coalition partners, the Liberal Democrats, to hold a majority. What this resulted in for the NHS is outlined by Dixon in her Kings Fund blog in 2010, reporting: 'The NHS White Paper 'Equity

and Excellence: liberating the NHS' are implemented in full, the changes will have far-reaching and significant consequences for the NHS. The result will be a health care system, unique internationally, that gives groups of general practitioners unprecedented control over public funding'.

3.5. The Conservative-Liberal Democrat Coalition and its impact on the NHS

The entrenchment of neoliberalism is articulated by Stuart Hall and his neo-Marxist perspective on the Conservative-Liberal Democrat coalition, writing in *The Guardian* in 2011. Hall writes that 'the formation of a Conservative-Liberal Democratic coalition in May 2010 was fully in line with the dominant political logic of realignment', and this was 'another unresolved rupture of that conjuncture which we define as "the long march of the Neoliberal Revolution"…spanning from the 1970s…through Thatcherism and New Labour…Now the coalition is taking up the same cause' (*The Guardian*, 2011).

For the NHS, the literature informs us that the mechanics behind the command White Paper, (Department of Health, 2010) and the subsequent Welfare Reform Act (*Health and Social Care Act*, 2012), began with a dramatic challenge to abolish the PCTs, (Gorsky, 2011, p. 4). The whole process of reorganising the NHS and the wider social welfare system was not as well choreographed as one might have wished, and Glennerster reminds us:

> Those drawing up the more detailed legislative programme, notably Oliver Letwin and Danny Alexander, had little or no experience of health policy…What emerged from the negotiating team was what one insider called a 'spatchcocked mess' (p. 294).

To what extent this is any different to the usual process of government policymaking cannot be confirmed in the literature. However, what is clear is at

the time of the reforms there was criticism from many perspectives concerning Lansley's NHS and social welfare reform programme. For example criticism from the Royal Colleges; the British Medical Association (BMA), the Royal College of Nurses and the healthcare workers unions alike all resolutely condemned these reforms. Much of Lansley's rationale flowed from budget control rather than the enhancing of service provision.

However, due to its controversy, the literature informs us that in the spring of 2011 Prime Minister David Cameron, called for a 'pause' to the passing of the Bill (*Health and Social Care Act*, 2012), and time for a consultation to take place. However, Glennerster suggests this 'pause' can be attributed not to Cameron, but to two Lib Dem peers, Baroness Shirley Williams and Lord David Owen, (2015, p. 297).

Lansley was replaced in 2012 by Jeremy Hunt. It was hoped that this appointment would act as a conciliatory influence, in the wake of the Mid Staffordshire scandal (Glennerster, 2015). However, more recent events in the NHS involving junior doctors, the BMA and Jeremy Hunt suggest otherwise.

Here we see an as yet, unresolved conflict between the government and the junior doctors' union, the BMA. Seen through the eyes of Williams, through his concept 'structures of feeling', his notion 'differentiated structures of feeling to differentiated classes', Williams (1977, p. 134), this forms a similar perspective to the examples Williams provides concerning outlines of irreconcilable standpoints originating from differentiated values effected by change. What is especially interesting in Williams' theory is that he does not draw on any tidy solutions, as it is characteristic of numerous examples of conflict. Instead Williams provides us with a set of variables within an historical context, where

arguably the outcomes and solutions may be found in the passage of time through a reconciliation, but not necessarily so. Instead, what may remain is a superficial assimilation, or acceptance, all the while an inward opposition to the dominant culture is sustained. Therefore I argue that what Williams has given us here is an identification mechanism, and as such a pre-emptive method by which to assess the terrain of group conflict.

3.6.   Summary

This chapter, has reviewed some of the literature concerning the transition from a social democratic epoch to a neoliberal epoch. However, seen through the lens of Williams' 'epochal' analysis, there is the omnipresence of a 'dominant' hegemony in whatever form. In this case whether this is the medical profession or alternatively, aspects of state mediation such as general management in relation to Griffiths in 1983, the overarching generic applicability of Williams' concept here perhaps offers a potential to track the 'dominant' culture through whatever transfiguration it takes.

In the next chapter, a further understanding of what the impact of neoliberalism has been on the case study group of doctors, nurses and managers in this research, is garnered. Again Williams' two concepts are transposed onto this, and there is a discussion about how this may alter the existing perspectives of the literature as a result.

4. Doctors, nurses and managers in the NHS – a review of secondary sources

This chapter reviews the literature concerning the three groups in the case study: doctors, nurses and managers. The discussion begins with a focus on the literature concerning the medical profession and the maintenance of its jurisdiction through a Weberian model of social closure (Abbott *Et al.,* 1988), and what the literature tells us about the well-established hegemonic power of the medical profession after the advent of neoliberalism.

The discussion then moves to nursing, with a focus on the literature concerning the impact of neoliberalism, its development towards professional nursing since 1980 and how this has impacted on the medical profession and also traditional nursing practice in terms of inter- and intra-occupational behaviour.

The last discussion in this chapter concerns management and how neoliberalism has impacted on the development of management, transforming administrative support to the medical profession to a management function as an agent of change. There is a focus on whether management can be considered as a profession, or if its generalised role keep it from being so. New forms of management in the NHS are discussed: the colonising of management roles by nursing and more recently, the medical profession.

4.1.   The medical profession

The literature informs us that since the mid-nineteenth century, the medical profession has operated a peer-regulation system, similar to that of the legal profession. With the establishment of the Royal Colleges and the Medical

Registration Act in 1858, this sought to control medical education, commissioned by royal charter (Rivett, 1986, p. 57).

The literature also informs us that the medical profession has operated within a national framework based on the bureaucratic social closure system (Weber 2009) who observed 'aspect of the closure of relationships in turn is the monopolization' of 'advantages'' (Weber, 2009, loc 860). From a socialist left prospective, Larson (2013) places emphasis on its dominant position within the bourgeois culture as Larson suggests - of the '"subjective illusion" it finds *material* existence in the institutions, relations, and symbols of social practice' (Larson, 2013, p. 239). However, there was a distinct hierarchy between the different types of doctor within the medical profession and Baeza (2005) observes how the Guillebaud Report (1956), acknowledged 'the administrative divorce of curative from preventative medicine and of general practice…[and] the predominant position of the hospital service and the consequent danger of general practice and preventative and social medicine falling into the background. (Quoted in Allsop, 1995, p. 44)' (2005, loc 185).

4.1.1. Social closure and traditional accountability

It is Weber (2009) who observed the mechanism by which the professions form 'closed relationships' consensually managed with the state through a recognised standard of professional knowledge, accountability and regulation where by an endorsement of trust for the client or patient is created in return for 'monopolized advantages' (Weber 2009, loc 863). Susskind and Susskind (2015, p. 9) observe, this '"grand bargain" – the traditional arrangement that grants professionals both their special status and their monopolies over numerous areas of human activity'. Abbott (1988) suggests the mechanism is held together through the professions' ability to set themselves apart from other

occupations, by 'claiming jurisdiction' (Abbott, 1988, p. 59). However, the wider

impact on society, Johnson's (1972) is critical of 'sociologists' at that point in the

1970s for the avoidance of addressing what he perceived 'on the one hand the

professions were seen as a positive force in social development, standing

against the excesses of both *laissez-faire* individualism and state collectivism,

and on the other as harmful monopolistic oligarchies whose rational control of

technology would lead to some form of meritocracy' (Johnson, 1972, p. 12).

Through the lens of Williams' 'epochal' analysis, the medical profession

represents the 'dominant' hegemony, (Williams, 1977, p. 125). There is little

question concerning this and the relationship the medical profession has had

with the state since the creation of the Ministry for Health in 1918 (Larkin, 1988,

p. 90), which has only sought to strengthen its position in society. Also the

'dominant' is representative of the medical profession through 'tradition' through

its maintenance of traditional practice, reinforced through its relationship with

the state, tradition which has held in place values noted by Shils (1981, p. 25;

as quoted in Jacobs, 2007, p. 143)

However, there have been challenges to the legitimacy of this medical

dominance, and the writings of Shaw as far back as the turn of the twentieth

century are an informative starting point. Later authors still refer to Shaw, and

among them are Susskind and Susskind (2015), who refer to Shaw's

condemnation of the incontrovertible power of the medical profession. They

note that Shaw was the 'most illustrious ambassador' among a group of

'conspiracy theorists' who shared Shaw's contempt for the professions as being

secretive and elitist. Shaw famously observed in his play *The Doctor's Dilemma*

(1908) the mechanism by which the medical profession and the professions in

general through a system of social closure protect themselves against forms of

criticism, and Shaw writes: 'the medical profession a conspiracy to hide its own shortcomings. No doubt the same may be said of all professions. They are all conspiracies against the laity' (1908, p. 16) – and this is recounted in Susskind and Susskind (2015, p. 28).

In relation to Williams' theory, I refer back to his discussions concerning the notion of 'advanced capitalism' (Williams, 1977 p. 125) and to some extent, although not contextually aligned in the historical sense, Williams' notion, 'Plan X' and its ubiquitous nature. The medical profession had progressively established what had become the sanctified position as the custodians of medical knowledge and diagnosis. Without others having generalised access to this there was little opposition or even a desire to oppose a system that by and large offered a set of logical solutions within an accepted societal framework.

4.1.2. Threats to established jurisdiction and accountability

Macdonald reminds us that 'only a knowledge system governed by abstractions can redefine its problems and tasks, defend them from interlopers...Abstraction enables survival in the competitive system of professions' (Abbott, 1988, p. 9; as cited in Macdonald, 1995, p. 163).

After the Second World War advances in technology and the shifting social stratification of the working classes had left the war-torn West 'between two worlds…an age of cultural and technical revolution, where everything and anything seemed possible' (Hall, 1974, p. 274).

The literature informs us that a new sense of self-assured confidence, generated during the 1970s, led to an academic sociological focus to emerge concerning the professions, which Freidson suggests emanated from a renewed interest in Marxism, coupled with a renewed interest in economic

liberalism, of which he says 'those otherwise mutually hostile ideologies joined in attacking the social standing and economic privilege of the professions', (Freidson, 1994, p. 4).

Furthermore, from an economic liberal stance, Friedman (1962) writes, 'Trained physicians devote a considerable part of their time to things that might be done by others', (p. 156). This is part of a wider discussion by Friedman concerning the use of technicians as an alternative to the heavily controlled and costly environment of supply and demand of physicians, or as he describes it, the 'licensure, and the associated monopoly in the practice of medicine' (Friedman 1962, p. 157). It could be argued here that this was an emergence; the dialectic that would follow the medical profession from the 1970s onward and create an ongoing threat to its jurisdiction (Abbott, 1988, p. 9).

4.1.3. The sociology of the professions

Macdonald (1995, p. 8), notes the work of Larson as the turning point in the way the professions are viewed in society from the 1970s onward and the challenges to the traditional rhetoric of jurisdiction of the professions. Furthermore, '[t]he revival of Marxist analysis in the United Kingdom and the United States from the 1960s on also made its mark on studies of professions'. (Freidson, 1994, p. 4). Dent (1995) suggests later key contributors include Freddi and Björkman (1989) and Johnson, Larkin and Sak (1994), and the 'the concept and issue of professional autonomy and the prospects of de-professionalization and/or proletarianization of doctors' (Dent, 1995, p. 881).

Viewing this through the lens of Williams is perhaps where we see the embryonic beginnings of an epochal shift, towards what Dent (1995) calls, 'the

movement towards post-Fordist flexible specialization', (Piore and Sable, 1984; as cited in Dent, 1995, p. 878).

As Freidson observes, 'the de-professionalization thesis, which is most closely associated with the work of Marie R. Haug (1973; 1975; 1977), is fairly pragmatic. Essentially, the argument is that the professions are losing their position of prestige and trust [due in part to the increased mass access to technology]' (Freidson, 1994, p. 135). Furthermore, Freidson (1994, p. 132) says:

> The proletarianization thesis emphasizes the circumstances of professional work in large organizations. This stems from Marx's theory of history, in which he asserts over time the intrinsic characteristics of capitalism will reduce virtually all workers to the status of the proletariat, i.e., dependent on selling their labor in order to survive and stripped of all control over the substance and process of their work.

However, Larson (2013), suggests a greater understanding in modernity of the 'contradiction' which has arisen concerning the challenges to the 'traditional presentation' of the professions, in that 'the character of intellectual workers is not a static feature, but the outcome of a complex historical situation and of ongoing social and political conflicts', (Larson, 2013, p. xv). Larson also suggests it is Antonio Gramsci's categorising of intellectuals which assists in the greater understanding of what are basically two distinct groups. The first is the 'traditional' mode of the professions, whose continuation is governed by legacy agreements with the establishment. The second, an 'organic intellectual' who has evolved outside of the 'traditional' sphere, due to an emerging oppositional unfulfilled requirement. Gramsci describes this as the potential of all people, yet not all have the necessary wherewithal to achieve this, he explains:

> The notion of "the intellectuals" as a distinct social category independent of class is a myth. All men are potentially intellectuals in the sense of having an intellect and using it, but not all are intellectuals by social function (Gramsci 1971, loc 1695).

However, Larson's view, which is heavily influenced by Gramsci's Marxist standpoint, advances this discussion from the subordinated perspective only. However, through the lens of Williams' 'epochal' analysis the opposite or contrary position would be deployed to compliment this debate, and in the case of the NHS the outcomes of the Griffiths Report pose such a condition.

4.1.4. Ramifications of the Griffiths Report

The literature suggests that the Griffiths Report (1983) acted to challenge the medical profession's traditional standing as the sole hegemonic power in the NHS, (Dopson *Et al.*, 1997). However, Dopson (1997) revises this in a later chapter, suggesting the doctors still felt somewhat elevated, although still mistrusting of the implications of Griffiths, because of their longstanding hegemonic position. Dopson (1997) argues, '[d]octors, as an established and powerful group within the NHS, remained largely sceptical about the introduction of general management and frequently saw it as part of a government strategy to undermine, if not the NHS itself, then certainly the conception of the NHS held by many doctors', (Dopson, 1997, p. 98).

Through the lens of Williams this would perhaps be symptomatic of a hegemonic counter-culture forming in the shape of the embedding of general management via Griffiths. However, what is also interesting, is from Dopson's account above, the medical profession seemed to have formed an indifference to Griffiths, albeit with some reservations about its future intentions towards doctors. This may align to Williams (1977) and his suggestion that the myopathy

characteristically demonstrated by the 'dominant' order, in the case of the 'emergent' and oppositional, 'specifically the dominant social order neglects, excludes, represses or simply fails to recognize' (Williams, 1977, p. 125).

Johnson (1972) suggests that the professions are a 'homogeneous occupational community'. However, as they become increasingly specialised into diversified practice, this may result in the incremental diminishment of their homogeneity as one professional group (Johnson 1972).

The literature tells of threats to the occupational hegemony of the professions, as part of the changes introduced through neoliberalism. Since then in Britain and elsewhere, new professional roles have been defined which no longer subscribe to the traditional 'homogeneous occupational community' which Johnson (1972) had observed in the 1970s, Furthermore, specifically concerning the NHS, Causer and Exworthy (1999) suggest this has led to 'the existence [of] 'hybrid roles in which the exercise of formalized managerial responsibilities is carried on alongside continuing engagement in professional practice' (p. 83). They suggest this may have damaged the 'equality of competence', a practice held up by the professions as a benchmark of their craft (Freidson, 1994, p. 142; as cited in Causer and Exworthy, 1999, p. 85). Larson (2013) also observes this phenomenon and uses education as an example of how climbing the career ladder may result in professionals becoming less client-orientated and may 'lead to technobureaucratic positions', (p. 179). In the NHS there has been a call for greater use of what is termed 'boundary spanning' roles (Gilburt, 2016, p. 7), with clinicians being encouraged to contest traditional demarcation practices in favour of what might be suggested are steps towards multiple clinical and non-clinical occupational hybridization.

Through the lens of Williams, within Williams' concept 'structures of feeling', his notion 'differentiated structures of feeling to differentiated classes' (Williams, 1977, p. 134) arguably come into play here. In the NHS the increasing dilemma manifesting seems to be a compromise between the traditional priorities of licensure over corporate, neoliberal career progression. As we observe more 'technobureaucratic' (Larson, 2013) roles have been created, this may also bring forth greater levels of differentiation as once occupationally homogeneous groups such as the medical profession and nursing become increasingly fragmented as traditional roles transmute to the hybridization of clinical and non-clinical roles, leaving a paradoxical mix of clinical professionals who have sought to take on hybridized roles, whilst others choose to remain wedded to the confines of their traditional boundaries, which viewed through the lens of Williams' may result in what he terms 'differentiated structures of feeling to differentiated classes' where differentiation exists within a framework of convergence.

One paper in particular by Dent and Burtney (1996) examines how the medical profession (GPs) guarded against denigration of their status through change and the ramifications of the imposed 'culture of teamworking' in primary care in the 1980s. Dent and Burtney suggest this formed part of the culture of '"new managerialism" evident in the NHS and its attempts to redefine professionalism and professional autonomy' (Dent and Burtney, 1996, p. 13). The paper considers the restructuring of primary care in England and Wales in the 1990s, and questions the success of 'teamworking' as part of a government-led movement towards 'multidisciplinary partnerships', which Dent and Burtney (1996, p. 16), suggest is 'part of the quality management movement…total quality management (TQM)'. They also consider the 'proletarianization' thesis

(Larson, 1980; as cited in Dent and Burtney, 1996) but conclude the challenges posed to the dominant hegemony; the GPs, result in a relationship similar to that of the 'clinical directors in the acute sector have with hospital staff…a new kind of "professional dominance". The GPs 'move from essentially a state/profession *accommodation* to a reasonably comfortable *incorporation*', which demonstrates, moving from the traditional 'independent contractor' role, to a new form of dominance as 'GP-led PHCTs…exploit[ing] the *logocratic* organizational dynamics of general practice rather than providing an interdisciplinary egalitarianism between medics and nurses'. (Dent and Burtney, 1996, p. 22).

However, through the lens of Williams' 'epochal' analysis, Dent and Burtney's conclusions present a different perspective. The emphasis can be shifted towards the developing inter-occupational dynamic forming between the three groups: GPs, nurses and managers. The 'dominant' is still representative of the GPs, however, through Williams' lens the 'emergent' may also be representative of the more long-term aspirations of nurses and managers, both of which, in Dent and Burtney's study (1996, p. 22), have made gains in the process of government reform through the GPs enhanced dependency on their labour as a result of the introduction of 'teamworking' into general practice.

This, I argue is where Williams' concept of 'epochal' analysis, provides a tool with which to widen the debate to a focus on cultural totality. Through Williams' lens, the individual elements, the 'dominant', the 'residual' and the 'emergent', remain stereotypically compartmentalised, however, as Williams suggests, 'it is necessary to examine how these [elements] relate to the whole cultural process rather than only to the selected and abstracted dominant system' (Williams, 1977, p. 121). By adjusting the focus to place greater emphasis on the two

other players in Dent and Burtney's study – the nurses and managers – this opens up a wider scope within Williams' 'epochal' analysis and a dialogue to how their contribution may impact on the doctors in the long-term and also demonstrates just how interrelated the three groups - doctors, nurses and managers are.

4.1.5. Summary

This section explored some of the literature concerning the medical profession: how it professionalised in the mid-nineteenth century and how professional status and professional knowledge was protected through a system of social closure (Weber, 2009), the mechanism the medical profession developed to guard against interlopers (Mcdonald *Et al.*, 1988), and how post-war society began to challenge this, with advancements in technology, and divergence of orthodox political thinking to a left wing kind which sought to challenge the status quo. The final discussion concerned some of the literature which has looked at aspects of the medical profession in relation to the de-professionalization and proletarianization theses observed by (Freidson *Et al.*,1994). These in turn relate to Friedman (1962, pp. 156–7) and his theory of monopoly and licensure. In the next section the literature relating to the professionalization of nursing is considered.

We have seen the through the literature discussed in this section, within Williams' 'epochal' analysis, the 'dominant' representative of the medical profession and through 'tradition', which has held in place values noted by Shils (1981, p. 25; as quoted in Jacobs, 2007, p. 143), as tradition as an inertial force in society. Through a study carried out by Dent and Burtney in 1996, centred on the various ramifications of government-mediated teamworking in primary care during the 1990s in the NHS we saw how the dominant position of the GPs was

ultimately maintained through the exploitation of new mechanisms of organisational control, yet through the lens of Williams' 'epochal' analysis, the 'emergent' – the last of Williams' notions within 'epochal' analysis – may be representative of the increased dependence the GPs had on nurses and managers in the new structure. (Dent and Burtney 1996).

We also discussed some of the literature concerning the incremental hybridization of professional roles in the NHS (Causer and Exworthy, 1999), and the dilution of client-orientation for professionals and as Larson (2013, p. 179) observing the increased developments in 'technobureaucratic positions' and how this was extended to the possible relationship with Williams' notion 'differentiated structures of feeling to differentiated classes' (Williams, 1977, p. 134) in relation to the traditional lines of demarcation redrawn and the dilemma faced by medics concerning career progression into senior bureaucratic positions in the NHS forfeiting some of the traditional importance over licensure.

4.2.   Nursing

The literature concerning nursing, by contrast, throws up an interesting counterpoint to the medical profession. Traditionally a female-dominated role, although now two percent of nurses in the English health service are male, (Health and Social Care Information Centre, 2015), nursing has undergone a transformation from a 'traditional' subordinate relationship to the dominant patriarchal hegemony, the medical profession, to an occupational stratification shift where nursing is now deemed a profession in its own right. This has been partly achieved since the series of neoliberal reforms in the NHS by successive governments after 1979 however, the process of professionalization of nursing practice, which includes the establishment of consultant-level nurses and

nurses on all the strategic boards in hospitals and CCGs, began in earnest after the culmination of the First World War.

4.2.1. Nursing and social closure

The literature search revealed that a turning point came for nursing practice largely as a result of the contribution made by women during the First World War which, it is argued, 'reflected in the extension of the franchise in 1918' (Dingwall, Rafferty and Webster, 1988, p. 84). This led to the Nurse Registration Act 1919 set up by the General Nursing Council (GNC) and the subsequent GNC register in 1923, (Dingwall, Rafferty and Webster, 1988, p. 4).[2]

However, Rafferty (1996) notes that 'role stereotyping was endemic and that even reform from the point of the mid-nineteenth century was less an attempt to redefine the role and more to reform the nurses' character', (Rafferty, 1996, p. 8). Furthermore, Dingwall *Et al.* (1988), remind us that within nursing itself there were those who were in favour of registration and those who wished to retain the status quo, which led to the struggle for nurse professionalisation being one of a factionally charged discourse between a 'complex mixture of economic interests and gender rivalries' (Dingwall, Rafferty and Webster, 1988, p. 78).

A socialist feminist critique by Witz (1992) observes how midwives as early as the 1860s had sought to instigate a form of social closure similar to that of the then-newly instigated medical profession through the '1858 Medical Act' (Witz, 1992, p. 117). However, this attempt never reached fruition due to the structure of society at that point, in what Witz, citing Hartmann (1979) suggests was the

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[2] Also Dingwall *et al.* (1988) remind us that this was according to 'Mrs. Bedford Fenwick', Matron at St Bartholomew's and a leading campaigner for nurse registration suggested this would create a 'pacifying effect' in the climate of militancy which had been ignited in Britain and elsewhere by, amongst other factors, the workers Revolution in Russia in 1917, (Dingwall, Rafferty and Webster, 1988, pp. 71-84).

interconnectedness between capitalism and patriarchy which '[had] created a vicious circle for women. (Hartmann 1979: 230, 298)' (Witz, 1992, p. 14). Witz concludes, the '[m]edical men's de-skilling strategy was also informed by a gendered discourse…[t]hus, gendered discursive as well as gendered closure strategies were used in the construction of sexually segregated spheres of competence in the emerging medical division of labour' (Witz, 1992, p. 127). Here, Witz draws heavily on the classical patriarchal dominant/subordinate relationship theory which it is acknowledged curtailed the rights of women.

However, Wicks (1998) in her critique of writers who in her opinion fail to consider the necessary consideration of the zeitgeist, said '[by] viewing the nineteenth century formation of modern nursing only in terms of capitulation and defeat', what is often overlooked is how nurses seized 'limited opportunities…as creative, and often artful, strategies, which allowed them to not only to do their work but to carve out significant areas of practice within the dominant power relations' (Wicks, 1998, p. 5).

It could be argued that this bears a relationship to Williams' two concepts used in this research in a number of ways. Through the lens of Williams this is arguably representative of Marxian-based Gramscian hegemony. The longstanding patriarchal dominant/subordinate relationship of the medical profession and nursing is symbolic of the relations of the 'dominant' element within Williams 'epochal' analysis and his discussions in *Marxism and Literature* (1977) concerning the accepted controlling nature of hegemony, as Williams suggests the relations of domination and subordination, are all part of the mechanism of hegemony which he suggests '[i]nstead [hegemony] it sees the relations of domination and subordination, in their forms as practical consciousness, as in effect a saturation of the whole process of living' (Williams,

1977, p. 110). Conversely, the attempt by nursing to create a social closure system similar to that of the medical profession (Witz, 1992) may also be seen as the 'emergent' element of Williams' 'epochal' analysis – the moment where nursing attempted to parallel the medical profession. It may also be indicative of 'differentiated structures of feeling to differentiated classes' (Williams, 1977, p. 134), within Williams' concept 'structures of feeling', but within a far more complex network of differentiation than in Williams' examples (1977). Here the complexity spans between the doctors and nurses in one sense, as nurses attempt to meet the 'dominant' medical profession with a social closure system of their own, to gain control of their registration. But also through the lens of Williams it may be representative of the embryonic division of an intra-occupational dialectic in nursing practice where those in favour of registration vied against those who did not approve. Applying Williams' notion 'differentiated structures of feeling to differentiated classes' (Williams, 1977, p. 134), I argue it provides us with a viewpoint as to the nature of any future dialectic, not in the classical sense between doctors and nurses necessarily but within nursing itself.

4.2.2. Neoliberalism, nursing and different levels of accountability

So far the literature has informed us how nursing struggled to achieve independent status in its subordinate role to the medical profession, and how it attempted to emulate the medical profession by creating a social closure system of its own, but in which it was ultimately unsuccessful in the late-nineteenth to early-twentieth centuries.

Turning now to what the literature informs us about how this changed, and how a series of neoliberal initiatives promoted and elevated nursing practice in the NHS from 1979, Bradshaw (2001) suggests, for the first time, in 1979, nursing

in the NHS 'became responsible for its own self-regulation…[with] the introduction of the Nurses, Midwives and Health Visitors Act 1979' (Bradshaw, 2001, p. 14). This also applies to Project 2000, first implemented in 1989 with the mandate to replace task-based, instructional, on-the job-training, with classroom-based higher education for nurses, (Bradshaw, 2001, p. 47). Under the then-Secretary of State for Health, Kenneth Clarke, academic training was accepted as a prerequisite. Nurse prescribing, which had been considered as far back as 1978, was included by the Conservative government in its command paper, (Department of Health, 1987).

However, (McFarlane and Castledine, 1982; as cited in Bradshaw, 2001) observe that the dialectic this created, as articulated in an account by Professor J. R. A. Mitchell, a doctor, 'formalized a bid for nursing independence and autonomy and the removal of medical constraints, a concern of many doctors. Nurses were setting themselves against doctors' (Bradshaw, 2001, p. 21).

Traynor (1999) suggests nurses themselves suspected that if they did not engage in the new roles on offer they would be confined to the role of 'the handmaiden of all the other professions, doing the fundamental care whereas the more intellectually stimulating, more rewarding aspect of caring will be taken over by someone else' Traynor (1999, p. 124). Similarly, Dopson (1997) suggests one outcome of the Griffiths Report in 1983 was that the 'status and power of the nursing profession appear[ed] to have declined within the new managerial structure. Nurses were often given quality assurance roles which were frequently seen as "non-jobs"' (Dopson, 1997, p. 97).

In relation to Williams' concepts deployed in this research, this raises the question: was this an emergence by nursing, or were the nurses part of a wider

dominant hegemonic structure, mediated by government to achieve political objectives rather than advancements in patient care? Bradshaw (2001, p. 21) suggests this was the case and observes 'the new method of organizing nursing care, drawn from North America'. The medical profession disapproved at the lack of discussion between it and the government,' (*BMJ*, 1983: 439) and wondered whether this would lead to transfer of clinical care away from doctors to nurses (Bradshaw, 2001).

4.2.3. Inter-occupational resentment

A dialectic formed, and increasing antagonism developed between the medical profession and nursing practice. The primary care sector, was the most affected; hospitals continued to operate to the traditionally ordered ward-based environment. Rivett reminds us in general practice 'the concept of the "nurse practitioner" became a semantic battleground' (1997, p. 414). The difficulty was the incompatible vision held by the nursing profession itself and what pragmatically went on, especially in the community within 'multidisciplinary teams' (Rivett, 1997, p. 414). Mark and Dopson (1999) add that 'contested boundaries in primary care where the development of new roles – notably that of nurse practitioner – challenge the status quo' (Mark and Dopson, 1999, p. 3).

This concurs with a study by Soothill and Mackay (1990), soliciting a range of views by medical and nursing staff in hospitals and community areas in the NHS from 1989–90. Revealing behaviour characteristics such as the classical patriarchal dominant and subordinate hierarchy between doctors and nurses, the study demonstrates this still existed well into the late 1980s in the NHS.

A more contemporary paper by Hughes (2010) relates to the same dilemmas as nursing attempting to function alongside, and not subordinate to, the medical

profession. Hughes observes how as a result of government-mediated strategy, necessary adjustments to behaviour conceded by senior nursing staff, those who already held high rank within nursing itself, but in order to participate at strategic planning level alongside the medical profession as part of the local strategic policy-making team in Local Health Groups (LHG). Nurses had to deploy a number of measures, including 'getting it right', 'achieving the right balance', 'self-presentation', and 'unassertiveness' (2010, p. 1). Furthermore, through the lens of Williams' 'epochal' analysis in Hughes's study nursing arguably appears an 'emergent' element, yet to manage their oppositional position to the medical profession the 'dominant' hegemony, tactics of assimilation rather than opposition were deployed by nurses wishing to secure strategic board positions in the organisation.

4.2.4. Gender as an issue?

The doctor/nurse relationship forms a emphasis in the literature which as Fagin and Garelick (2004) suggest, '[t]raditional sociological studies of the doctor–nurse relationship describe its patriarchal nature (Dingwall & McIntosh, 1978), understood in terms of sexual stereotypes, with gender assignations of nurturance and passivity to the female role, and decisiveness and competitiveness to the male role (Savage, 1987)' (2004, p. 280).

In a study by Remen, Blau and Hively (1975), the notion of the object of masculinity and femininity is expanded, thus removing the physical determinate of 'gender' as the primary focus. In contemporary terms, the issues raised by Remen *Et al.* (1975) are transferable to today's NHS. Accepting that Remen *Et al.*'s study (1975) was conducted some 40 years ago, their perspective – that it is not the physical gender but the gender characteristics that form cultural behaviour in clinical settings – is more comparable in contemporary terms. This

concurs with Wicks (1998, p. 174), who suggests, 'In order to more adequately understand the sometimes contradictory actions of nurses it has been necessary to look beyond the behaviour of nurses and doctors, to the underlying and dynamic development of the feminine and masculine *identity'*. In Remen *Et al.*'s (1975) study (see Table 4-1) that the majority of tasks set out for nurse are of a subordinate nature to the dominant medical activity. Although what is particularly fascinating is the only masculine function carried out by nursing is in the management of a subordinate within nursing itself, as part of nurse-to-nurse activity.

The masculine principle, the feminine principle and humanistic medicine

Traditionally-held views of health professional activity

Doctor	**Nurse**	**Nurse's Aide**
Diagnoses patient (identify problem) *(Masculine principle)*	Does not participate	Does not participate
Performs Surgery *(Masculine principle)*	Carries out orders of doctor, giving doctor instruments he decided he needs for his purposes. *(Feminine principle)*	Prepares the patient for doctor (shaving, washing, dressing); delivers patient to doctor. *(Feminine principle)*
Decides on therapy (medications, treatments,	Does not participate directly in these decisions	Does not participate directly in these decisions

observation, diagnostic studies). *(Masculine principle)*		
Issues orders for those plans *(Masculine principle)*	Receives and carries out orders for medications and treatments and deals with patient fears and noncompliance. Keeps notes to inform the doctor of patient's condition and when his orders were carried out. *(Feminine principle)*	Receives and carries out orders for observations (BP, temp, pulse, fluid output and input). Concerns self with comfort and cleanliness: 1) makes beds; 2) helps patient to wash and dress; 3) backrubs; 4) waters flowers; 5) helps patient to east; 6) positions patient in bed, assists to bathroom, etc. *(Feminine principle)*
	Supervises nurse's aide. *(Masculine principle)*	

Table 4-1 The masculine principle, the feminine principle and humanistic medicine – Remen, Blau and Hively (1975)

This poses the question in relation to contemporary nursing practice: how significant is the physical gender dynamic in nursing practice? Remen *Et al.* (1975) illustrate how the 'traditional' patriarchal dominant/subordinate, or masculine/feminine principle between doctors and nurses translated to the behaviour within nursing practice itself, within its own hierarchy, between junior and senior nursing staff. Furthermore, as Wicks (1998, p. 118) observes, 'insights into nurse/nurse conflict are important because they show that the sexual division of labour, like gender relations, more generally is not simply imposed form above'.

4.2.5. Intra-occupational rivalry

The developing hegemonic dynamic in post-neoliberal nursing practice suggests the challenges from within its own ranks pose an interesting counterpoint. Marvin *Et al.* (2008) suggest what is evident in wider literature concerning women in the workplace, through broader feminist texts, but which is less examined in critical feminist studies, is the concept of intra-gender rivalry. Furthermore, Wacjman (1998; as cited in Mavin, 2008 p. 77) suggest 'many women undermine other women's authority' where there is no united sisterhood as is often portrayed in literature and film, and this unilateral viewpoint is disputed by Mavin and her collaborators: 'the contradictions of solidarity behaviours versus queen bee behaviours (Staines *Et al.*, 1973; Abramson, 1975)' (Mavin, 2006, p. 349).

Furthermore, Bradshaw (2001) observes that the Briggs report in 1970 had several ramifications: - it advocated the transition from vocational training to education for nurses, and in addition supported the removal of any influence by doctors in nurse training. However, Bradshaw continues this was not the widely held view of those in nursing itself at the time who greatly valued nurse training

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by doctor educators. There was also at this point still a high proportion of nurses who felt that vocational training was more beneficial to their needs and as Bradshaw *Et al.* (2001, p. 14) also suggests 'many nurses and ward sisters, amongst whom there was a strong resistance to change'. This arguably aligns to Williams' notion of the 'dominant' in several ways, firstly, the need for the nurses to remain connected and influenced by the doctors is suggestive of traditional dominant/subordinate relationship between doctors and nurses, and secondly, that many nurses at that point in time did not see the value of educations as a replacement for vocational training, is arguably also indicative of what Williams observes is the effective and powerful force tradition holds in the maintenance of the status quo. (Williams, 1977, p. 115).

4.2.6. Summary

In this section some of the literature concerning the transition to professionalised nursing has been discussed, how a method of social closure was attempted yet not successfully (as in the case of the medical profession) and how the turning point came for professionalised nursing in the neoliberal era following government mediation, admittedly as part of a much wider remit to address the economic challenges of the 1980s to reduce public spending.

I now turn to the literature concerning the final group in this discussion; the managers. This group currently has no mandatory licensed framework and therefore is not regulated in the same way as the other two groups in this case study. However, what has added to the complexity that surrounds the term 'manager' in the NHS is the 'colonising' (Thorne, 2002) of management posts by both nursing and the medical profession as part of neoliberal change, and this has led to a homogeneous topography within the sphere of management in the NHS, setting it somewhat elusively in more than one camp for those in the

social sciences and beyond who wish to understand its mechanism and how to achieve efficiencies through its deployment.

4.3. Management

The literature search concerning developments in management in the NHS following neoliberal policy reforms exposed a number of interesting results. Before the Conservative government took power in 1979, management functions in the NHS were by and large consigned to the precincts of administrative support to the medical profession (Davies and Harrison 2003). However, the literature tells us that in the NHS as early as the 1970s we see evidence of the 'management consultant McKinsey's and the work of the Brunel Health Services Organisation Unit' involved in the restructuring of the NHS in 1974 (NHS Reorganization 1974; Dopson *Et al.*, 1997). Attempts to reorganise the NHS were met with resistance from the medical profession and Lapping (1970) observes '[i]t might appear that the simple, radical answer to these difficulties would have been a sharp downgrading of the status of doctors' (Lapping, 1970, p. 156).

The literature tells us it is the Griffiths Report itself that arguably formed the turning point for management culture in the NHS acting as the principle agent for change (Dopson *Et al.*, 1997). The rhetoric surrounding Griffiths at the time was such that it formed a sense of cognitive capture, a solution to a problem where there was no feasible or logical alternative, and was seen as the catalyst towards systemised management, greater control of the organisation and a challenge to the medical profession's dominant hegemon in the NHS, (Rivett, 1997; Ham, 2009; Dopson, 1997).

However, as discussed previously, the Griffiths reforms were initially ineffective, and management struggled to establish shared power and control with the medical profession, (Harrison and Lim 2003; cited in Gorsky 2008). Furthermore, the ramifications of Griffiths have recently been lambasted by Jeremy Hunt, the Secretary of State for Health, who is noted as saying in November 2016 'We should today ask whether the NHS made a historic mistake in the 1980s by deliberately creating a manager class who were not clinicians rather than making more effort to nurture and develop the management skills of those who are,' (*Mailonline*, 2016).

It could be argued that Hunt's remarks perhaps demonstrate the latest in a long line of government sidestepping in the wake of failing top-down change. And this is suggested in a report by The Kings Fund in 2016 who refer to an earlier report by The Nuffield Trust from 2008, which highlighted 'in an independent and expert review published by the Nuffield Trust…which characterised the quality reforms of the previous decade as "a bewildering and overwhelming profusion of Government-imposed policies and programmes" (Leatherman and Sutherland, 2008)' (Ham, Berwick and Dixon, 2016, p. 7).

However, the pointed remarks by Jeremy Hunt raise the question: who are the managers in the NHS? Nigel Edwards, the Chief Executive at the Nuffield Trust articulates the complexity of the range:

> Many people find their way from clinical roles, others work their way up from clerical or admin jobs, and some come in through more formal routes. This makes talking about them [managers] as a group difficult (2016).

Therefore, unlike the two other groups in this study, management poses a different discussion. With no set formalised regulatory body or council to

oversee its conduct or defend management, managers are often portrayed as the '"grey suits", and "fat cats"', (Preston and Loan-Clarke, 2000, p. 101). Although it is also suggested that management is used as the '"scapegoat" rather than a "saboteur"' (Fenton-O'Creevy, 1999)' (Preston and Loan-Clarke, 2000, p. 101). Although, Brooks (2009, p. 241) suggests managers are often perceived as exercising 'covert power' as the custodians of the dissemination of information. In the wake of the Mid Staffordshire scandal in 2013, formalised professional parameters have been suggested to provide more control over the management function in general, and the NHS and politicians have called for a 'GMC for managers' (*MiP election briefing*, 2015, p. 7). This has been a sustained area of interest and debate for researchers and commentators who question whether management can be regarded as a profession.

4.3.1. Is management a profession?

There is an ideology behind management as a profession and this is underpinned by a body of expert knowledge in management which can be transferred from one setting to the next. On this basis, it may be claimed that management is a profession. This body of knowledge is obtained by the possession of a Master of Business Administration (MBA) qualification or, prior to that, a Diploma in Management Studies (DMS). The content of MBAs is fairly standard: strategy; operations; human resources; marketing; finance, etc. However, there is no one recognised body with control of entry, or control of the curriculum, for management to be recognised as a profession as such. On the other hand, the Chartered Institute of Management calls itself the professional body for managers and may well, at some point, perform that role. Many of the individual components of the management 'knowledge base' have their own professional bodies, such as the Chartered Institute of Marketing or the

Chartered Institute of Personnel and Development. Finance has a number of professional bodies which, interestingly, include the Chartered Institute of Public Finance and Accountancy (CIPFA) which is concerned purely with public sector finance.

However, arguments have been made on both sides, and the most acknowledged writer here is Henry Mintzberg, who has challenged the notion of management as profession, maintaining 'the professional administrator maintains power only as long as the professionals perceive him or her to be serving their interests effectively' (Mintzberg, 1989, p. 181).

Furthermore, Barker (2010) adds to the debate, suggesting the key definition of a professional is 'asymmetry of knowledge' which is the 'mark of the true profession; as consumers, we have no option but to trust the professionals with whom, we transact' (Barker, 2010, p. 6). He suggests, 'true professions have codes of conduct, and the meaning and consequences of those codes are taught as part of the formal education of their members' (Barker, 2010, p. 2).

Therefore, there needs to be a debate on who is best placed to manage healthcare institutions. The extent of the work still to be achieved by the NHS is highlighted in a document by the Nuffield Trust (2016) which recommends 'NHS managers – both medical and non-medical – need to be valued…[yet] [e]vidence from the medical and non-medical managers in this study suggests that there is a long way to go' (Nuffield Trust, 2016, p. 50). Linstead, Fulop and Lilley (2009) suggest 'the most common barriers that influence the change process [are] *organizational inertia* and *hostility*' and that those attempting to cope with the 'trauma' of change react in stages from 'shock' to 'adaption' and 'internalization' over time. (Linstead, Fulop and Lilley, 2009, p. 648).

However, the question remains: who should manage the NHS, should it be medical consultants or other senior clinical people, or are management skills the key factor? After all, the ethical considerations which form the professions can be seen in regular conflict with the considerations managers have to make on a daily basis. However, Barker (2010, p. 9) suggests, 'in general, the professional is an expert, whereas the manager is a jack-of-all-trades and master of none – the antithesis of the professional'. However, this could also be levelled at GPs, who are unquestionably generalists who refer to specialists. Therefore, taking this into consideration, should GPs be classified as experts or generalists?

4.3.2. Doctors and managers

The many restructures of the NHS (Rivett, 1997; Ham, 2009) have sought to solve the issue of who is best placed to manage the organisation. This research is situated in the period after the Conservatives came to power under Margaret Thatcher in 1979, and the modernisation programme which took place after that was centred on a neoliberal ideology and the reconfiguring of the 'relationship between the policy-makers and service providers' (Ham, 2009, p. 29). Furthermore, Brooks (2009) observes, 'NHS staff often refer to the inherent 'tribalism' of their service' (p. 261). The subsequent reforms (Department of Health, 1987; 1997; 2010) have led to what Degeling *Et al.* (2003) suggest has resulted in the 'destructive antagonism over health service modernisation' (p. 649). They refer to Edwards and Marshall (2003) and their call for a 'constructive dialogue to replace the mutual suspicion between doctors and managers…[and] the recent tensions over the negotiation of the new UK consultant contract should be seen as part of a "deeper problem [with] a long history"' (Degeling, *Et al.* 2003, p. 649).

This paper highlights several key points, the frequently mismatched 'perceptions' of priorities and outcomes between management and clinicians, faced with the task of actualising a healthcare modernisation agenda both in the UK and elsewhere, (Degeling, *Et al.* 2003), and the perception of clinical 'intransigence' in the face of what they interpret to be management-driven 'impositions'. The paper also observes 'multidisciplinary team based systems [nurse driven]…provide the basis for re-establishing "responsible autonomy" as the primary organising principle of clinical work' (Degeling, *Et al.*, 2003, p. 651). However, this contrasts with Dent and Burtney (1996), discussed earlier, where they found that a move towards 'responsible autonomy', away from 'professional autonomy' was construed as a retrograde step for doctors.

In their conclusion, Degeling *Et al.* warn that to avert a 'danse macabre' and a continued culture of mutual 'distrust', 'doctors and managers [should] engage more directly with nursing and allied health professionals' and to 'refer to healthcare issues as primarily a medical and management debate narrows the range of alternatives and perhaps more constructive approaches…to reform issues' (Degeling *Et al.*, 2003, p. 651). Whilst King and Lawley (2016, p. 190) suggest creating a collective team identity to attempt to redress situations similar to that described above by Degeling *Et al.*, (2003).

However, by reframing Degeling, *Et al.* through the lens of Williams' 'structures of feeling' (1977), and his notion 'differentiated structures of feeling to differentiated classes', their observations would arguably take on a different perspective and could situate all three groups – doctors, managers and allied health professionals – in a differentiated position. Rather than any conformity towards one group or another, through the lens of Williams, all three may remain differentiated. However, this need not be a force of negativity, but it

would be an acceptance of difference. As Grossberg (2010) observes, 'structures of feeling' is 'located as a way of being in the irreconcilable difference – it need not always be a negativity, a conflict…' (p. 30).

4.3.3. 'The Doctor Manager' and 'leaderism'

The literature also informs us of 'the rise of the doctor-manager', and Day (2007) suggests this has contributed to the level of increased clinical engagement in the NHS. Other senior NHS commentators have stated that 'Doctor-managers…see the importance of engaging other clinicians in management decisions' and '[u]nfortunately, there are some surgeons who simply won't listen to other people if they're not doctors' (Day, 2007, p. 335).

However, the 'doctor-manager' proposition was initially unattractive to doctors, and Thorne (1997, p. 169; citing Pollitt and Harrison, 1992) suggests this may be because of the terminology – 'power' and 'authority' are managerial terms, whereas 'influence' and 'leadership' are recognised as part of the traditional professional role. Thorne states that for the successful transition of the clinician into management there must be a focus on leadership terminology and behaviour, to 'unlearn traditional, hierarchical managerial behaviour' (Thorne, 1997, p. 170–71).

O'Reilly and Reed (2011) have extended this theory and suggest 'leaderism' is a hybrid that has evolved out of two other modernising discourses – 'manageralism and professionalism' – and that 'leaderism illustrates the complex interpenetration of processes of organizational transformation…within which organizational agency is necessarily embedded…with new forms of engagement on the part of key stakeholder groups – such as public service professionals' (O'Reilly and Reed, 2011, p. 1096).

Re-framed through the lens of Williams' 'epochal' analysis, the medical profession's emergence into the role of management could arguably constitute a form of assimilation or 'incorporation' into the 'dominant' hegemony (Williams, 1977, p. 125). Assuming that the 'dominant' hegemony is representative of the government in this instance, this would then represent a furtive attempt by the government to subsume the medical profession into the system of managerialism. This would then render the term leaderism as synonymous with managerialism rather than professionalism.

Moreover, Thorne (2002), asserts that whilst opportunities for doctors to take up posts as medical directors appeared to constitute a 're-professionalization, rather than *de-professionalization*,' in what she suggests amounts to '[d]ouble closure', (Murphy, 1988; Parkin, 1972; as cited in Thorne, 2002, p. 14). However, Thorne (2002) is cautious and suggests that this 'increased re-professionalization or an era of "management by medicine" may sow the seeds of the profession's destruction if more doctors became full-time managers' (Thorne, 2002, p. 24).

4.3.4. Nurses as managers

The role that nursing has played in management since the neoliberal reforms of the NHS, compliments their increasing autonomous position in some areas of clinical care, as has been discussed earlier in this chapter. Moreover, the role of the nurse as a manager has typically constituted the expanded role of the ward sister into general management duties such as human resource management, (RCN, 2009). Furthermore, (Bolton, 2003), suggests this is also characteristic of the development of the '"modern matron"' (DoH, 1999, 2000, 2001; as cited in Bolton, 2003). However, the colonising of nurses into general management roles since the neoliberal changes in the NHS in the 1980s has arguably served

to distort the ratio of non-clinical and clinical managers there are in the NHS. Moreover, Traynor (1999) observes '[a]s part of the 1991 NHS reforms, the government stipulated that Trust boards should include a director with a nursing background [as] nurse executive directors' (pp. 78–79). The National Institute for Health Research also reported in 2013, '[a]lthough official records state that 3% of staff are managers, most of these managers occupy dual roles as clinicians and managers…[t]hese hybrid managers may outnumber general managers by four to one – management capacity is more widely distributed than we thought' (NIHR, 2013).

4.3.5. Revised and new approaches to old dilemmas resulting from change

Much of the attention concerning management theory and practice in the NHS is now taken up by discussions concerning leadership, and we have already discussed the concept of 'leaderism' (O'Reilly and Reed 2011) in section 4.3.3 above. Grint (2010), in questioning 'What is leadership?' suggests that 'we appear to be no nearer a consensus as to its basic meaning, let *alone* whether it can be taught or its effects measured and predicted' (Grint, 2010, p. 1). Teelken (2012) observes some of the inherent weaknesses in current leadership theory in relation to its application in the public sector, including that 'leadership theories often do not take underlying social structures or the institutional environment adequately into account, [where] powerful groups (e.g. medicine) are well established and 'the state' tends to be very different institutionally from 'the firm''' (Teelken, 2012, p. 3). The characteristic Teelken describes has dogged the NHS and the wider public sector since the first neoliberal wave of reforms in the 1980s and this is also observed by (Pollitt 1990; Hood 1991; Dopson 1997; Rivett 1997; Ham 2009).

At a team development level Robbins and Judge (2009, p. 666) suggest that 'a major area of concern in OD [Organizational Development] is the dysfunctional conflict that exists between groups', suggesting 'intergroup development' techniques may help to build a more cohesive group behaviour. Furthermore, Brook (2009, p. 144) observes the advantages and disadvantages of diverse teams, whilst 'diverse teams may well generate higher levels of creativity (Guzzo and Dickson, 1996)'. However, Brook goes on to suggest that the task of leading and managing diverse teams may prove highly problematic and, '[t]hey may simply be too diverse and 'spread', and can sometimes present all the difficulties of leading people with extremely differing views and opinions about almost everything!' (Brook, 2009, p. 144). A current approach to the restructuring of occupational roles in the NHS is to attempt to build cohesive practice across a health and social welfare service which at an operational and strategic level requires a high degree of integration to achieve whole system solutions for complex health and social care needs, is the hybridisation of clinical and non-clinical roles together. The focus of a report by Helen Gilburt a Fellow in Health Policy at The Kings Fund, has recently produced a paper in which Gilburt (2016) suggests:

> Skills in communication, management and creating relationships are vital, and may be required by professional and non-professional groups more broadly. Interdisciplinary training, training of managers as well as practitioners, and cross-organisational placements can help develop and spread the necessary skills and competencies (Gilburt, 2016, p. 4).

However, Gilburt also reports there is evidence that the uptake of 'boundary spanning' (p. 7) has met with some discordance and is hindered by 'a culture of protecting professional and organisational identities' and early implementations have indicated clinical professional's fearing 'job losses, the blurring of roles,

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and possible loss of professional identity and status all stand firmly in the way of new roles spanning health and social care'. (Gilburt, 2016, p. 20). This situation is further complicated by elements of intra and inter-occupational rivalry evokes by the concept of boundary spanning and Gilburt also observes the '[t]he literature on professional roles and boundary-spanning contains a number of notable references to the concept of professional 'turf ' and 'turf wars' (Nasir et al 2013; Freeman et al 2012)' (Gilburt, 2016, p. 21).

However, there is currently a lack of available data to substantiate the 'cost-effectives of new roles' (Gilburt, 2016, p. 35-57). Linstead, Fulop and Lilley (2009, p. 648) suggest, 'the most common barriers that influence the change process [are] *organizational inertia* and *hostility*'. At present the effectiveness of these new initiatives is yet to unfold. However, in another report commissioned by The Kings Fund in 2016 it was recognised that much of the inertia which has dogged the NHS quality agenda in the past has been due to '[t]he adoption of many dissonant means of improving quality is symptomatic of the use of different approaches to reforming the NHS in England' (Ham, 2016, p. 9 citing Ham 2014).

Whilst there is no preferred managerial or leadership exemplary for the NHS at present, Timmins (2015) reported for The Kings Fund on how system leadership may provide the key to harnessing the normative qualities of chaos. Timmins draws on the leadership theory of Senge *Et al.* (2015), in the article 'The dawn of system leadership' to set out the 'Core Capabilities of System Leaders', suggesting 'system leaders' (p. 28) are people who can span boundaries, across departments and whole organisations if necessary. However, they remind us that this approach is as yet unproven, suggesting that 'system leaders' are still emerging. However, Senge *Et al.* are adamant that a

key element to the success of the system leader is 'learning on the job' and 'reflection and collaboration' and the 'building [of] one's own toolkit' (Senge *Et al.*, 2015, pp. 32–3). In other words, an approach built on adaptability in the face of change.

What is interesting about both Timmins (2015) and Senge *Et al.* (2015) is that these ideas are not revolutionary. At an organisational level Weick (2009) amongst others, had explored the concept of making sense of organisational chaos as a response to the increased convergence of what became an influx of global organisations in the 1990s and 2000s. Weick asserted that the contemporary manager is one who can create ''order out of chaos' (Chia, 2005, p. 1092)' (Weick, 2009, p. 90). Meanwhile, Meyer and Rowan (1977, p. 349) and their early forays into ways in which organisations may attempt to maintain stability in unpredictable change environments resulted in the convergence strategy of 'institutional isomorphism', a structure whereby an organisation will survive by adapting its business philosophy to accommodate heterogonous elements which may have an impact (Meyer and Rowan, 1977, p. 349) and is maintained through a process they termed 'rationalized institutions [which] create myths of formal structure which shape organizations' (Meyer and Rowan, 1977, p. 350).

DiMaggio and Powell (1983) extended the theory of Meyer and Rowan (1977), suggesting this was originally a response to the Weberian theory of bureaucratization, Di Maggio and Powell observing Weber's assumption that in capitalist society the inevitable prognosis was one where the modus operandi had 'become an iron cage in which humanity was, save for the possibility of prophetic revival, imprisoned "perhaps until the last ton of fossilized coal is

burnt" (Weber, 1952: 181-182)' (DiMaggio and Powell, 1983, p. 147). However, DiMaggio and Powell challenged Weber's logic, suggesting:

> The bureaucratization of the corporation and the state have been achieved…[however] structural change in organizations seems less and less driven by competition or by the need for efficiency…[but instead] out of the structuration (Giddens, 1979) of organizational fields…(DiMaggio and Powell, 1983, p. 148).

DiMaggio and Powell (1983) named three main isomorphic pressure structures, 'normative' – shared ideologies, coercive – hegemonic pressures and mimetic – imitations to cope with uncertainty (Guillen, 2014). Weick (1976) suggested different types of organisation require different levels of control to be successful, and he graded this from tight to loose couplings. Gauging this correctly can mean the difference between an organisation's survival or demise and he suggests that more often than not in increasingly heterogeneous organisational frameworks the '[p]revailing image that elements in organizations are coupled through dense, tight linkages [to the contrary] elements are often tied together frequently and loosely' (Weick, 1976, p. 1). Weick also observes (Chia, 2003) in this respect 'that organization is really a loosely coordinated but precarious 'world-making' attempt to regularize human exchanges…that management is more about the taming of chance, uncertainty, and ambiguity than about choice'. (Chia, 2003, p. 201; as cited in Weick 2009, p. 4).

There is consensus among academics that in a post industrial age a significant level of complexity has arisen due to the increased flexibility required to accommodate 'flexible specialization' (Heydebrand, 1989; as cited in Dent 1995, p. 878). Organisational theories which incorporate concepts such as those discussed above concerning system-wide approaches across one organization, nationally or globally have attracted the interest of social scientists

for a number of years. Convergence at a global level has been examined by Guillen (2016), who reminds us that after the global economic and political turmoil of 1970s 'sociological theories of convergence were replaced by more nuanced institutional approaches [and] economic theories of convergence swiftly gained prominence' (Guillen, 2016, p. 3). However, these theories did not address national differentiation and the increased complexity often associated with wide systems of convergence both at a national and international level.

Guillen (2016) extends this theory in a study in which he questions the current 'conventional wisdom' concerning the level of convergence or differentiation of 'cross-national patterns of corporate governance' (Guillen, 2016 p. 3). He suggests that the current stance regarding the so called 'globalization of markets thesis' remains open to debate, and that the findings of his study pose a distinct proposition 'against convergence' in that the findings suggest firstly, the differentiated legal frameworks countries have seek to set institutions and also nation states apart. In addition ensuing political change which may subsequently occur in countries may also ultimately serve to destabilize previously established forms of global convergence, (Guillen, 2016, p. 12-22).

Through the lens of Williams' one concept used in this research, 'structures of feeling', and within this, his notion 'differentiated structures of feeling to differentiated classes', I suggests holds a usefulness in the further understanding of how humanly constructed embedded cultures within society impact in ways that are not always immediately evident yet may have a profound effect on how successfully change is embraced by those it affects. Therefore in relation to the previous discussions concerning the question of convergence or indeed differentiation as raised by Guillen (2016), transposed to Williams' concept here may offer a lens by which to gauge the existence and

also possible extent of differentiation evident within occupational groups, where levels of convergence are sought to achieve and maintain hybridized roles, processes and structures in the pursuit of enhanced organisational adaptability as a response to change.

In the case of Senge *Et al.* (2015) the ramifications of boundary spanning across departments and organisations throws up a number of questions concerning how existing cultural structures will adapt, and this includes the points raised by Guillen (2016) at a wider global convergence level. The findings of his research suggest a clear level of differentiation remains in organisations despite undergoing robust programmes of global corporate convergence, due to the very nature of local cultural traits and practices predominantly due the individualised legal structures of the different nation states, and when this is overlaid onto the suppositions of Senge *Et al.* (2015) and Timmins (2015), it raises the distinct question of how to manage the ongoing differentiation that continues to exist in an organisation, and just how this may be addressed by the 'system leaders' and the boundary spanners of the future in the NHS?

In Williams' view, differentiation is part of the whole structure of a culture; it is not separated or reduced to an inconsequential outlier, and to the contrary it is integral to individual cultural identity and considered as an alternative to assimilation. Differentiation is omnipresent in society and therefore needs to be recognised and assessed for its potency. In this study it is hoped that by using 'differentiated structures of feeling to differentiated classes' used as an a prior coding system this may offer the potential to identify the elements of occupational behaviour which remain differentiated and resistant to forms of convergence and assimilation and which therefore need to be understood and

managed in ways which accommodate differentiation as part of the network of collaboration, as part of the whole system.

4.3.6. Summary

The review of the secondary sources in this section has exposed an interesting development emanating from the impact of neoliberal reforms which has led in one sense to greater opportunities within the management function, opportunities for all three occupations in this case study. However, it seems that simultaneously this has created a level of organisational complexity, as new 'hybrid' occupational roles seek to both empower and also possibly endanger the existing traditional occupational framework in the NHS and the replacement of the 'traditional' language of the organisation with the new language of 'leaderism', (Thorne, 1997; O'Reilly and Reed, 2011).

4.4. Overall conclusion

What has emerged from the literature review is that the dominant hegemony, in whatever form, has continued through epochs continuing to promote the neoliberal ethos. This has impacted on the NHS and the three groups in the case study in this research in a number of ways. The increasing hybridisation of roles has produced what I argue has resulted in an occupational 'tripartite'. It is becoming increasingly the case that doctors, nurses and managers in the NHS will no longer perform occupationally isolationist functions, which may elevate or separate them significantly. Hybrid roles are now the focus of new national organisational initiatives and this seems set to continue. Furthermore, this review has also provided the opportunity to explore how Williams' two concepts of 'epochal' analysis and 'structures of feeling' may be applied to reframe the situations described in the literature, sometimes towards a different perspective, from a wider range of perspectives, from the perspective of a cultural totality or

as Williams suggests, the 'whole cultural process rather than only to the selected and abstracted dominant system' (Williams, 1977, p. 121).

In the next chapter, I discuss the methodology. I discuss the rationale for the particular methodology chosen including methodologies that were rejected and the reasons for these decisions. I then discuss the chosen methodology and its relationship to the theoretical framework and its application in the research question. I then discuss how this influenced the research design, its presentation, research activities and the validity of the interpretation and generalizability of the research theoretical orientation and methodology. I conclude with a discussion concerning the limitations of the chosen hybrid methodological approach.

5. Research methodology

This chapter focuses on the research methodology, the rationale, its strategy and the chosen methods. Also, it explains the case study group selection, describes the research instruments and requirements and explains the procedures carried out to comply with both NHS and university ethics approval. There is a discussion concerning data analysis, the design and how the validity, reliability and generalizability of the research has been assessed. This chapter concludes with a discussion concerning some of the limitations of the chosen methodological design.

5.1.   The research strategy

This research study considers what has been the impact of successive neoliberal health policies on a case study of 27 doctors, nurses and managers in a PCT in South East England. However, because of my own occupational experiences in the NHS I was conscious of the influence of auto-ethnography and as Muncey (2010, p. 3) reminds us, 'None of us live in a disconnected world'. It was therefore important that my version of the NHS and my lived experiences working in the organisation did not overpower the views of the case study group in this research. For this reason I was interested in methods that would help with the achievement of minimal intervention during the interview process.

5.2.   Positivism and numeration

Before any decision was made I investigated the use of positivism. I was aware that positivism would not serve to unlock the more subtle aspects of the dialogue captured in my interviews with the participants, although positivism is

widely used in research in the NHS. Oliver (1998, p. 105) reminds us, 'a positivist epistemology may employ a questionnaire with ranking scales…would tend to treat knowledge as objective verifiable and replicable…an interpretive epistemology might explore the different understandings' – the latter being in line with the kind of research I wished to conduct. Smith, Flowers and Larkin (2009), considering the uses of numeration, suggest:

> …taking account of frequency with which a theme is supported. This is definitely not the only indicator of its importance, and should not be over emphasized – after all, a very important theme, which clearly unlocks a further set of meanings for a participant, may sometimes be evidenced only once, Smith, Flowers and Larkin (2009, p. 98).

If the data frequency is low, (which it proved to be in this research – see Figure 5-1 below), attempts at charts to demonstrate patterns in the themes identified in the data would prove very difficult. Even attempts to weight the data to add emphasis and enhance the illustration of the data may only serve to distort the data. Therefore numeration of data to illustrate the potential significance of the various abstracted themes was not preferable in this research.

SUPER-ORDINATE THEMES Table 8.1

Theme	Colin - non clinical manager	Ajam - Doctor	Jill - non clinical manager	Betty - non clinical manager	Frankie - clinical manager	Ben - non clinical manager	Claire - clinical manager	Robert - non clinical manager	Dennis - clinical manager	Janice - non clinical manager	Paul - Nurse	Carol - Nurse	Douglas - Doctor	Malik - non clinical manager	Brenda - Nurse	Beth - non clinical manager	Chris - non clinical manager	Stuart - clinical manager	Dave - non clinical manager	Tracy - non clinical manager	Lilly - clinical manager	Kelly - clinical manager	Franz - non clinical manager	Rokh - clinical manager	Jillani - Doctor	Sue - Nurse	Sean - Doctor	theme occurrence count total
Epochal Analysis (EA) - Super-ordinate theme																												
Subordinate themes																												
Awareness of Dominant culture (D)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0				2
Awareness of Residual culture (R)	1	1	0	1	0	0	0	0	0	0	2	0	0	1	0	0	0	1	0	0	0	0	0	0				7
Awareness of Emergent culture (E)	1	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0				4
Total	2	3	0	1	1	1	0	0	0	0	2	0	0	1	0	1	0	0	1	0	0	0	0	0				13
Structure of Feeling (SOF) - Super-ordinate theme																												
Subordinate themes																												
Changes of Presence (CoP)	1	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0				4
Differentiated structures of feeling to differentiated classes (Dsoftdc)	3	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	1	0	0	1	0				8
Total	4	1	0	0	0	0	1	0	0	1	0	2	0	0	1	0	0	0	1	0	0	1	0	0				12

Figure 5-1: Extract from Appendix E illustrating the low frequency rate for each respondent

5.3.   Qualitative phenomenology

The data did not demonstrate any obvious frequency spikes; instead, as the interviews progressed, the data developed into a collection of personal narratives displaying various phenomena that were not necessarily repeated again by the interviewee or for that matter others interviewed. Therefore, qualitative phenomenology was quite possibly the best route. However, qualifying which branch of phenomenology was still required. Willig (2013) acknowledges many academics now recognise the restrictions that descriptive phenomenological analysis alone carries, and she suggests 'interpretive phenomenology [which] aims to gain a better understanding of the nature and quality of phenomena as they present themselves…instead, it draws on insights from hermeneutic tradition and argues that all description constitutes a form of interpretation' (Willig, 2013, p. 86).

5.4.   Sample or case study?

It is Silverman (2013) who asserts the differences between quantitative and qualitative research: '[v]ery often a case will be chosen simply because it allows access' (Silverman, 2013, p. 144). This had some bearing on this research and because I had a limited amount of time to carry out the interviews and an increasingly limited group from which to choose participants in the sample group.

This was due to another large scale restructuring of the primary care system in England, which coincided with this research project through a tranche of health policy reforms initiated in 2010 by the Conservative-Liberal Democrat Coalition which had called for the eventual abolition of PCTs, as discussed in Chapter 3 of this thesis. Therefore, working with my director of studies at the University,

we agreed a feasible plan in light of the organisational upheaval in primary care at the time, that a research group of a minimum of four doctors, nurses and managers would form a practicable case study.

However, Silverman (2013) observes when using case studies: '…This gives rise to a problem, familiar to users of quantitative methods: "How do we know…how representative case study findings are of all members of the population from which the case was selected?"' (Bryman, 1988, p. 88; as cited in Silverman, 2013, p. 144). This raises the question: could I be completely sure that the case study group I had interviewed would meet the test of rigor required in all research whether quantitative or qualitative? The theoretical position in this research was to explore the further understanding of what impact neoliberal reform in the NHS has had on the case study group. Yin (2009, p. 15) suggests '[t]he short answer is that case studies, like experiments, are generalizable to theoretical propositions, not to populations or universes'. Therefore as long as a proportion of the selected occupational group was represented in equal numbers, this should meet the requirements of consistency.

5.5. Wengraf and semi-structured intervention

The next step was to design how the interviews would be delivered. Wengraf (2001) argues that by modelling the research interview into a structured, semi-structured or unstructured format we can help to govern not only the degree to which the interviewer intervenes during an interview but also the direction the interview takes (Wengraf, 2001, p. 61). This approach is adopted because of the potential it proposes for non-intervention between interviewer and interviewee, and in light of the discussion earlier concerning auto-ethnography, Wengraf's model seemed appropriate for this research.

Wengraf (2001) suggests the separation of TQs, and IQs is paramount; the rationale being that theory questions presented to the participant amount to the researcher introducing a 'particular "reality"', and to counteract this he suggests that '[t]he evidence is problematic because the relation between theoretical concepts and their empirical indicators is always across a gap' (Wengraf, 2001, p. 54). Separating the theory concept from empirical responses given by the participants this will result in the data being more concerned with the thoughts and feelings of the participants and less about theoretical steer on the part of the researcher, and Wengraf says of qualitative research 'as such the theory is emergent from the research' in the form of interpretation or arrangement (Wengraf, 2001, p. 56). He suggests the solution is to create separate 'theory concepts (TC) and empirical indicators (EI)' which are the 'measurement, an observation, a datum, which is taken to be "evidence" for a particular theoretical concept (TC) being in one "state" or another…social polarization, etc.' (Wengraf, 2001, p. 53). In this research EIs were abstracted as 'themes'.

This is illustrated in the model below by Wengraf (2001), where the interviewer has control over any intervention, or withdraws from participation during the interview – whichever is thought more advantageous to the optimisation of best results. Furthermore, as Wengraf suggests, '[i]nasmuch as the interviewer is in charge of the development of the interview…a particular instrumentation theory that will govern your attempt to create this or that type of session with its pattern of (non) interventions' (Wengraf, 2001, p. 63). See Figure 5-2 below:

Research Purposes (RP)

Central Research Question(s) (CRQ)

Theory-question$_1$ Theory-question$_2$ Theory-question$_3$

II/IQ$_{1A}$ II/IQ$_{2A}$ II/IQ$_{2B}$ II/IQ$_{2C}$ II/IQ$_{3A}$ II/IQ$_{3B}$
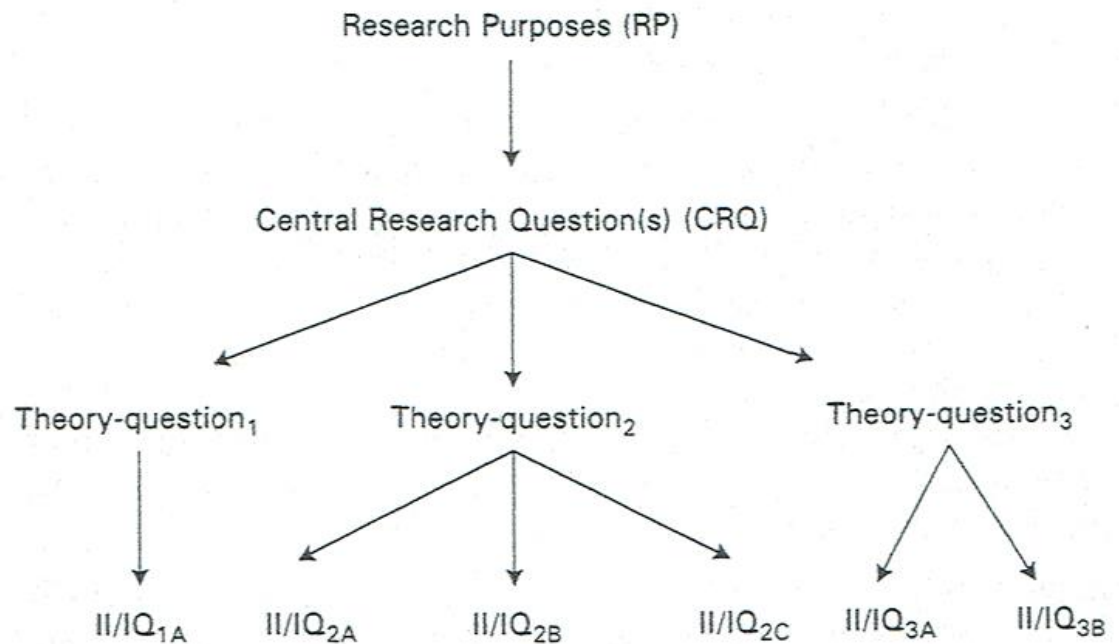
Figure 5-2: CRQ – TQ – IQ/II: Pyramid model – Wengraf (2001, p.63)

In the Pyramid model (Figure 5-2) above we can see that the central research question (CRQ) has additional TQs beneath it, and a further separation of IQs, with interview interventions (IIs), should the interviewer be required during the course of the interview to make interventions. For more information, see Appendix F, which provides several examples of areas in the transcript data where IIs have been applied during the interview process in this research.

In this study the research purpose (RP) is to establish the impact of neoliberal policy reform in the NHS on a case study group of doctors, nurses and managers in the NHS in England. The TQ also serves as the CRQ, with a single IQ below this, followed by IIs (a reiteration in some form or another of the IQ) to draw the interviewee back to the IQ as and when required. This was combined with the use of a SQUIN, another aspect of Wengraf's methodology; 'single question aimed at inducing narrative' (Wengraf, 2001, p. 69). Wengraf states that while the intention on the part of the interviewer is to 'listen attentively' while

taking notes, '[m]ost interviewees, however, may need to be actively supported but not directed in their narrating activity' (Wengraf, 2001, p. 125).

5.6.   IPA – strengths and weaknesses

In addition to this an epistemological methodology, IPA (Smith, Flowers and Larkin, 2009), developed by Jonathan Smith, Professor of Psychology at Birkbeck University of London, in 1996. Smith, Flowers and Larkin remind us that the origins of IPA stem from Husserl, Heidegger, Merleau-Ponty and Sartre, who began theorising how 'the complex understanding of 'experience' invokes a lived process, and unfurling of perspectives and meanings', first explored by 'Schleiermacher at the turn of the nineteenth century…offering a holistic view of the interpretive process text', (Smith, Flowers and Larkin, 2009, p. 21) – now understood as the 'hermeneutic circle', (Willig, 2013, p. 86).

This was incorporated as this method uses single core questions, which Smith *Et al.* claim is effective because 'a single core interview question [may be used by an experienced interviewer] which they will ask at the beginning of each interview…how the interview unfolds will then depend entirely on how the participant answers this first question', (Smith, Flowers and Larkin, 2009, p. 69).

The rationale for including IPA (Smith *Et al.*, 2009) Willig (2013) suggests, is that this methodology has the explicit intention of 'gaining direct access to research participants' life worlds', and it acknowledges that the objective is to discover the participant's own involvement and perception'; which may, in turn, include the perception of the researcher also. (Willig, 2013, p. 87).

I planned to follow a notational coding system suggested by Smith, *Et al.* (2009, pp. 84–8), which categorised the data into 'descriptive', 'linguistic' and 'conceptual' comments. However, once the research coding process was

underway it became evident that most themes contained all three notational elements. Therefore, I decided to abandon this process, as it did not seem to add any value to the research analysis in this particular case. In hindsight Wengraf (2001) and the 'CRQ – TQ – IQ/II: Pyramid Model' was sufficient but because both Wengraf (2001) and IPA Smith *Et al.* (2009) seemed to be easily reconciled, IPA was used as the method of abstraction because it help to facilitate the emphasis on pathways leading to themes, and for this reason I decided to replace EIs (Wengraf 2001), with abstracted themes (Smith *Et al.* 2009).

5.7. Adapting Williams' concepts to an a priori deductive coding system

I believed that adapting and incorporating two of Williams' concepts would help to realise an analysis of views from a variety of perspectives. This was the conceptual design I had in my mind, and so I searched for a proven methodology that had taken a similar approach. Willig (2013) states: 'Jennifer Fereday developed a hybrid approach of inductive and deductive coding and theme development (Fereday and Muir-Cochrane, 2006). As such, her study constitutes an excellent example of how thematic analysis can benefit from the strength of both data-driven and theory-driven coding', Willig (2013, p. 63). Willig goes on to suggest that this was in line with 'Boyatizis' (1998) guide to data-driven and indicative thematic analysis as well as Crabtree and Miller's (1999) model of the use of priori template codes' (Willig 2013, pp. 63–4).

Therefore, I decided to incorporate the inductive methodology of IPA together with Williams' two concepts 'epochal' analysis (EA) and 'structures of feeling' (SoF) as an a priori deductive theme structure, which I coded with relevant

abbreviations. The data produced a number of 'abstracted' themes that I had identified and interpreted as aligning to Williams' deductive conceptual coding structure. I began by transposing abstracted themes onto a 'Master Table of Themes', as suggested in Smith, Flowers and Larkin (2009), (see Appendix B) creating a matrix to then align onto Williams' conceptual framework. Each theme structure contained 'superordinate' and 'subordinate' sections. Not all of the themes abstracted on the Master Table of Themes, were utilised, and this exercise served to filter the data down into manageable pieces. However, it should be noted that subsequent trawls through the original transcriptions often meant marking up by hand, which proved far more useful in terms of accessibility to get the data analysed as there was no need for a computer. I then carried out a further abstraction process searching for relationships, both connected and polarised. By this time many of the transcripts had become very familiar to me and the process of making connections and observing disparities become less onerous.

5.7.1. Superordinate EA and subordinate – 'Dominant (D), Residual (R) and Emergent (E)'

Below is the extract, used in an earlier section in this thesis that demonstrates the 'Superordinate and Subordinate Themes Matrix'. It illustrates the themes as a frequency table, also discussed earlier in this chapter, with the participants' views that best matched to the 'superordinate' and 'subordinate' themes aligned

to Williams' two concepts. See Appendix E and Figure 5-3 below:

Super-ordinate themes v5 Ray Williams version - Microsoft Excel

AC15 — =SUM(AC13:AC14)

SUPER-ORDINATE THEMES Table 8.1

	theme occurrence count total
Epochal Analysis (EA) - Super-ordinate theme	
Subordinate themes	
Awareness of Dominant culture (D)	2
Awareness of Residual culture (R)	7
Awareness of Emergent culture (E)	4
Total	13
Structure of Feeling (SOF) - Super-ordinate theme	
Subordinate themes	
Changes of Presence (CoP)	4
Differentiated structures of feeling to differentiated classes (Dsoftdc)	8
Total	12

Figure 5-3: Extract from the superordinate themes matrix table from Appendix E

I designed my adaption of Williams' concept of 'epochal' analysis with the abbreviation (EA) as the main superordinate theme, with three further subsets or subordinate themes below it, the 'dominant' (D) 'residual' (R) and the 'emergent' (E), which Williams reminds us are his three dynamic interrelated cultural elements contained within EA. I mapped the data abstracted against each of the themes as my interpretation.

Superordinate 'structures of feeling' (SoF)

The second 'superordinate' theme structure is Williams' concept as discussed in the theory chapter – these are 'structures of feeling' (SoF). Williams describes these as the 'pre-form stage', prior to any palpable converted product forms, Williams (1977, p. 131). Which 'are emerging or pre-emergent, they do not have to await definition, classification, or rationalisation before they exert palpable pressure and set effective limits on experience and on action' (Williams, 1977, p. 132).

Subordinate 'changes of presence' (CoP)

Beneath the superordinate structure 'structures of feeling', I devised two subordinate structures: the first, 'changes of presence' which Williams suggests are the moments when changes occur to 'structures of feeling'.

Subordinate 'Differentiated structures of feeling to differentiated classes' (DSoFtDC)

The second theme, the subordinate structure, 'differentiated structures of feeling to differentiated classes' (DSoFtDC), in this study, 'classes' translate to groups. I used this notion of Williams' to identify how different groups resist assimilation through a number of oppositional mindsets, often not overtly.

So far, I have described the design of the deductive a priori framework adapted from Williams' two concepts: EA and SoF, and the inductive methodology of IPA which I have adapted as a hybrid approach, similar to that used by Fereday and Muir-Cochrane (2006, as cited in Willig; 2013, p. 63).

5.8. Incorporating Fereday and Muir-Cochrane's hybrid approach

Fereday and Muir-Cochrane (2006, p. 1) designed a 'methodological approach [of] integrated data-driven codes with theory-driven ones based on the tenets of social phenomenology'. This design is a 'hybrid' construction of 'the data-driven inductive approach of Boyatzis (1998) and the deductive a priori template of codes approach outlined by Crabtree and Miller (1999) to reach the second level of interpretive understanding' (Fereday and Muir-Cochrane, 2006, p. 2). The overarching design of their research process was constructed from a methodology by 'Schutz (1967) studying social action involving two senses of *verstehen* (interpretive understanding)…[a] process by which people make

sense of or interpret the phenomena of the everyday world…[and how this] involves generating "ideal types" through which to interpret and describe the phenomenon under investigation' (Fereday and Muir-Cochrane, 2006, p. 2).

Therefore, aspects of the Fereday and Muir-Cochrane (2006) model are used together with Wengraf's (2001) 'semi-structured' gradient from fully- to unstructured intervention in interviewing, (Wengraf, 2001, p. 61). In conjunction with a 'pyramid model' (Wengraf 2001, p. 63), where IQs, intended to be 'indicative-material-seeking', distinguishing between the 'theory-questions which 'govern' the production of the interviewer-questions, but the TQs are 'couched' in the 'theory-language of the research community', whereas the IQs are 'couched' in the language of the interviewee, and therefore these are expected to connect to the interviewee in the language of lived experience. (Wengraf, 2001, pp. 62–3).

In this research the adaption integrates Fereday and Muir-Cochrane's (2006) hybrid integrated deductive/inductive theory and data driven methodological approach, incorporating Wengraf's (2001, p. 63) 'Pyramid model'. The intention in this research to provide the process mechanism to distinguish the theory from data driven phenomena, as Wengraf (2001, p. 54) suggests to prohibit the researcher from inadvertently influencing the participant by 'introducing a particular "reality"'. The interpretation of the data is by means of a deductive a priori coding system based on two of the cultural theorist Raymond Williams'; 'epochal' analysis and 'structures of feeling', separated into superordinate and subordinate theme and sub-theme structures.

5.9.   The research instruments and requirements

5.9.1. The research question

As discussed earlier in this chapter and also in the first chapter of this thesis, my research question is a SQUIN (Wengraf, 2001, p. 69) and, also adapted from Wengraf, a 'Pyramid Model'. Its design is built around the concept that there should be a separate TQ, as below:

> What has been the impact of successive neoliberal policy reforms in the NHS since 1980 on the views of a case study group of doctors, nurses and managers in a Primary Care Trust (PCT) in the South East of England concerning their occupation in relation to those of the others they work with?

The IQ given to the recipients, (also see Appendix C):

> How has successive strategic policy implementation in the NHS since the introduction of the internal market in the 1980s, and more recently the introduction of integrated working in the 1990s, impacted on inter-occupational behaviour between doctors, nurses and professional managers and also service performance delivery in the NHS?

The TQ was designed 'to capture the inner logic, the dynamic, of the decision-making process' (Willig, 2013, p. 60), and to enhance the opportunities of understanding how the participants felt concerning neoliberal reform in the NHS and how it had impacted on their own occupational standing and that of the others they worked alongside.

5.9.2. Access and the research setting

I applied to the National Ethics Committee, the Central Office of Research Ethics Committees (COREC), which was mandatory at that point for all research studies conducted within the NHS, regardless of whether patients were involved or not. Once this was ratified I was granted two locations for this

research. The first site was a PCT. This trust has a geographical location in South East England and is responsible for the healthcare needs of approximately 300,000 patients in the area it serves. The second site is a local doctor's surgery in the same area, also under that same PCT.

The conditions of COREC and, in part, access, were also governed by the availability of the participants and how they could free time up to see me, and whether there was suitable accommodation which met the requirements of COREC; that the room was private and nothing could be overheard. However, the process was lengthy, and involved a 12-member panel interview, ratification of which took some nine months to reach the approval stage. This had the ramification of eliminating any opportunity to carry out pilot testing, and some key participants had left the organisation before I could commence the interviews with them.

5.9.3. The case study group

To help ensure the group selection process for this study could be classed as a generalizable data set, I worked with my Head of Studies at the University of East London, Royal Docks Business School to devise a group for the case study. The group was not large and it is Oliver (2008) who suggests that research that is qualitative in nature will not routinely adopt a 'probability sample', reminding us, research samples 'within an interpretative perspective are usually much smaller, but the data collected is more detailed than in the case of a probability sample', (Oliver, 2008, p. 109).

In this study, the overarching principle in the selection of participants was that the case study group should comprise of at least four doctors, nurses and managers from these three core groups. The rationale here being, as is

customary with clinical personnel in the NHS, career pathways tend to begin in the acute hospital system and any migration by these personnel to the community system follows after a number of years. This has changed in recent years, although all of the clinical personnel in the case study group in this research had experience in both of the organisational domains of secondary (acute) and primary care. In addition to this, further subsets and divisions could have been included, for example, midwives, therapists, clinical managers and so on, but the premise would still stand that these are all branches of one of the three core groups.

I had an established network of contacts in the area where I work – which had two distinct advantages; firstly, many participants for this research had shown a keen interest in being involved in the study – this was an immense help to me and saved time during the canvassing of potential participants. Secondly, the CEO and senior management team at the local PCT were also very supportive and encouraged this study.

However, the case study group was eventually governed in principle by two key factors. Firstly, as Reid, Flowers and Larkin (2005, p. 22) suggest, 'less is more' as IPA often challenges the traditional linear relationship between the number of participants and the value of research. Secondly, as Oliver (2008) states:

> In some forms of qualitative research it is sometimes difficult locate appropriate people…In a study of employees who are in disagreement with the prevalent management ideology in a large organization, many such people may not wish to volunteer as respondents through fear of antagonizing their managers and even, ultimately, of losing their jobs (Oliver, 2008, p 110).

This second factor was very much applicable to this study; it had begun at a time of immense change in the NHS, not long after the introduction of the large-scale restructuring of health and social care by the recently-elected Conservative-Liberal Democrat Coalition in 2010. Undoubtedly, this had an impact on the willingness of those approached and, for that matter, the number of available participants to take part in the research.

The breakdown of the groups profiles are as follows:

Doctors

GPs who had normally experienced working environments in both the acute (hospital) sector and the community (primary care) sector.

Nurses

Either practice nurses who had stayed in nursing and normally had experience in working environments in both the acute (hospital) sector and the community (primary care) sector. Within this group, any nursing staff, e.g. midwives and associated practitioners including physiotherapists would not be identified as being part of their original occupational group if already in a management role, but would be placed in the management category instead.

Managers

PCT management originally from a clinical background, for example; physiotherapists, or pharmacists, or public health, or a non-clinical background altogether, including practice managers.

The aim was to provide a group for the case study that formed a typical snapshot of clinical and non-clinical professionals working in the PCT in question. The matrix (Table 5-1, below) indicates the participants' role and

pseudonym for anonymity purposes required by COREC to conduct the study. I have also decided not to provide a profile as is typical in this sort of research as this was not permitted by the National Ethics Committee, being viewed as a risk of the code of confidentially agreed to with the Committee. This was a mandatory requirement by COREC for the approval to carry out the research.

No.	Pseudonym	Clinical/non- clinical
01	Colin	Non-clinical manager
02	Ajam	Clinical doctor
03	Jill	Non-clinical manager
04	Betty	Non-clinical manager but clinical background
05	Frankie	Non-clinical manager but clinical background
06	Ben	Non-clinical manager
07	Claire	Clinical – other
08	Robert	Non-clinical manager – other
09	Dennis	Clinical – other
10	Janice	Non-clinical manager
11	Paul	Clinical – other
12	Carol	Clinical nurse
13	Douglas	Clinical doctor

14	Malik	Non-clinical manager – other
15	Brenda	Clinical – nurse
16	Beth	Non-clinical manager
17	Chris	Director other
18	Stuart	Clinical professional
19	Dave	Director other
20	Tracy	Non-clinical manager
21	Lilly	Non-clinical but clinical background
22	Kelly	Non-clinical but clinical background
23	Franz	Non-clinical
24	Rokh	Clinical – other
25	Jillani	Clinical doctor
26	Sue	Clinical nurse
27	Sean	Clinical doctor

Table 5-1: Interviewees, their pseudonyms and their actual roles in the NHS

5.9.4. Ethics and avoiding bias

Working in the NHS, I was required to follow the conditions laid down by COREC, as previously discussed in this chapter, as well as my own University ethics procedures. I was required by both the NHS and the University committees to demonstrate assurance concerning consent and anonymity of the participants, confidentially and safekeeping of the data collected and integrity about its use at the time of the study and in the future. Consequently,

the participants' names and specific identifiers unique to the organisation within which they work that may act as identifiable markers have been removed or changed.

COREC, in line with the University Ethics Committee, stipulated that it would be necessary for me to gain informed consent from each of the participants in a written format (please see Appendix A) and to supply the participants with an information pack prior to interview. Following the interview, should the participant wish to review and / or correct or withdraw the transcript, they would be able to do so (see Appendix D, Participant Pack, the information leaflet). Furthermore, Oliver (2008, p. 115) reminds us, 'one of the best known principles is that of informed consent. This places upon the researcher the obligation to ensure that before the participants agree to take part in the research, they are made fully aware of the nature of the research and of their role within it'.

The process for COREC involved an application via the National Integrated Research Application System (NIRAS) before research procedures and ethics clearance within the NHS was approved. The application through NIRAS was submitted, which then had to be ratified by COREC before permissions could be granted after seven months.

As previously discussed I was required to attend an interview approval/rejection regional COREC panel made up of a section of 12 lay and academic members. The meeting was held at the regional branch of COREC, and a conditional offer was granted with minor changes. These concerned the number of interview sites and the exact process by which informed consent would be secured. Once the changes were resubmitted the committee granted permission to carry out the research.

Following COREC approval, the Chief Executive Officer of the PCT kindly

agreed that meetings with the PCT personnel could take place during the

working day. In line with COREC process requirements, all participants were

interviewed in private rooms without interruption and each participant was

provided with explanatory documentation (Appendix D) prior to interview. This

explained the nature of the study, what was expected of the participant and

what they should expect from the researcher, how their data would be

anonymised, stored and kept safe. An opportunity to withdraw from the study

should participants wish to do so was highlighted prior to, and at the interview

stage, and also following the interview – all in line with the ethics requirements

of both COREC and the University. In addition to the COREC process, the

University process stipulated a risk assessment protocol be completed to

identify and mitigate risks.

However, the danger of bias is heightened due to the nature of qualitative

research in general, perceived as far more subjective than quantitative

research, having far less reliance on binary conclusions of a numeric kind.

Furthermore, the cultural complexities now characteristic in a neoliberal NHS

advanced certain responses, and Martin (1992) draws our attention to some of

advantages and disadvantages of this, suggesting 'Whereas modernism is

"associated with the removal of mystery and ambiguity from social life," the

Fragmentation perspective, like postmodernism, celebrates "indeterminacy,

heterogeneity, and ambivalence." Nevertheless, most Fragmentation studies

are written as if the author's presentation of cultural members' interpretations

constituted an objectively accurate portrait' (Martin, 1992 loc 4591-4599).

Some would suggest that this is further heightened when using case study

approaches and Yin (2009, p. 72) suggests this may pose a problem if: 'an

investigator seeks only to use a case study to substantiate a preconceived position'. Furthermore, he warns against this situation from arising with the suggestion that 'to test your own tolerance for contrary findings, report your preliminary findings – possibly whilst still in the data collection phase – to two or three critical colleagues' (Yin, 2009, p. 72). My method of meeting this requirement and avoiding the possibility of what Yin warns, was to meet with my supervisors on a regular basis to discuss particular abstracts from the data and my interpretation of these, to use this as a form of grounding against any form of bias manifesting in the research process.

5.9.5. Timeframe of the study and lead up to the interviews

The national ethics process I have described governed a significant period of the research timeframe and until ethics approval had been granted, the interviews could not commence. The research enrolment was in late-2009; the 27 unstructured interviews could not commence until June 2012, which ran to April 2013. The participants working in the PCT all received an interview pack and had consented prior to the interview stage, again verified on the day of interview to reaffirm consent before the interview commenced. All participants were advised of the opportunity to withdraw from the study after the interview if they wished to. All interviews were carried out in the two geographic sites identified and ratified by COREC as the designated research sites.

5.9.6. The interviews

The interviews generally took the form of an informal chat in a private room, either in the local PCT or the doctor's surgery where I work. Carried out at various times of day, the schedule was governed to fit around the participants.

Being able to secure enough time with the participants during working hours seemed to work well and there was little appetite on the part of the participant to meet after working hours. This seemed to act as a positive incentive providing some enthusiasm on the part of some participants. Some participants viewed the opportunity as a therapeutic experience, 'letting off steam' and having a break from their normal daily work routine to discuss their views. Correspondingly, Oliver (2008, p. 117) suggests 'the respondent or participant should feel at ease and able to feel some sort of control over the data collection process'.

I felt that for the vast majority of the time the participants felt completely comfortable and relaxed with the process and seemed to enjoy what they were doing, although one or two were very apprehensive about the future in general.

The interviews were mostly arranged by telephone, backed up by a letter sent by email explaining the process (see Appendix D). Each participant responded, only one refused, with one refusing to be taped but agreeing to notes being taken. The rest of the interviews were audio taped and transcribed later. At the beginning of each interview the participants were given the opportunity to pause the interview and the tape at any point should they wish to, this is in line with Oliver (2008, p. 117) suggesting that participants may want to stop the tape and speak without being recorded on certain subjects.

It was hoped that holding the interviews in the workplace would help set the scene for the participant to discuss the events and views that related to their workplace. Knowing most of the participants as fellow work colleagues also helped to create an atmosphere of friendliness and relaxation, putting participants at ease whilst they discussed a variety of issues and what those

issues meant to them. Willig (2013, p. 87) reminds us, 'the role of the researcher within this context resembles that of a person-centred counsellor who listens to the client's account of their experience empathically, with an attitude of unconditional, positive regard and without questioning the external validity of what the client is saying'.

The participants nearly always began with a chronological account of the key events as they remembered them from when they entered into the NHS. This seemed to work well, as it served to set the scene and provide a contextual backdrop for the participants to organise their thoughts around their view of the wider events posed in the research question.

Each interview went something along these lines: after the initial chronological lead in, the participants generally began to isolate and discuss in detail their views concerning various events in the policy history in the NHS since 1980: those which the participants remembered were significant to them, what had happened to them in the organisation on an occupational level as a result and what this had meant to them on a personal level too. Again, without exception, all of the interviews culminated in a 'tidying up' summation with concluding thoughts for the future of the NHS. Smith, *Et al.* (2009), suggest 'the general flow or rhythm of an interview tends to shape the tone of a transcript from the broad and general (in the beginning) to the specific micro-detail of events (towards the middle of the interview), to some kind of synthesis or "wrapping up" at the end of the interview" (2009, pp. 82–3).

In an attempt to reduce the mammoth task of typing the transcriptions, which took approximately eight hours to type 30 minutes of recording, I began transcribing the earlier interviews and carrying out the initial noting, as (Smith,

Et al., 2009) suggest. I did this alongside carrying out the later interviews. I assured all participants that the information gathered via audio tapes and transcription notes was anonymised using a number coding system (at that point in time) and pseudonyms at a later stage to protect the identity of the participant in line with national and University ethics approval. The transcriptions, tapes and USB memory stick were all kept in a locked fireproof cabinet at the surgery where I work.

Applying the SQUIN, Wengraf (2001) and the 'Pyramid model' (Wengraf, 2001, p. 63) and using a semi-structured minimal intervention technique I needed a good deal of self-discipline not to intervene and to respond to the participant's gestures to get involved with the discussion. Whilst it was difficult to guide participants back to the subject as some were prone to 'drift off' to discuss unrelated matters, IIs were used in the form of re-stressing certain aspects of the original IQ (Wengraf, 2001, p. 63) (see Appendix F).

5.9.7. The transcriptions

The interviews were transcribed using a transcription software and were typed onto a template that I had designed, please (See Appendix G), the Transcription Extract. Each transcription took approximately eight to ten hours to transcribe and usually lasted between 30 minutes and one hour in recording length. This is in line with Saunders, Lewis and Thornhill (2000, p. 264) who remind us, 'Robson (1993) observes that a tape recording lasting one hour can take up to ten hours to transcribe'. The length of the interview depended on the participant. Several soon grew tired of talking, and this I accepted, and I did not force the situation if this was the case, but others continued on for the full hour. Occasionally, a participant would dry up but then start talking freely again after a short pause, but every participant had grown weary of discussion by one

hour. In this study the interviews were taped and transcribed and the recordings took approximately 230 hours to transcribe in total. The overall process of interviewing and transcription took approximately nine months.

5.9.8. Deconstruction methods used in IPA

Smith *Et al.* (2009), suggest that the deconstruction or de-contextualising of the data can help to reveal a more detailed focus on the participants' words and meanings, suggesting one possibility is to 'fracture' the narrative flow of the interview text, by reading the narrative backwards. They argue that this can help to distance the researcher from the 'words' themselves and towards the surrounding 'context' (Smith *Et al.*, 2009, p. 90). I applied this method to a limited number of extracts where I had success with one particular extract and I found that this method did seem to bring to the surface the repetitive use of certain words and to draw out emphasis to recurrent contextual themes in the data. I concluded that in further research projects I might apply this method again in a more detailed fashion.

5.9.9. How the data was analysed and written up

The data was analysed by reading the transcriptions again after the data gathering exercise had finished, then leaving the transcripts for a while and then revisiting them again and again, if necessary, until I felt I had understood and could feel comfortable that my interpretation was as close to the sentiment of the participants as possible. Furthermore, Smith *Et al.* (2009) remind us:

> Because the process of identifying emergent themes involves breaking up the narrative flow of the interview, the analyst may at first feel uncomfortable about seeming to fragment the participant's experiences through this re-organization of the data. This process represents one manifestation of the hermeneutic circle (Smith, Flowers and Larkin, 2009, p. 91).

This process was carried out on the transcripts once all of the transcripts had been transcribed, then the process of categorisation began, the themes that could be interpreted as having an alignment to the conceptual framework of Williams' two concepts, EA and SoF were abstracted onto a Master Table of Themes (see Appendix B). By transposing these to a frequency count table it became apparent just how connected and/or polarised the phenomena abstracted was, and to what extent there were 'patterns of connection' or 'polarisation', (Smith, *Et al.*, 2008, pp. 96–7).

For the write-up of the thesis, I drew on Lynch (2014), derived from Silverman (2013). I also used Willig (2013) and Oliver (2008), together with regular meetings with my supervisory team concerning iterations.

5.9.10.   The responsibilities of the interviewer

It is Hall (1974), who makes the observation concerning the huge responsibility a researcher faces in attempting to capture the fundamental message the participant is trying to convey, ensuring this is interpreted and articulated how the participant meant it to be. Hall (1974, p. 273) articulates through his own reflections the challenge of having to separate himself objectively from the primary source material in front of him, much of which he could easily have prejudiced with his own personal close proximity to the subject matter, sharing the same period in time and location as his research sample. In discussing the dramatic period of social change from the 1950s in post-war Britain, Hall sums up the importance, the responsibility, and the contextual challenges history poses to a cultural critic, especially when confronted with primary source material:

> I have tried to focus on what seem now to be major, powerful and significant strands in the period. But it remains, necessarily, selective, an interpretation – my interpretation, (Hall 1974, p. 274).

In this study, after the interviews had been completed, I could still visualise the faces and the voices, the times of emotion where participants shared experiences that they felt passionate about – moments I hoped that I would take forward for them as they wanted. Furthermore, my role as the interviewer in this research developed into one of conciliation. I began to feel the weight of the responsibility for this as the process went on. This research was carried out in a time of great change for the NHS and the organisation, with a high level of instability as a result of the neoliberal reforms implemented by the Conservative-Liberal Democrat Coalition after 2010. There were instances where the participants seemed eager to contribute to something that they valued as a way of documenting this turbulent time and their personal experience of it, comfortable that this would be anonymised. Furthermore, this is in line with Oliver (2008), who suggests when collecting data, '[t]hey [the participants] would also probably want reassuring that they would not be named in connection with the research, and that there would be no way in which the opinions they expressed could be associated with them personally', (p. 116).

5.9.11. Validity and reliability

I now wish to consider the validity and reliability of this study. Due to the nature of qualitative phenomenology and its reliance on interpretation, it is often suggested that in studies of phenomenology it may be more of a challenge to achieve validity and reliability than in a quantitative study which relies on numerically justifiable facts rather than interpretation, which is often criticised for its tendency to lean towards the subjective.

In seeking the advice of others, Smith, Flowers and Larkin (2009), turn to the

writing of Yardley, amongst others, defining the necessary requirement of

qualitative psychology to justify validity in qualitative IPA. Smith, *Et al.* (2009)

suggest Yardley (2008) offers a number of principles including the

'demonstration of sensitivity to context' in amongst the 'the socio-cultural milieu

in which the study is situated, the existing literature on the topic, the material

obtained from the participants' (Smith, *Et al.*, 2009, p. 180). Another of Yardley's

principles is 'impact and importance…a test of its real validity lies in whether it

tells the reader something interesting, important or useful. We think this is true

of IPA as well and that the IPA researcher should be aspiring to do this' (Smith

Et al., 2009, p. 181).

Willig (2013) suggests that a key difference between qualitative research

quantitative research is that the former is often carried out in real-life

environments rather than a 'laboratory', which eliminates the requirement to

relate simulated results back to the 'real-world' again (Willig, 2013, p. 24). And

Glaser and Strauss, (2012, Kindle Locations 426–428) suggests 'in generating

theory it is not the fact upon which we stand, but the conceptual category (or a

conceptual property of the category) that was generated from it'.

Validation of the interpretations of the abstracted data in this study also

concerns the use of the literature review, which in effect forms a secondary

source companion to this work allowing the examination of an otherwise,

'snapshot' piece, providing the contextual, historically seated comparisons

against similar events and experiences of the group in the case study. It could

also be argued this constitutes as Mellor (2001) observes ''double fitting',

(Baldamus, 1972, p. 295) '…[d]uring this process the data help build a theory

while at the same time the theory helps the researcher see the data in a new

light' (Mellor, 2001, p. 467). This also aligns to Wengraf (2001, p. 61) that 'theory questions must be distinguished from interviewer questions' as discussed earlier in the necessity to separate the interviewees' empirical evidence from the theory to avoid the directional influencing of the participants views.

Furthermore, the data has been corroborated through working with a coder at my University who crosschecked with me my various interpretations, concluding at times that the extracted data posed more than one interpretation, and that extracts could have easily been aligned to more than one of the deductive codes. Where this occurred, I relied upon what seemed to be the most powerful or overarching theme in the extract to take precedence and coded accordingly.

I find myself returning to the words of Stuart Hall and his observation concerning the interpretation of contemporary primary source material, where he reminds us: 'it remains, necessarily, selective, an interpretation – my interpretation' (Hall, 1974, p. 273).

5.9.12. Generalizability

This leads onto the question of generalizability, which in case studies is recognised as being a contentious one, however, Yin (2009) suggests a response to this dilemma:

> Case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study, like the experiment, does not represent a "sample", and in doing a case study, your goal will be to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization) (Yin, 2009, p. 15).

Furthermore, it seems that this is an area of qualitative research where there is still much to consolidate and as such, Willig (2013) suggests that the 'argument concerning the nature of generalizability in case study research has not been resolved'. She draws our attention to the view put forward by Alasuutari (1995, pp. 156–7), who suggests one possible solution is to replace the term 'generalization' with 'extrapolation' to refer to the ways in which 'the researcher demonstrates that the analysis relates to things beyond the material at hand', (Willig, 2013, p. 112).

In view of this, I would argue that in this study, the usefulness of the application of Williams' concepts as an a priori deductive coding system provides just that – a form of 'extrapolation'. Taking this into consideration, I would argue that the generalizability of this work and the conceptual framework and methodology used could be applied to other studies of groups of doctors, nurses and managers in other geographical locations in the NHS in England to extrapolate their views. I would also suggest the proposition that the design I have created using Williams' concepts could be used as a generalised tool in other qualitative research analysis where an understanding of the 'holism' is required in the ordering of disparate views and perspectives.

Moreover, Williams' fascination with 'holism', concurs with Willig (2013) who suggests that case study research accepts that 'the world is a complex place…where…experience or behaviour are never expressed in predictable or uniform ways…a holistic *perspective*…Thus case study research perceives the world as an integrated system that does not allow us to study parts of it in isolation' (Willig, 2013, p. 110).

However, I think that the final word here should go to Cornel West, who observed how Williams provides us with 'indispensable analytical tools', (West, 1992, p. 8), already discussed in this thesis, and this is why I argue that Williams' concepts are so generalizable and so transferable. His synthesis of ethnographic anthropology which encompasses the various historical epochs and their influences on society, its sociology and cultural development, all lean to the generalizability of his concepts as analytical tools in social science research.

5.10.   Limitations of the methodology

There are a number of limitations that needed to be considered in this research study, one of which aligns with the ethnographic dilemma suggested by Oliver (2008, pp. 114–15). For example, working in the environment where you are carrying out the research can lead to a lessening of objective acuity due to overfamiliarity with the research subject, but conversely it can also lead to valuable insights that those outside of the environment would be unaware of.

This was a concern in this study. As I have discussed earlier, I was also part of the organisation in which I carried out the research, however, all the participants that I interviewed I did not work with on a daily basis and, as such, our contact together was minimal. This helped reduce the risk of overfamiliarity. In addition to this, a phenomenon occurred where the participants seemed to distance themselves as they gathered together their thoughts to give as detailed and as uninterrupted account as possible. It seemed that, in most cases, it became a performance on the part of the participant and I became the support as the audience, and as such a new relationship occurred for the duration of the interview. This, I think, was not a limitation and sending the preliminary material to the participant before the interview date, (see Appendix D), together with a

discussion with the participant just before the interview began acted to prepare the participant for what was to become their performance.

However, notwithstanding the cautiousness of using case studies in qualitative research as already discussed in this chapter, I would argue the overall strengths of the methodology far outweighed any weaknesses. However, perhaps the greatest oversight of this study, also previously discussed in this chapter, was the sheer volume of data gathered in relation to the level of detailed analysis required. With interviews that lasted on average between 30 minutes and an hour, this created an almost overwhelmingly large amount of data to be transcribed which took between eight and ten hours to do for each interview, creating an almost impossible timeframe to abstract data onto the Master Theme Framework (see Appendix B). On reflection, I contemplated whether a smaller group would have been more appropriate and, as already discussed in this chapter, concerning 'less is more', and the critical mass required in research using IPA, suggested by Smith (2004, as cited in Reid, Flowers and Larkin, 2005, p. 22). Conversely, I could have used 'computer programs such as SPSS and NVivo' (Wisker, 2008, p. 319), but I am not convinced that this would have helped with the interpretation of the data. Using Smith, Flowers and Larkin's (2009) notational text coding system, discussed earlier in this chapter, in hindsight, this added little in relation to this study as almost all of the participants' contributions fell into all three areas contained in the notational system: 'descriptive, linguistic and conceptual'.

Finally, the turbulent nature of the NHS at the time I conducted the research, the cutbacks and redundancies due to another round of restructuring in the wake of reforms by the Conservative-Liberal Democrat Coalition government from 2010, meant that several opportunities were missed to interview key NHS

personnel, who left prior to national ethics granting permission. As already mentioned, the lengthy process required by national ethics, which took seven months, formed the missed opportunity for a 'pilot' testing interview phase, which may have provided valuable insights and lessons into how to adapt several of the research instruments or discard them altogether in this research.

In this chapter, I have discussed the rationale for the chosen methodology – IPA – as an inductive methodology and the development of a hybrid, with a deductive a priori theoretical orientation using two concepts of Raymond Williams (1977). I have discussed alternative methodologies, those within the camp of phenomenology and also outside of this – for example, positivism. I have discussed access issues, ethical procedures and the time considerations these involve and the dangers of research bias in qualitative phenomenological research and the recognised potential pitfalls of using a case study. I have also discussed the interview and transcription process as well as the write-up process and issues of validity, reliability rigor, and also generalizability of this research. Finally, I considered the limitations of the methodology and in the next chapter I discuss the research findings and analysis.

6. Findings and analysis

The previous chapter discussed the construction of the methodology and the research process. This chapter describes and analyses the findings of this research. I begin with an overview of how the interpretation was made and how the conclusions will be formulated from this. The majority of this chapter is dedicated to a discussion concerning the interpretation of various abstracted extracts from the transcripts and in what ways these align to Williams' two concepts: EA and SoF – the theoretical orientation for this research study, already discussed in Chapter 2, as well as the relationship the abstracted phenomena has to the secondary source material already discussed in Chapters 3 and 4 of this thesis.

To recap on discussions in the last chapter, the data was gathered through interviews carried out in the NHS in a primary care setting, between 2012 and 2013, using one-to-one semi-structured interviews based on an IQ (Wengraf, 2001) with a group of doctors, nurses and managers, collecting 27 transcripts in total. I abstracted the themes from the transcripts onto the Master Table of Themes (see Appendix B) (Smith *Et al.* 2009), highlighting various extracts, which were connected or polarised in nature.

The interpretation was undertaken by coding the phenomena abstracted against the a priori deductive coding system adapted from Williams' two concepts. Firstly as a 'superordinate' theme, and then dividing this into further subordinate sub-theme categories after that. The superordinate theme structure, EA and SoF, were used as the overarching superordinate theme structures in this analysis and, in addition to this, the subordinate themes were incorporated. Under EA, the 'dominant' (D), 'residual' (R) and 'emergent' (E);

and under SoF, 'changes of presence' (CoP) and 'differentiated structures of feeling to differentiated classes' (DSoFtDC) (see Appendix E).

In this study the interpretations are primary, however whilst reading the extracts some had the potential to span across either of Williams' adapted concepts. However, it is the primary interpretation that is the focus, where the voice heard can reasonably be interpreted as connected or polarised in nature even in its embryonic form.

Concerning the question of validity and reliability of the data I return to my earlier discussion in Chapter 5 of this thesis. It is Smith *Et al.* (2009, p, 181) who observes Yardley (2008) and her principles which test the validity as being whether the data essentially provides 'something interesting, important or useful'. (Smith *Et al.*, 2009, p. 181). The validity and reliability in this research stems also to an extent from its companion secondary source material contained in the literature review of this study, which underscores what Willig (2013) suggests is the contrast between qualitative research and quantitative research, in that qualitative research more often than not involves real-life environments rather than a laboratory conditions and as such qualitative research environments reflect what has actually happened rather than what has been simulated or supposed, (Willig, 2013, p. 24).

Furthermore, as previously mentioned in Chapter 5 of this thesis the data has been corroborated through working with a coder at my University who crosschecked with me my various interpretations, concluding at times that the extracted data posed more than one interpretation, and that extracts could have easily been aligned to more than one of the deductive codes. Where this

occurred, I relied upon what seemed to be the most powerful or overarching theme in the extract to take precedence and coded accordingly.

That said, again I find myself returning to the words of Stuart Hall concerning the subjective nature of interpretation: 'it remains, necessarily, selective, an interpretation – my interpretation' (Hall, 1974, p. 273).

As already discussed, all of the interviews took place either at the PCT in a private room, or in a private room in the surgery where I work. The interview and transcription process took approximately nine months to complete. The following extracts are the result of the face-to-face discussions I had with 27 doctors, nurses and managers who all work together in one form or another, whether in the same building or the same district, or have other connected work relations. The following discussions represent my interpretation of the participants views recounted to me in the interviews.

In the remainder of this chapter each extract will be discussed, along with a rationale for its interpretation against one of Williams' two concepts – EA or SoF – and what is the impact of neoliberal reform in the NHS on the case study group of doctors, nurses and managers in this research.

6.1. 'Epochal' analysis (EA) – Superordinate theme

6.1.1. Subordinate – Awareness of dominant culture (D)

In extracts 1 and 2 below, I discuss the themes abstracted from the data which are interpretative of an awareness of the D culture within Williams' EA (1977) amongst the group in the case study.

Extract 1 – Awareness of dominant culture (D)

> "I think there is an inherent tension between some doctors and nurses, I have witnessed that some senior nurses are feeling ermm…there is a feeling, I think, that some nurses think that some doctors feel they [the nurses] need to prove themselves and there is a tension I think sometimes with this."

Stuart – clinical other (ref 61/4)

In this extract, Stuart has observed the tensions between the doctors and nurses whilst in meetings with them. Stuart suggests that the doctor/nurse relationship is such that the nurses feel that they need to 'prove themselves'. This is an indicator of the hegemonic control the medical profession has through its dominant relationship with the nurses (Soothill and Mackay 1990; Hughes 2010).

Whilst nursing had made thwarted attempts to define a closure system of their own at the turn of the twentieth century (Witz, 1992, p. 127), this was actualised much later (*Nurses, Midwives and Health Visitors Act*, 1979) (Bradshaw, 2001, p. 14). Moreover, with subsequent government-mediated initiatives (Department of Health 1987; 1997) this acted as the main catalyst to the professionalization of nursing during the 1980s and 1990s in the NHS. However, it seems in the extract from Stuart that the traditional dominant/subordinate relationship is still evident between the medical profession and nursing (Rivett; 1997) and (Bradshaw; 2001).

Through the lens of Williams' EA, this may be interpreted as an awareness of the D culture which is representative of behaviour of the doctors. In this extract the doctors' reaction is to form a challenge to the nurses to 'prove themselves' (Hughes; 2010) otherwise the nurses will not be incorporated into the

hegemony dominated by the doctors (Weber, 2009). It may also be argued here that this is representative of Williams' notion of 'selective tradition', where the dominant culture will deploy measures to supress or exclude those who oppose it until assimilation into the dominant culture is achieved. (Williams, 1977, p. 123).

Extract 2 – Awareness of dominant culture (D)

> "What they used to do; still do get, and it's not so much to do with the internal market it is more to do with professional rivalry, I think, between certain doctors…and nurses for that matter…obviously consultants feel that they are the very best in their field actually hospital doctors in general ermm… so, I think, I think there are tensions, particularly when it comes to kind of collaborative working and integrated working."

> Ben – non-clinical manager (ref 83/22-30)

In Extract 2, Ben is certain that doctors in general display a high level of professional rivalry. He refutes that this has much to do with the neoliberal reforms in the NHS, and instead suggests that this has more to do with historical cultural practice within the medical profession itself, through the traditionally elitist attitude that many of those in the medical profession still promote, and this has an impact on many of the doctors' day-to-day ability to work successfully in intra-occupational collaborative teams in the modern NHS. Ben explains that this manifests between sectors, in the secondary care sector and also the primary care sector, within the hospital itself between the junior doctors and consultants and between consultants and GPs in primary care.

Furthermore, the secondary source review carried out for this thesis revealed evidence of intra-occupational rivalry and occupational tribalism noted as far back as the Guillebaud Report (1956) (quoted in Allsop, 1995, p. 44 and Baeza, 2005, loc 185), and Shaw (1908) (Susskind and Susskind, 2015, p. 28) and

Brooks (2009) and the view that 'NHS staff often refer to the inherent 'tribalism' of their service' (p. 261). However, Ben's example raises questions over some of the observations by Johnson (1972) concerning the colligate behaviour of the medical profession. Furthermore, this also raises questions concerning the successfulness of clinical 'leaderism' as a methodology by which to encourage doctors into management roles in the NHS. Thorne (1997) and (O'Reilly and Reed 2011, p. 1089–90). Whilst they suggest 'leaderism' has emerged out of the constructed topology and terminology of hybridization of two other modernising discourses –'managerialism and professionalism' – where the language of managerialism and leadership has been couched in such a way as to enable doctors to assimilate into management roles in the NHS. Ben's example suggests that to the contrary, both doctors and nurses are capable of intra-occupational rivalries which have the potential to hinder collaborative working in the same way as inter-occupational rivalries between clinical and non-clinical personnel can, those suggested by Degeling *Et al.* (2003), and as such this throws a significant element of doubt over the whole efficacy of clinical leaderism over other leadership and management models in the NHS.

Furthermore, it could be argued that Ben's extract demonstrates that there are still considerable hurdles to overcome concerning the successful uptake of the new initiatives introduced much more recently, where attempts to hybridize clinical and non-clinical roles across organisational and occupational boundaries have already been met with some resistance from traditional dominant hierarchies in the NHS (Gilburt, 2016).

Ben's extract is also suggestive of an indicator of an 'awareness of dominant culture' in nursing practice too. Certainly, as nursing began to professionalized during the 1980s and 1990s (Department of Health 1987; 1997), a new dynamic

manifested within the ranks of nursing where the traditionalists – those nurses who did not welcome collaborative working initiatives between doctors and nurses – resisted modernisation initiatives. (Bradshaw, 2001, p. 14). Therefore it could be argued this formed actions of intra-occupational rivalry, which developed between senior and junior nursing staff, and may therefore align to (Mavin *Et al.*, 2006) who observe that the dominant behaviour of women in senior business positions towards other women in subordinate positions expressed the 'the contradictions of solidarity behaviours versus queen bee behaviours' (Staines *Et al.*, 1973; Abramson, 1975; cited in Mavin, 2006, p. 349).

Ben's extract, through the lens of Williams' EA, has been interpreted as an awareness of the D culture. In both the case of the doctors and the nurses that Ben describes who reinforce aspects of 'traditional' practice within their own occupational group to maintain the status quo. This can be argued as exhibiting the tendencies described in Williams' notion of 'selective tradition', where the 'dominant' culture strives to force any opposition into assimilation through 'reinterpretation, dilution, projection, discriminating inclusion and exclusion' supresses beliefs and practices which the 'dominant' culture wishes to exclude for specific reasons (Williams, 1977, p. 123).

Extract 3 – Awareness of dominant culture

> "Ermm 1980s I…I had just qualified in 1979, 1980s I got my first sister's post on an acute ward in cardiology, ermm…

> "…The reason I got that post was that, ermm, I'd decided I would go off and do a course in cardiac care, but the nursing officer at the time felt that it was totally inappropriate for a nurse to go and do extra training…

"…Anyway, I went off and did this training and there were only about three of us, ermm and it was a totally new thing to do, before that you just went and did your SRN training and did your nursing and didn't specialise in anything…

"…The sister in charge said, 'Did I think I was going to be a doctor?'"

<div align="right">Carol – Registered Nurse (ref 28/2-5)</div>

And…

Extract 4 – Awareness of dominant culture

"A consultant led the course and he [the doctor] was very proactive and forward thinking and thought this was the way to go, although I must admit some nurse colleagues felt a little bit disgruntled that this sort of new type of nurse was coming forward."

<div align="right">Carol – Registered Nurse (ref 18/6)</div>

Extracts 3 and 4 appear in the same transcript from Carol. Although these two extracts relate to two different episodes in Carol's life, they happen at roughly the same time in her career. These two extracts have been interpreted as connected phenomena using IPA (Smith, *Et al.*, 2009) and abstracted as such.

Firstly, in Extract 3, Carol describes her personal development, and my comments in the initial noting process (Smith, *Et al.*, 2009) indicate Carol's emotion and frustration at how she felt she was being held back, even though this was some time ago, in the 1990s. Furthermore, when interviewed, she was still utterly perplexed by the negative response she had experienced from the senior nurse in charge. Carol, as the subordinate nurse, found the attitude of the nurse in charge intentionally vindictive. Again in Extract 4, Carol is shocked by the negativity she experienced from the member of the senior nursing staff and sees this behaviour as an attempt to curtail her progression into new areas

of nursing practice. This arguably has a relationship to 'solidarity behaviours versus queen bee behaviours' (Staines *Et al.*, 1973; Abramson, 1975; cited in Mavin, 2006, p. 349) mentioned earlier.

Both extracts are coded as being part of a D element within Williams' EA, because the behaviour of the nurse in charge towards the junior nurse (Carol) is characteristic of dominant/subordinate relations. It may also be argued that this is indicative of the 'masculine/feminine principle' and the way in which senior nurses demonstrated 'masculine' behaviour towards their junior nursing staff. (Remen *Et al.*, 1975, pp. 30–31).

Furthermore, through the lens of Williams' EA it could also be argued that Carol's experience is indicative of 'tradition' as the driving force behind much of the behaviour by the senior nurse towards Carol. This resonates with observations by Bradshaw (2001), who suggests there were pockets of resistance which occurred where many in nursing practice during the 1980s and 1990s rejected the development of professionalised nursing away from its traditional vocational role. (MacGuire 1961; Marsh and Wilcox, 1965; Dutton, 1968; Singh, 1970, 1971a, b; Singh and MacGuire, 1971; Parry-Jones, 1971; cited in Bradshaw, 2001, p. 14). Moreover, through the lens of Williams' EA this represents what he suggests is the power of tradition, where 'tradition is in practice the most evident expression of the dominant and hegemonic pressures and limits' (Williams, 1977, p. 115). This concurs with Shils, who describes it as the 'inertial force which holds society in a given form over time'. (Shils, 1981, p. 25; quoted in Jacobs, 2007, p. 143).

6.1.2. Subordinate – awareness of residual culture (R)

This section discusses the themes abstracted which I have interpreted as being part of 'an awareness of residual culture' within Williams' EA (1977). R elements represent the meanings and values that coexist with the D culture and are 'lived and practised' but are part of some previous formation or tradition. The R elements are in 'limited respects alternative or oppositional', but will not substantially challenge the 'dominant culture', yet will resist incorporation into it (Williams, 1977, p. 122).

In the next five extracts are themes which are connected using the methods of abstraction suggested by Smith *Et al.* (2009). Whilst it is possible to connect these phenomena it is clear that the five extracts are from different perspectives, however they have all been interpreted as being representative of an 'awareness of a residual culture', which in this case is demonstrative of forms of a resistance to change, or alternatively, observations of this behaviour.

Extract 5 – Awareness of residual culture

> "So, the people who are taking on a lot of these roles used to work on the front line and don't necessarily have management training or any education in management…Have taken on these roles, it makes it quite difficult to work with them because they don't grasp which role or which hat they are meant to be wearing at that time."

And…

> "I would say, probably, most managers in the PCT have never had management training!"

> > Lilly – manager and former nurse (ref 53/102)

And…

Extract 6 – Awareness of residual culture

"I think there are multiple hierarchies in the NHS because of the professional bodies, obviously doctors are part of one professional body, nurses another, managers usually aren't part of the professional body, but some of them may be doctors and nurses ermm…so I think there are parallel hierarchies that can make things ermm difficult."

<div align="right">Stuart – clinical professional (other) (ref 61/3)</div>

And…

Extract 7 – Awareness of residual culture

"They are getting all the power completely [GPs], which is what they want, like I said, some of them are trying to almost flaunt that, we [the GPs] can go up to the PCT laughing saying we have all the power…"

And…

"…But ultimately, the power comes back to the PCT."

<div align="right">Beth – non-clinical manager (ref 63/57 and 45)</div>

And…

Extract 8 – Awareness of residual culture

"Ermm…they [doctors] didn't have much control over what was going where, and we could put tighter reins on it you know, and we did that exercise with other clinical providers and consultants."

<div align="right">Betty – non-clinical manager (ref 64/28)</div>

This group of extracts, although from different perspectives, have all been interpreted as part of the same element, the R in Williams' EA. The 'residual' element will oppose the 'dominant' culture not to the stage that it becomes an emergence against the 'dominant' culture yet the 'residual' will resist incorporation into the 'dominant' culture. (Williams, 1977, p. 122).

Extracts 5 and 6 above are a connected theme set, Lily and Stuart, although they come from different backgrounds within the NHS, they are both from clinical backgrounds originally. In these two extracts it is interpreted that the participants observe the effects of a 'residual' element. Firstly, Lily and Stuart both feel very strongly that there is no clear, regulative governing body or mandatory training for managers in the NHS, as is the case for medicine and nursing. Both participants question the whole issue of the professional status of the manager in the NHS, questioning the whole lack of parallel hierarchy that exists for non-clinical management. Both Lily and Stuart seem to imply that this is a remnant of a epoch - the neoliberal reforms initiated by the Thatcher government in the 1980s spearheaded by the Griffiths Report in 1983, which clinicians perceived as the embedding non clinical management as belligerent agents of change, (Learmonth 2001; 2005 as cited in Gorsky, 2008, p. 446) but also as interlopers with no comparable professional prominence. Lily and Stuart think that management culture in the NHS lacks the regulatory controls expected of the other two groups, and that this 'can make things…difficult'. As the doctors and nurses are critical of a management structure which lacks comparable regulatory monitoring and control and this echoes the writings of Mintzberg (1989) and Barker (2010) and questions whether management can be classed as a profession.

In the next two extracts, 7 and 8 Beth and Betty are both non-clinical managers and their perspective contrasts to that of Lily and Stuart. In these two extracts it has been interpreted that Beth and Betty enact a 'residual' element because of their resentment of the dilution of power and control of managers in favour of GPs after the reforms of 2010 (Department of Health 2010). Beth and Betty regardless of the GPs holding the D role in the NHS, believe that managers

remain powerful because they are the only group who have experience in the operational and strategic organisational processes, and they are the group who still monitor quality and improvement measures in the organisation. This resonates with Brooks (2009, p. 241) and the 'covert power' managers hold through the control of the dissemination of information in organisations. Furthermore, Beth and Betty express their views that whilst the GPs who have recently been given power over the commissioning of primary care services in England (Department of Health, 2010 and Glennerster, 2015, p. 315) the managers still attempt to hold on to elements of 'residual' power, in the face of change because at that point in time they are the ones be placed in the knowledge of NHS processes and operations.

At the time of the interview recording, the management structure in the NHS was showing severe signs of abatement in the wake of the seismic restructuring of the organisation implemented by the coalition government (Department of Health, 2010). However, Beth and Betty are proud that as managers they still hold an ultimate sanction over the medical profession, as the custodians of the management instruments of audit and performance monitoring, a legacy of the Griffiths recommendations of 1983. (Harrison and Ahmad 2000, p. 134; as cited in Gorsky 2008, p. 446).

I argue that through the lens of Williams' EA, what Lily and Stuart describe is a remnant from the past, a period in NHS history which still affects the NHS as an organisation today. Arguably, through the lens of Williams' EA it is an R element which is affecting the D culture. Furthermore, part of the impact of the Griffiths Report (1983) – the removal of the consensus model of administration in favour of a general management structure – was intended to act as an agent for change. (Learmonth 2001, 2005; as cited in Gorsky, 2008, p. 446). However, it

is suggested that little impact was made on the traditional hegemony of the medical profession. (Harrison and Lim 2003; cited in Gorsky, 2008). Whilst Griffiths brought change, it also arguably forged a fault line between management and the medical profession in the NHS which endures to this day (Dopson 1997; Rivett 1997).

Through the lens of Williams' EA, Beth and Betty's reaction and attitudes are interpreted as R behaviour bringing forward R beliefs and practices into the present culture, an R culture which harks back to Griffiths as Harrison (1988, p. 16; as cited in Gorsky 2008, p. 446) reminds us heralded an end to the days of '"consensus management", whereby health authority decisions required approval by a multidisciplinary team'. In the interpretation of Beth and Betty's extracts the R element forms a resistance to the D culture which by 2010 had been returned to the medical profession or rather the GPs (Department of Health 2010). Management had become at that point in time a 'displaced' management culture with the imminent removal of the PCTs in favour of Clinical Commissioning Groups (CCGs). (Gorsky, 2011, p. 4).

By applying Williams' lens the thoughts and attitudes expressed in the above four extracts have been interpreted as part of an 'awareness of the residual culture'. The emphasis is on the management function in the NHS becoming one of a somewhat concealed recalcitrance in the face of neoliberal change in 2010 (Department of Health, 2010), and if we consider this in relation to the extracts from Stuart and Lily, and their condemnatory view of the management function in the NHS at that point, it can be argued that a classification of the management function as being an R element, neither acting as clinical support in a tradition (pre-Griffiths sense) nor being truly effective as a radical agent for change (in a post-Griffiths sense), (Dopson *Et al.,* 1997), or for that matter even

being accountable, we can see that whilst management is still exerting influence on the other occupational groups in the case study, the influence is of a 'residual' nature as opposed to any form of overt dominance or future emergence.

6.1.3. Subordinate – Awareness of emergent culture (E)

In this next section I explore some of the extracts that I have interpreted as being E elements. As discussed in the theory chapter of this thesis Williams says the emergent elements of a culture are those which are 'substantially alternative or oppositional…rather than merely novel (Williams, 1977, p. 123).

However, because the E is new, it is far less obvious and so far more challenging to identify. As Williams suggests, 'emergent elements do not carry any identifying social history' (Williams, 1977, p. 124). Therefore, it is argued in this thesis that this is the most problematic element to interpret.

Extract 9 – Awareness of emergent culture

> "When the internal market was brought in it changed the WHOLE picture of the NHS…
>
> "…People started competing, the private sector was involved…Fundholding was introduced."
>
> Ajam – clinical doctor (ref 80/15-17*)*

In this extract, Ajam, a doctor, is adamant that the introduction of the internal market changed the whole dynamic in the NHS (*National Health Service and Community Care Act*, 1990). My initial noting indicates that Ajam is excited that something new and different was happening and he felt part of it, and regarded it as an opportunity to make a difference. However, this is viewed as a ramification GP fundholding (Palmer, 2005, p. 380), that the new found nature

of competition in the general practice had impacted on the stability of the acute sector with some winners and losers. For Ajam the impact of this particular neoliberal policy reform, the introduction of the purchaser/provider split was a positive move for him personally and for the organisation as a whole, a chance for him to grasp new opportunities and the ability to engage in competition through GP fundholding, all of this was viewed with excitement, emanating from neoliberal moves to encourage the marketization of the NHS after 1979 (Whitfield, 2006 and *National Health Service and Community Care Act*, 1990).

This concurs with Harvey (2005) who points to the intended nature of neoliberalism, that it promotes 'individual freedom' (Harvey, 2005, p. 5; Friedman, 1962). However, according to Gilbert *Et al.* (2014) a pessimistic view of this is that the ideology of neoliberalism sought to systematically reassign British cultural behaviour to strive to be over-competitive as the 'normal model for all types of social interaction'. (Bauman 2001, Curtis 2013; as cited in Gilbert, 2014, p. 30).

Extract 10 – Awareness of emergent culture

> "So in doing this you were, you were saying we need the clinical thinking, but actually there is a group of people who may have been clinicians or may not have been…Who began to develop and carve out this professional manager role…"

> Frankie – Manager (Ref 11/22-23)

And…

Extract 11 – Awareness of emergent culture

> "Once there were no managers…nowadays in hospital wards the nurses have changed to managers! Deputy managers, and there are more managers than nurses!"

And…

Extract 12 – Awareness of emergent culture

"In the '80s, the NHS was MOSTLY run by doctors…I remember the good old days when the hospital Chief Executive used to be a consultant, used to work as a medical consultant or surgical or depending on his speciality but, at the same time, also was the head of the hospital…

"…There were no Chief Executives, no directors, and not many of the other civil servants that we have now. It worked to some extent and the consultants cooperated with him…they planned things together… there used to be committees where the primary care people were the GPs and they used to set the whole programme for a year in advance…

"…I MUST SAY that they did RULE but at the same time the nurses were out of the picture to a great extent…

"…THEIR job was NURSING! And you knew what NURSES meant!...

"…The doctors do the rounds, the nurses used to come and support us and work to instructions we left, the nurses made sure this was carried out…

"…So, as a group, it worked very well because it was a doctor, nurses, auxiliary staff, clerical staff…WE had secretaries where the letters were dictated, were typed and they were signed by the doctors and were sent to the GPs…

"…There were not many civil servants and there were not many directors and Chief Executives floating around with clipboards."

Ajam – clinical doctor (ref 79/2-11)

In these extracts, which I have interpreted as an 'awareness of an emergent culture', Frankie, in Extract 10 describes how she had taken the opportunity to develop her career following her appointment as a manager. This opportunity

emanated from the neoliberal reforms in the NHS in the 1980s, during which time Frankie felt encouraged to move away from her substantive post as a nurse to a role as a hospital manager. Conversely, Ajam, the doctor in Extract 11 views this sort of migration from clinical roles to management roles as being detrimental to the status quo of the medical professions' dominant hegemonic position in the NHS, and to the organisation as a whole.

The initial noting in Frankie's extract indicates she viewed her move from a nurse to a manager (although she observes clinicians and non-clinicians took up this challenge) as the pivotal moment in her career. For her this was a turning point when she was able to circumvent the hierarchical dominance held by the doctors, in favour of a new management role as part the expanding management structure in the NHS. Traynor (1997), Wicks (1998) and Hughes (2010) consider the often 'artful', strategies, deployed by nurses 'to carve out significant areas of practice within the dominant power relations'. (Wicks, 1998, p. 5). This is a positive experience for Frankie, who views this as an emergence for her, where she can as she says 'carve out this professional manager role'. Furthermore, it can be argued this points to the intended nature of neoliberalism, that it promotes 'individual freedom' (Harvey, 2005, p. 5; Friedman, 1962).

In Extract 12 Ajam the doctor provides the counterpoint to Frankie: Ajam nostalgically recalls how he remembers the NHS operating in the early 1980s prior to the changes brought in with neoliberal reform by the Conservatives. This is a nostalgic look back by Ajam at the 'traditional' hierarchical structure he remembers as working very well. Ajam regards a particular version of the past which he remembers as a time when nurses carried out the traditional nursing function and were subordinated to the medical profession (Bradshaw *Et al.*,

2001) and when administrators carried out what was purely a support function to the doctors (Dopson 1997; Rivett 1997). In Ajam's view these are all erosions of medical jurisdiction (Abbott, 1988). Ajam's observations do not necessarily form part of any attempt at de-professionalization/proletarianization theses observed by (Freidson *Et al.*, 1994*)*. However, it could be argued that his observations chime with Causer and Exworthy (1999, p. 83), and ramifications of the fragmentation of roles in the NHS through 'hybrid roles'.

It could also argued that the frustration Ajam experiences here expands the debate over a politicized or de-politicized NHS which has been examined and revisited by leading industrialists and politicians alike, (Moorcroft 2000 and Hawkes 2007).

Through the lens of Williams, extracts 10 to 12 are interpreted as an awareness of E culture. These extracts are indicative of emergence evocative of either positive or negative connotations for those involved. Ajam feels threatened at the prospect of nurses becoming managers, whereas Frankie, is excited at the prospect of empowerment that her new role away from the direct control of the doctors may bring. Therefore, arguably these extracts describe experiences which amount to two sides of the same coin, the perception of neoliberalism, where one side carries the excitement of competition and the possibility of success for those willing to take the risk, and the other the disadvantages associated with lack of control that competition poses to the status quo, and this perhaps typifies the impact of neoliberal reform in the NHS interpreted in this study.

Extract 13 – Awareness of emergent culture

> "My recollection; I understood the purchaser/provided split more than the staff who were there because they were wrapped up in a district general hospital culture."

<div align="right">Colin – non-clinical manager (ref 67/3)</div>

I interpreted this extract as an 'awareness of emergent culture'. Colin anticipates that he will apply the knowledge he has gained working in primary care about the purchaser/provider split to his advantage in areas of work where colleagues in the hospital sector in the NHS are not as knowledgeable, because Colin felt that they were not as close to the changes (*National Health Service and Community Care Act*, 1990) and that this changed the culture of the NHS and how individuals worked with each other, acting more competitively towards each other (Ham *Et al.*, 2009, p. 45). Furthermore, this also chimes with Papadopoulos, Stephenson and Tsianos (2008, as cited in Gilbert 2014, p. 45) that neoliberalism developed the reassignment of society to prize competitive behaviour as a strong asset over any form of (weaker) collaboration. This also supports the view of Harvey (2005) who suggests, neoliberalism personified the 'corporatization, commodification, and privatization of hitherto public assets has been a signal feature of the neoliberal project', (Harvey, 2005, p. 160).

6.1.4. Summary

In summary, out of a total of 27 doctors, nurses and managers interviewed in this case study I abstracted 13 extracts from transcripts which I interpreted as aligning to Williams' concept, EA, which were interpreted as either the D, the R or E elements of culture (Williams, 1977).

The D element appears to demonstrate that some in the case study group relied on 'tradition' to actively maintain the established order, and this agrees

with Shils, (1981, p. 25; as quoted in Jacobs, 2007, p. 143). Most in the dominant group relied on Williams' notion of 'selective tradition' (Williams, 1977, p. 123) used to apply pressure on any opposition to assimilate it into the dominant hegemony. This was exercised by doctors wishing to control the impact of nursing attempting to enter into their already well-established social closure system based on methods of 'group monopoly' (Weber, 2009).

Furthermore, the D element was indicative in the form of intra-occupational rivalry manifesting within the medical profession, between secondary and primary care sectors, as well as the ranks of nursing. And an interpretation was made here suggesting a D element had manifested between the junior nurse who felt that she had experienced a level of intra-occupational rivalry in the 1990s directed towards her by the senior sister in charge on her ward. (Bradshaw, 2001).

Concerning an awareness of an R culture, this element was aligned to a number of aspects concerned with the legacy of the Griffiths Report (1983). Two abstracted extracts were indicative of this, concerning how members of the management team felt that the de facto position for them, post the coalition reforms of the NHS in 2010 (Department of Health, 2010) was to develop a covert resistance to the new CCGs led by local GPs in the area.

Furthermore, awareness of an R element was interpreted in the responses of two clinical managers who felt strongly that the general management structure in the NHS was poorly developed with no clear management professionalised body parallel to that of medicine and nursing, and this agrees with the writings of Mintzberg (1989) and Barker (2010).

An 'awareness of 'emergent' culture' was indicative of both positive and negative indicators relating to this element. These abstracted extracts aligned to the organisational cultural reassignment in the NHS undertaken during the introduction of the internal market as part of the neoliberal reforms under the Conservative government at the beginning of the 1990s (*National Health Service and Community Care Act*, 1990). These extracts were recognised as part of the E behaviour as a result of neoliberal notions of individualisation and competition, observed by Gilbert *Et al.* (2014).

However, an 'awareness of emergent culture' produced diverse indicators in relation to the impact of neoliberal policy reform in the NHS. This concerned positive notions of E empowerment as a result of the growth in management function and the opportunities this posed especially for nursing at the time in the mid-1980s (Traynor, 1999), despite E elements which manifested as negative thoughts concerning the effects of neoliberal reform on the traditional dominant hierarchy of the medical profession, and the potential harmful effects on its jurisdiction in the longer term (Abbott, 1988).

I have now reached the end of my interpretation of the abstracted data concerned with Williams' EA. In the next section, I will discuss the findings which I have interpreted as relating to Williams' SoF. Adapted as a superordinate theme structure in this research to identify how various feelings exhibited by the participants can be interpreted in relation to the two subordinate theme structures, CoP and DSoFtDC, where in this case 'classes' relates to groups in this study.

6.2.   'Structures of feeling' (SoF) – superordinate theme

The remainder of this chapter describes and analyses those abstracted extracts and themes which align to Williams' SoF, introduced in the theory chapter of this thesis. Williams describes SoF as 'defining a social experience which is still *in process'* (Williams, 1977, p. 132). In this research I have adapted SoF with an emphasis on Williams' text on CoP and also DSoFtDC.

6.2.1. Subordinate – changes of presence (CoP)

Within SoF Williams distinguishes CoP as being the very moments when changes of feeling occur, as Williams suggests:

> *[C]hanges of presence*…although they are emergent or pre-emergent, they do not have to await definition, classification, or rationalization before they exert palpable pressures and set effective limits on experience and on action (Williams, 1977, p. 132).

 In the next three extracts I discuss the phenomena abstracted in the data which I interpret as aligning to Williams' 'changes of presence', illustrating where I have interpreted participants' sense the beginnings of change, or change that has already happened, yet has perhaps not been fully recognised until self-reflection has suggested this to be part of a wider heteronomous imposition that may have already taken affect, thus altering the perception of the change.

Extract 14 – Changes of presence (CoP)

> "No nothing we just, you know…it all stood still, ermm…I think a lot of the problem from our point of view, a lot of the nursing stuff went on completely without input from us the GPs…

> "…So that the PCT spent huge amounts of money on nurses for this, nurses for that, I've got no problem, but they were all facing the wrong

direction and they weren't communicating with the GPs, so they were absolutely no use to us."

<div align="right">Douglas – clinical doctor (ref 30&3/40-41)</div>

And…

Extract 15 – Changes of presence (CoP)

"Then that all seemed to be taken away and it is only really quite recently because ermm…of commissioning and GPs are saying we want to know our nurses, we want to work together, that all of a sudden they have been allowed ermm…"

<div align="right">Carol – nurse (ref 86–103)</div>

Both Extract 14 from Douglas and Extract 15 from Carol describe changing events witnessed by participants concerning the neoliberal policy reforms designed to develop autonomous caseloads for nurses and nurse prescribing (Department of Health, 1987; 1997 and Rivett, 1997; Bradshaw, 2001). In the initial noting Douglas is 'emotional' about this; he feels that the government had gone about this in such a way that nursing teams in general practice no longer report to GPs, and as Douglas observes the nurses had 'gone in a different direction with no input from us [doctors]'.

Using a method of deconstruction suggested by Smith, *Et al.* (2009), reading the extract back to front, 'words and the meanings are isolated and so the process focuses on what is said and not what you think the participant is saying', (Smith, *Et al.*, 2009, p. 90), I carried out this process and by doing it fractured the textual flow and revealed the emphasis of 'we', 'our' and 'us'. This suggested how clearly Douglas felt that he should retreat into the colligate protection of the medical profession. (Johnson, 1972, p. 45) and the closed

mechanisms of monopoly the medical profession relies on to maintain control (Weber, 2009, loc 860) and (Freidson, 1994).

Extract 15, from Carol, is again concerned with the period of reform discussed above (Department of Health, 1987; 1997). However, in Carol's recollection she senses that, as a result of the policy manoeuvring by the government during the Conservative administrations under Thatcher and Major and also the Blair and Brown years with Labour, the mediation was one which purposefully cultivated divisions between doctors and nurses and that it was not until the reforms of the NHS after 2010 (Department of Health, 2010) that GP-led commissioning boards had a level of autonomous management control sufficient to change this.

Interpreted as is Williams' notion CoP, within his concept SoF, the rationale here is that both Douglas and Carol represent indicators of a similar structure of feeling concerning government-mediated change and its ramifications on the groups and individuals.

The level of inter-subjectivity Douglas and Carol experience is notable; they are not connected and have never worked together, yet both participants independently of each other have directly been affected by the same changes and arrived at considerably similar conclusions. Reiterating what Williams writing on SoF, says:

> *[C]hanges of presence*…although they are emergent or pre-emergent, they do not have to await definition, classification, or rationalization before they exert palpable pressures and set effective limits on experience and on action (Williams, 1977, p. 132).

Through the lens of Williams' notion CoP, extracts 14 and 15 see both Carol and Douglas demonstrating that these are changing thoughts and feelings which they have harboured for some time. While they have never truly articulated them before, they have nevertheless both reached a similar conclusion that these connected events may pose long-term ramifications for the NHS.

Extract 16 – Changes of presence (CoP)

"Ermm, in the good old days you used to, after graduating you become a house officer and became an SHO for about eighteen months, and after that you had to do some postgraduate qualifications and then become a registrar for at least three years followed by five to eight years as a senior registrar before you could even think of becoming a consultant…

"…In Tony Blair's time this changed, you immediately became an SHO and within six months you became a SPR, which was Specialist Registrar, and after three years of that you could become a Consultant. So you can imagine the stepladder to the profession, how quicker one could become a Consultant…Obviously the experience wasn't there, the confidence wasn't there and so the quality was not there."

Ajam – clinical doctor (ref 58 – 42&43)

In Extract 16, Ajam discusses the point in the timeline of NHS reforms in the late 1990s, where he senses this may have long-term ramifications on his profession and also on the organisation. Initial noting indicates that Ajam is uneasy about an aspect of the health policy reforms initiated by the Labour administration under Tony Blair from 1997 (Department of Health, 1997) and the underpinning 'NHS Plan', (Department of Health, 2000, Cm 4818-I). During this time Labour's planned core objectives included a drive to recruit and retain, increasing numbers of hospital consultants, GPs and nurses and other clinical personnel by 2008. However, Seldon and Kavanagh (2005, p. 295), remind us

that the Blair administration's improvements led to positive aspects such as reduced waiting times for treatment and outpatients' waiting times by more than a third from 1999 to 2004.

I argue that through the lens of Williams' CoP, within his concept of SoF, applied to Ajam's situation helps to illustrate the paradoxical experience of an outward sense of present optimism, coupled with an inner sense of apprehension about the future. Furthermore, this chimes with Grossberg's explanation of Williams' CoP. Grossberg says that what Williams is trying to articulate with CoP is what is being sensed and lies between two senses, the 'modern…historical time' and 'eternal contemporaneity' (Grossberg, p. 23).

In the next section I discuss the second subordinate theme group within SoF: DSoFtDC (or groups, in relation to this study).

6.2.2. Subordinate – Differentiated structures of feeling to differentiated classes (DSoFtDC)

As discussed in Chapter 2, Williams describes his notion of DSoFtDC as:

> The complex relation of differentiated structures of feeling to differentiated classes. This is historically very variable…when a formation appears to break away from its class norms, though retain its substantial affiliation, and the tension is at once lived and articulated in radically new semantic figures, Williams (1977, p. 134).

What Williams seems to be suggesting here is that cultural formations other than those of the D culture may appear and behave in a superficially cohesive manner, however, aspects of the differentiation covertly resist the D culture, yet at some point this SoF gathers momentum which builds into a clearly differentiated SoF with its own set of polarised meanings and values, whilst coexisting with the D culture.

The next two extracts concern management, and these form part of a series of criticisms of management noted in the NHS in this research which have been discussed in other parts of this analysis. The extracts I am about to discuss concern how groups fracture and break away from the D culture, yet exist alongside it exhibiting resentment towards the D culture.

Extract 17 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

> "If you are talking about a reorganization then a lot of people think you have got three years, because you have got 18 months lead up to reorganization and 18 months lead out, so at the moment, ermm…where we are at the moment we are going into 'cluster' with another PCT, and people doing a job, I am doing a job that a lot of people working in the organization – a lot of people who are thinking, well am I going to be here in six months' time – do I need to bother?"

Colin – non-clinical manager (ref 25–47)

Extract 17 can be interpreted as DSoFtDC. Initial noting indicates that Colin observed morale was low as a result of the endless rounds of organisational change in the NHS. Colin observes that this has slowly cultivated a dissident workforce who lack any incentive to work in the interests of the organisation. Weary of change, this group prefer instead to do the least possible, assuming that a redundancy option could come at any moment.

In the initial noting Colin suggests that the behaviour of his colleagues, although subdued, represents a potent source of disruption in terms of organisational efficiency and has a direct impact on the morale of the group and workforce productivity, to the point where it seems a subculture of highly differentiated views has formed. Brooks (2009) reminds us that 'in most healthcare sectors throughout the world, a series of subcultural groups work alongside one

another' (p. 261). Furthermore, (Pollitt, 1990, p. 148; Baldamus, 1967) and (Linstead, Fulop and Lilley, 2009, p. 648) suggest 'the most common barriers that influence the change process [are] *organizational inertia* and *hostility*'. Robbins and Judge (2009, p. 666) suggest that 'a major area of concern in OD [Organizational Development] is the dysfunctional conflict that exists between groups', suggesting 'intergroup development' techniques may help to build a more cohesive group behaviour.

Through the lens of Williams' notion of DSoFtDC, what Colin is describing is a differentiated group forming which, continues to participate as part of the culture of the organisation, yet holds differentiated views (Williams, 1977, p. 134–5).

Extract 18 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

> "I arranged lunchtime sessions for talks…I had a GP there, he is still around the patch in fact, quite a well-known GP, and he gave a talk about how he became a GP etc., and he actually said our training is that we are taught to feel like God basically…"

> "…And they have that perception. But that's where they're coming from."

> Colin – non-clinical manager (ref 68-12)

In this extract, Colin is keen to disclose that he has gained an insight into medical education programmes and the value judgement used to foster elitism within the group. (Shaw, 1906; cited in Susskind and Susskind 2015). Colin accepts this as part of an organisational culture and that he is accustomed to it. He says: 'they have that perception. But that's where they're coming from,' as if to say that it is not an issue for him. This agrees with (Weber, 2009 and Freidson, 1994, p. 114) and methods of 'group monopoly'.

Through the lens of Williams' notion of DSoFtDC, the level of acceptance on the part of the non-clinical manager, masks a latent resentment by Colin that whilst he accepts the doctor's discussion forms part of a nostalgic recollection, this is tolerated because he wants the doctor to continue delivering the lunchtime talks. Furthermore, Colin is acceptant of this behaviour by the doctor, primarily because he has worked in the NHS for such a long period of time that he knows it is not likely to change. He understands that this is differentiated behaviour and that it separates him from the doctor, and whilst they work together they exist in polarised occupational communities within the same organisation, where the doctor still refers to the element of tradition dominance over the manager, through his training as a doctor many years ago and where the imprint of differentiation remains part of the doctor cultural antecedence. As mentioned above in that last extract Brooks (2009) suggest that subcultural groups within most healthcare structures 'which work alongside one another' (p. 261).

Extract 19 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

"Right, I don't have a deal of contact with doctors and nurses and GPs but I will give you my perceptions of it. I think that there is a potential conflict between them…"

"…And doctors will say something…they won't explain things to nurses properly and they just expect nurses to do whatever nurses do for example. And I think that there is an issue around the whole training process for nurses at the moment and I think that the majority of a lot of nurses are not nurses in the sense that I would count."

Colin – non-clinical manager (ref 69–26 and 70–27)

I interpret Colin's viewpoint in the extract above as DSoFtDC. Here Colin seems to be tapping into a traditionalist's perspective – a level of subdued resentment at the level of change the professionalization of nursing has brought to the NHS. This phenomena is also observed more widely by Rivett (1997), Taynor *Et al.* (1999) and Bradshaw (2001).

In the late 1980s the Conservatives (Department of Health, 1987) introduced schemes such as the nurse practitioner and the development of nursing in general practice towards autonomous caseloads. This continued through the 1990s under Labour and the leadership of Blair (Department of Health, 1997), with an extensive programme of integrated working between all clinicians in the NHS, however, this had ramifications and this is observed in Dent and Burtney (1996) also (Dopson 1997; Rivett 1997, p. 414). Whilst these reforms were beneficial and served to partly address the ever-increasing resource dilemma in the NHS by extending the service offering of care and treatment of more patients. (Seldon and Kavanagh, 2005, p. 294).

Extract 20 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

> "It is vice versa as well, you can have a conversation in a room with managers and clinicians together and you ask them what they are going to do about the situation, you will get different answers."

> Rokh – clinical other (ref 66–92)

Extract 20 from Rokh has been interpreted as DSoFtDC. Initial noting suggests Rokh was frustrated that none of the three groups in this case study, the doctors, nurses or managers, can see things from the same prospective. Rokh feels passionate about what he is witnessing, which he views as some sort of fracturing of the possibility of cohesive working. He is perplexed by the

conflicting opinions, insisting that this 'is not the way that historically things have been done'. Furthermore, Rokh senses this is not a particularly positive process and is unsettled by it. However, he acknowledges that this is the current way of thinking and behaving in the organisation, and that this spilling over into the day-to-day operations where doctors, nurses and managers are in constant conflict with each other, and that this is causative of a working environment where no one seems to agree and too many varied opinions means that nothing seems to get done.

In this extract, one of the most significant aspects Rokh's comments is the evident differentiation between the groups of doctors, nurses and managers which he perceives is the reason for the impasse and the inertia of effective decision-making in the organisation. This supports Robbins and Judge (2009, p. 666), concerning 'dysfunctional conflict that exists between groups' and, supports Brook (2009, p. 144) groups that are 'too diverse' will be extremely difficult to manage the 'differing views and opinions about almost everything!' and in a wider sense, also to Dopson (1997) and the 'unintended' consequences of change in the NHS, in relation to the Griffiths Report (Dopson, 1997, p. 54). Rather than any form of isomorphic convergence (DiMaggio and Powell 1983), what seems to be happening in Rokh's example, at an organisational level is more akin to Guillen (2016) and his organisational theory of differentiation and the cultural underscoring of uniqueness by different organisations in convergent situations. Through the lens of Williams' notion, 'differentiated structures of feeling to differentiated classes' Williams (1977, pp. 132–35) uses examples that typify embedded cultural values and how groups seek to actively differentiate from one another whilst co-existing in the same environment.

Extract 21 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

> "So, there is still that sort of delineation I suppose…ermm…I don't think that GPs are very good working in a multidisciplinary team, I think the reason they became GPs is probably a lot to do with the fact they like working on their own, they like the autonomy, they don't like having to discuss their reasoning with other people."

> Lilly – manager, formally nurse (ref 49–25)

Regarding Extract 21, the initial noting shows that Lilly was totally unemotional. In effect Lily has been desensitised by all that she has seen before and is resolute that she will still have to work under the supervision of doctors regardless of what happens, and she suggests their freezing everyone else out of their decision making is part of their culture and they will not change. Lily's substantive post was as a manager but she was originally a nurse and she seemed to understand the GPs' hegemonic status in the NHS.

I interpret this extract as aligning to Williams' notion of DSoFtDC because Lilly identifies a number of issues relating to the differences between GPs and the other groups in the NHS. She can see how this may influence the effectiveness of multidisciplinary teams in the NHS. Through the lens of Williams' notion of DSoFtDC, this provides a viewpoint that forms part of the analysis of cultural totality, and in relations to the NHS, where occupational groups operate and coexist in the same organisation, yet are differentiated at many levels.

Extract 22 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

> "It's an ego thing which is throughout the clinical staff at the NHS, I think, which actually plays on constraints and potential issues…

"…And I think that that is part of the reason for conflict with management, management don't have any clinical knowledge and can be seen by clinicians as ermm…potentially surplus because not understanding why they are needed, not understanding all the work that does need to be done to run a hospital or carry out the commissioning process and deal with the internal market workload…

"…So it's probably two sides of the fence and neither…they don't speak the same language potentially so they can't see what the other person is all about…

"…And I think that is where the games are played and I think that they actually impact upon the benefits to streamline processes and make them defunct basically."

Colin – non-clinical manager (ref 68-73/72-78)

And…

Extract 23 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

"So you get those sorts of battles, blinkered vision for…for you know and that sounds like painting a bad picture for all managers but it's not because some are very good, but it's the things that stick in your mind that are always a problem…

"…I mean if you look at the reams and reams now of paperwork that's there to be satisfied and the amount of staff needed to keep that going before the patient is even seen it doesn't seem it has enhanced a service provision it may well have enhanced service audit…

"…What is better for the patient is it the audit or the provision? I think most patients would want the provision of a service rather than the audit of a service they can't actually get hold of."

Paul – clinical other (ref 26, 27, 28 and 29–82)

And…

Extract 24 – Differentiated structures of feeling to differentiated classes (DSoFtDC)

"But it did surprise me with the NHS reforms, the white paper, the number of, ermm GPs and practice managers that were almost laughing at the PCT and saying you know you are out of a job now, we have control back…

"…As soon as we can get over this them and us, we need both sides you know, I always say if I wasn't in the job I was in, we would have nurses doing paperwork for 95% of their shift…

"…We need to have people monitoring targets and writing policy otherwise the clinicians are doing all of our work…and as soon as both sides realize that you need all elements to make the health service work, it tends to work."

Beth – non-clinical manager (ref 15, 16 and 17–83)

Firstly, in Extract 22, the observations from Colin, the non-clinical manager, indicate he is concerned with the lack of understanding medical staff have in relation to the contribution by managers. Furthermore, this is not necessarily one-sided and he stresses, 'neither understand each other's language', and the 'games' that are played 'actually impact upon the benefits to streamline processes and make them defunct basically'.

In Extract 23, Paul, the clinician, observes the overly-bureaucratic processes managers undertake without having the ability to see the problems and issues from any other occupational prospective. Paul is sceptical about the rationale behind much of the target-driven monitoring and control by management in the NHS, questioning the usefulness of the exercises set against other measures that would enhance provision of service, for example, and Paul makes the

assumption that resources would be better directed developing service provision than auditing and monitoring.

In Extract 24, Beth, the non-clinical manager, recounts more recent experiences following the Conservative-Liberal Coalition health reforms in 2010 and the implementation of CCGs. Initial noting indicated how upset Beth was by the way that GPs and their managers had spoken to her shortly after clinical commissioning was introduced and, in front of her, had praised the forthcoming demise of the regional manager once GPs could take control of clinical commissioning. Beth questions what would happen if regional managers were not there to perform all the administrative tasks required, observing that this would then most probably be passed to nurses and this would inevitably have implications on clinical resource time. Beth suggested it would be beneficial if 'both sides realize that you need all elements to make the health service work, it tends to work'.

The final three extracts I interpret as aligning to Williams' notion DSoFtDC. I argue all three extracts demonstrate that all three groups are highly differentiated in their views and feelings, only agreeing on the difficulty of working together and this is where each interviewee shares a commonality. The overarching connecting themes in this group of extracts is the level of differentiated opinion concerning their own contribution and that of each other's contribution in the organisation, and this chimes with Edwards and Marshall (2003, pp. 116–7; as cited in Degeling *Et al.* 2003, p. 649) and the impending 'danse macabre' if the situation is not addressed. However, I suggest the overarching optimism within these last three extracts lies in the level of inter-subjectivity the group has about their awareness of their dysfunctional behaviour.

Furthermore, through the lens of Williams' DSoFtDC, this is part of the normative process, that solutions are not necessarily achieved, rather differentiated meanings and values are accommodated as part of the continuum of cultural totality. Taking this into consideration, what SoF represent are the slowly accruing thoughts and feelings that individuals and groups develop and carry with them but which are kept repressed due to the pressures of official consciousness, which history has taught us often ignores the practical consciousness developing.

6.2.3. Summary

In summary, Williams' SoF, produced several findings which related to the phenomena interpreted as being part of 'changes of presence', these manifested as separately derived, yet similarly attested conclusions concerning a negative impact of neoliberal reform in relation to the professionalization of nursing practice away from the direct supervision or input of the medical profession. Admittedly CoP was a very subtle notion to identify, but the findings indicate members of the case study group sense their own changing attitudes, internalised at first, to government mediated change and what this meant for them and others they worked closely alongside.

Other key findings were demonstrative of high levels of differentiation among the case study group. Although the extracts recount isolated experiences, there is evidence of inter-subjectivity from different perspectives and the level of divided opinion among the group concerning the own roles and the roles of others.

I have now reached the end of the findings and analysis of my interpretation of the data concerned with Williams' EA and 'SoF concepts. In the next and final

chapter, I conclude by revisiting the purpose of the study. I then discuss the

summary of the findings aligned to Williams' theoretical orientation and revisit

the relationship this study has with previous work in the social sciences and the

contribution that this study has made. I then discuss the limitations of this study

and conclude with an autobiographical reflection.

7. Conclusions

7.1.   Summarising the argument

The research presented in this thesis set out to consider the impact neoliberal reform in the NHS has had on a case study group of doctors, nurses and managers in a primary care setting in the English NHS. Once the theoretical framework had been established, this was used to explore how two concepts by the cultural theorist and neo-Marxist Raymond Williams, 'epochal' analysis and 'structures of feeling', may contribute to the further understanding of the impact of change on the case study group. Williams' attention to cultural totality was a key factor in the analysis of the empirical data to capture thoughts and feelings from a range of perspectives, which are 'historically varied and variable' as part of the 'whole cultural process rather than only to the selected and abstracted dominant system' (Williams, 1977, p. 121). By approaching this from the perspective that the case study group are seen as an 'occupational tripartite', Williams' two concepts have facilitated a view of the changed and changing values and meanings of the case study group in this research and in this chapter I draw conclusions from this.

The research processes were carried out using a hybrid methodology design, which incorporated a number of qualitative methods. The research question was constructed using the interview techniques of Wengraf (2001), one-to-one semi-structured interviews based on a 'SQUIN' – a 'single question aimed at inducing narrative' (Wengraf, 2001, p. 69) and a 'Pyramid model', also by (Wengraf, 2001, p. 63), which serves to separate IQ, designed to be 'indicative-material-seeking', and a TQ, formulated in the theory-language of 'the research community' – in this study the TQ represented the CRQ, in Wengraf's model. I

adapted Wengraf's method into a synthesised model to incorporate the thematic phenomenology, IPA, an inductive coding system taken from Smith *Et al* (2009), and applied this together with Williams' two concepts: 'epochal' analysis and 'structures of feeling' as an priori deductive coding system – a 'hybrid', in line with Fereday and Muir-Coltrane (2006; as cited in Willig 2013).

7.2.   'Epochal' analysis

7.2.1. The 'dominant'

The first subordinate theme structure, 'awareness of dominant culture' produced several interesting findings. There was evidence of traditional behaviours and practices - for example doctors asserting their traditionally held hegemonic status and methods of 'group monopoly' (Weber, 2009 and Freidson, 1994, p. 114) to construct challenges for nurses to 'prove themselves' as worthy of inclusion in the dominant group (with doctors). This connects with the writings of Hughes (2010). Arguably in one sense this demonstrates an impact of neoliberalism in that the nurses feel able to challenge the doctors, due to a number of neoliberal reforms which leant in the nurses' favour (Department of Health 1987; 1997). However, in spite of this it also illuminates the relatively small impact neoliberal reform has had on the 'dominant' hegemony of the medical profession and the ingrained traditional core values in the NHS and the conventional hegemonic dominant/subordinate relationship between the medical profession and nursing - and this accords with (Soothill and Mackay, 1990).

Another finding indicative of the 'dominant' culture was the presence of intra-occupational rivalry between different departmental groups of doctors, noted as far back as the Guillebaud Report (1956; quoted in Allsop, 1995, p. 44; Baeza,

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2005, loc 185), and in the much earlier writings of Shaw (1908; Susskind and Susskind, 2015, p. 28). This raises questions over the extent of collegiate behaviour among doctors, observed by Johnson (1972). In contemporary terms it also raises questions over the successfulness of 'leaderism' as a management system designed to encourage the medical profession into management (Thorne 1997) and (O'Reilly and Reed, 2011). This finding suggests that whilst management models and approaches can be adapted to align more closely with the terminology used by the medical profession this will not remove the inclination by doctors to compete with each other especially those from different specialisms. Therefore this may do little more than replace inter-occupational belligerence between doctors and managers with an intra-occupational dialectic within the medical profession itself. This finding places a question mark over the successful trajectory boundary spanning initiatives which have been met with some resistance from traditional dominant hierarchies in the NHS, (Gilburt, 2016) and relates to the observations concerning the professional ''turf wars' (Nasir et al 2013; Freeman et al 2012)' (Gilburt, 2016, p. 21) in the NHS.

'Dominant' behaviours exercised by senior nurses towards their subordinate juniors were also found, where the junior ranks of nursing were curtailed from exploiting the opportunities made available through neoliberal reform in the NHS (Department of Health 1987; 1997) and this accords with Bradshaw (2001, p. 14). In this study all nurses interviewed were female and their recollections were of interactions between junior and senior female nurses, and this arguably aligns to Mavin (2006) and 'the contradictions of solidarity behaviours versus queen bee behaviours' (Staines *Et al.*, 1973; Abramson, 1975; cited in Mavin, 2006, p. 349).

Through the lens of Williams' notion of the 'dominant' culture it could be argued that the interpretation of these phenomena has been widened beyond any assumption of the stereotypical dominant group – the medical profession. Instead by approaching the case study group as an 'occupational tripartite' from within a dynamic cultural totality, the focus has extended this to aspects of dominant behaviour within nursing too.

7.2.2. The 'residual'

Williams' suggests the 'residual' will remain in opposition but in 'limited respects' and will rail 'against the pressures of incorporation, [where] actively 'residual' meanings and values are sustained' (Williams, 1977, pp. 122-23). Several of the non-clinical managers in the case study group demonstrated a resistance to change in an attempt to make sense of the present and their own role and relationships with others in the NHS. Possibly emanating from the neoliberal reforms that triggered the Griffiths Report in 1983, the non-clinical managers in this case called on remnants from a past epoch to enact 'residual' behaviours which still exerted pressure holding in place the premise that their understanding of the strategic and operational aspects of the NHS would help them to retain some control, albeit in the face of a fresh round of neoliberal change (Department of Health 2010) that sought to replace management control with that of the GPs and Clinical Commissioning. This stemmed from the neoliberal change programme introduced as part of the Conservative/Liberal coalition policy reforms of the NHS in 2010 (Department of Health 2010). With a mandate to abolish the PCTs in favour of CCGs this was led by GPs (Glennerster, 2015). Many non-clinical managers felt displaced and marginalised as a result and many were either redeployed or took redundancy. At the time of interviews in 2012 this process was underway and the managers

in this study reported feeling vulnerable, drawing on remnants of their past authority to bolster their current standing in the organisation.

In addition to this, clinical managers observed the contrasting arrangement for non-clinical management in the NHS and questioned the whole efficacy of the non-clinical manager which sought to create a complexity in the NHS through the polarising of the clinical and non-clinical occupational perceptions concerning each other's contribution in the organisation.

7.2.3. The 'emergent'

An 'awareness of an emergent culture' was interpreted as an indicator of mixed feelings among the participants. Some participants felt a sense of excitement and others a sense of trepidation. There was an 'emergent' optimism concerning some aspects of neoliberal reform in the NHS which had enabled new opportunities, new management positions and the ability to engage in competition through GP fundholding, all of this was sometimes viewed with excitement, emanating from neoliberal changes stemming from the marketization of the NHS the culmination of which had been the (*National Health Service and Community Care Act*, 1990) and the introduction of the internal market. This had other effects, a non-clinical manager interviewed saw the knowledge he gained being at the forefront of initiatives to implement the purchaser/provider split in primary care had left his colleagues in the hospital sector of the NHS not as knowledgeable. This had a deep impact on the participant who felt he had gained a competitive advantage and this agrees with Ham *Et al.*, (2009, p. 45). In also resonated with Papadopoulos, Stephenson and Tsianos (2008, as cited in Gilbert 2014, p. 45) and (Harvey, 2005, p. 160) and how the reassignment of society following neoliberalism forged the tenets

of a competitive ideology and individualism in favour of the collectivism experienced in the post-war social democratic era.

However, not all neoliberal initiatives were seen as an positive emergence by the group and one doctor found the transition of nurses from the wards to clinical management roles (Department of Health 1989; 1997) a form of emergence that he saw as detrimental to the traditional role carried out by the nurse in a subordinated position to doctors and this created an occupational dialectic between the two (Bradshaw *Et al.*, 2001). This also supports Causer and Exworthy (1999, p. 83), and their observations concerning the ramifications of 'hybrid roles'. This also connects with Larson (2013) and the ramifications of 'technobureaucratic positions', (p. 179).

7.3. 'Structures of feeling'

7.3.1. 'Changes of presence'

Williams' second concept to be deployed as an a priori deductive coding system is 'structures of feeling' and within this the first subset, 'changes of presence' (1977, p. 132) which served through adaption to form an identification process for the embryonic moments when in a culture there begins the development of a new sense of meaning. The interviews provided relatively little evidence of this, but perhaps this might be because it is difficult to capture. (Williams, 1977 and Grossberg, 2010).

Among the case study group a sense of change was suggested by a doctor and a nurse who felt on reflection an increased sense of apprehension concerning the transition of the nurse role in general practice towards autonomous caseload management and independent prescribers Bradshaw 2001; Traynor 1999).

A sense of change was also indicated concerning the initiatives deployed through later neoliberal reforms by Labour under Blair in the late 1990s to recruit greater levels of clinical personnel into the NHS as part of the NHS plan, (The NHS Plan 2000) and this is observed by Seldon and Kavanagh (2005, pp. 294-5). One doctor's perception in the case study group was that whilst he felt that there was a tangible investment being made in the NHS at this point in time, he also felt an underlying sense of apprehension concerning the possible future implications of putting less experienced doctors into hospital consultant positions and where this would lead to. This chimes with the writings of Freidson *Et al.* (1994) concerning the de-professionalization/proletarianization thesis. Both arguments are seen as threats to the social closure status of the medical profession and have the potential to erode the jurisdiction of the medical profession (Abbott, 1988; Macdonald, 1995).

7.3.2. 'Differentiated structures of feeling to differentiated classes'

I now turn to the final subordinate theme structure used within the a priori coding system based on Williams' concept of 'structures of feeling': 'differentiated structures of feeling to differentiated classes'. Williams suggests 'the complex relation of differentiated structures of feeling to differentiated classes…when a formation appears to break away from its class norms, though retain its substantial affiliation, and the tension is at once lived and articulated in radically new semantic figures (1977, p. 134).

All of the indicators here suggested the differentiated attitudes of the three occupations in this case study, the doctors, nurses and managers. One non-clinical manager observed how a dissident workforce had emerged who lacked any desire to work in the interests of the organisation due to the repeated change programmes since the 1980s which had often led to a wave of

redundancies and redeployments and this agrees with Linstead, Fulop and Lilley (2009, p. 648). The same manager also noted how medical training provides the necessary social conditioning to encourage and foster elitist attitudes towards other occupations in healthcare. However, this was accepted by the manager, as a value based decision to avoid destroying an opportunity to provide lunchtime talks which he saw as a good thing for the development of the department that he was managing at the time. This type of underlying resentment which, whilst tolerated by one group towards another, underpins the deep sense of cultural differentiation between those in the case study.

One indicator in this category concerned the differences between GPs and their methods of working, often in isolation and making a myriad of decisions in relation to others in the NHS who are used to working collaboratively. The nurse who observed this felt this was connected to the general lack of enthusiasm by GPs and the increased use of multidisciplinary teams in general practice (Department of Health; 1987; 1997), and this agrees with (Soothill and Mackay, 1990; Dent and Burtney, 1996).

Other indicators suggest a total sense of organisational disorientation as the transition from traditional roles into new roles created out of neoliberal change left great voids of communicative exchange between occupational groups which had hitherto worked in specific ways with each other, and as these new occupational groups of nurses and managers became immersed in different ways of working often not taking into account the previous chain of command emanating from traditional dominant structures.

What was of substantial impact in this study was the three groups were agreed on one thing – that there was a lack of consensus between them. Little seemed

to be agreed upon, raising questions over the impact of successive neoliberal reforms in relation to its efficacy as the driving force of productivity and the effectiveness of the organisation. Situations of conflict and competition were reported between managers and clinicians, and between clinicians themselves leading to an outcome that this achieved little other than a wide array of differentiated opinions. This supports the view of Ham *Et al.*, (2009, p. 45) and the changing culture in the NHS following neoliberal change. This also supports the arguments made by Edwards and Marshall (2003, pp. 116–7; as cited in Degeling *Et al.*, 2003, p. 649) and their observations concerning the level of 'intransigence' exhibited by doctors towards managers and the general culture of mutual 'distrust', in healthcare organisaitons (Degeling *Et al.*, 2003, p. 651), and Brook (2009) who observes the 'difficulties of leading people with extremely differing views and opinions about almost everything!' (Brook, 2009, p. 144). However, this is perhaps to be expected in light of Papadopoulos, Stephenson and Tsianos (2008, as cited in Gilbert 2014, p. 45) and (Harvey, 2005, p. 160) who observe how neoliberalism has crafted a nation which strives towards competition and individualism in favour of the actions of collectivized solidarity behaviour.

7.4.   Summary and contribution

The original contribution this study makes is through Williams' neo-Marxist theory, and the adaption of two of his concepts - 'epochal' analysis and 'structures of feeling' (1977), as a deductive a priori coding system. Deploying Williams' concepts in this way has provided a tool for analysis (West, 1992). Whilst some academics claim Williams' concepts and notions are at times unnecessarily complex (Matthews. 2001; Roman, 2013). I argue that Williams' approach to cultural interpretation is a response to the complexity of modernity,

furthermore, it is Grossberg (2010) who suggests 'structures of feeling' is Williams' 'absent theory of modernity' (p. 25). Whilst not a prediction tool, his concepts can help illuminate dynamic cultural totality beyond predetermined existing dominant structures, and whilst, it cannot be claimed that this study is directly replicable anywhere else, I suggest that by deploying Williams' concepts and notions in this way, there is the potential to provide a generalizable analytical tool for other research where there is a level of cultural complexity and uncertainty.

In this study, through the lens of Williams' two concepts, 'epochal' analysis and 'structures of feeling', it has sought to illuminate how both doctors and nurses use 'tradition' to maintain organisational inertia and an adherence to existing 'dominant' structures. The study has also brought to light 'residual' behaviour by managers in an attempt to disregard the neoliberal change programme in 2010 (Department of Health, 2010) where control was handed to the GPs in the NHS as the commissioners of health services. Finally, this study has illuminated the deep level of differentiation between members of the case study group and how they perceive their own contribution in relation to others in the NHS.

7.5.   Limitations of the study

It should be noted that this study has a number of limitations:

- The study is a snapshot of a primary care setting in South East England between 2012 and 2013 and does not incorporate any other sector in the NHS, for example the acute hospital sector or the wider community services, and although a good deal of contextual secondary source literature has been consulted as a literature review, a longitudinal study

would have provided a comparative analysis and this perhaps is a direction for future research.

- This part-time doctoral study has been carried out whilst continuing to manage a medium-sized GP practice as the full-time Practice Manager and this has caused a number of limitations in relation to protected time for this study.

- This study took place during one of the most controversial 'whole system' reconfigurations of the NHS to date (Department of Health, 2010). During this time the opportunities to secure participants for this research began to diminish and several key staff members who would have contributed greatly to this research left the NHS before the interviews were commenced.

- The possibility of bias was great, due to my auto-ethnographic connections with the NHS. This has had to be managed, but the specific methodology used for this study has helped limit the impact of this.

- The lengthy process to approval with COREC resulted in a key loss of research time to carry out a pilot interview process. I was later informed, after the COREC process had been completed that applications for non-patient related NHS research studies no longer required COREC approval.

7.6.   Autobiographical reflection

This research has been a valuable learning experience. I have experienced the frustrations and the rewards of undertaking this level of research. I have developed my own understanding of the behaviours of doctors, nurses and

managers in the NHS since carrying out this research. As such, this has provided me with a new sense of awareness when dealing with day-to-day issues in my own work in the NHS. I have also begun to assess my current contribution to the organisation, as well as what my future contribution may be following this research.

The research process has given me ideas for further research in this area. For example, a new study concerning the intended and unintended ramifications of hybridized roles in the NHS could be of significant interest.

For me personally my exposure to the work of Raymond Williams, who as a Cambridge academic took the unconventional route of challenging the dominant viewpoint at the time concerning cultural studies, when he and a group of likeminded academics promoted a revisionist stance that classical and popular culture should be studied together. A revolutionary approach which is arguably now undetectable in contemporary cultural studies with its accomplished sense of inclusivity, however, this belies the effort and passion of Williams and his academic compatriots who fought for the inclusion in cultural studies, of the once overlooked and disregarded voices and the values of people from all kinds of backgrounds.

7.7.   Recommendations to NHS organisations and educational units

In view of the findings reported in Chapter 6 and the conclusions discussed in this chapter, at a micro-, organisational level this research might impact on NHS organisations, whereby future training methods may be constructed that recognise a range of diverse and individualised perspectives, where the current organisational educational development approach be revised to incorporate a

programme based on the concepts of Williams used in this research, which may provide a useful insight into how cultural behaviour develops – and what causes tensions to arise. By focusing on the totality of the relationships within the organisation and treating the three groups examined in this case study, the doctors, nurses and managers, not as separate but as an 'occupational tripartite', whilst still recognising a range of perspectives in addition to those of the existing dominant structures and by accepting differentiation as part of neoliberal organisational complexity, and building this approach into the organisational change framework as part of the everyday dialogue of doctors, nurses and managers in the NHS, the emphasis would then shift to the active collaboration of pluralist views rather than the current existing dominant structures which seems to have led to the standpoint of entrenched differentiation.

7.8. Recommendations to policy makers at the Department of Health (DoH)

At a macro-level, it is suggested that this research could impact on policymakers by helping to provide what is currently understated in NHS policy: a view which extends to the understanding of cultural totality. At a time when the accent is on 'boundary spanning' (Gilburt, 2016, p. 7) and 'system leaders' (Senge *Et al.*, 2015, p. 28), revise policy design that accommodates the increasingly complex occupational relations that will undoubtedly ensue in the mêlée of shifting traditional boundaries and the move towards whole system thinking, this will require policy making which recognises dynamic cultural totality, as Williams' concepts do, and I would argue lends well to this focus. In the challenge that is the future understanding of how organisational improvement beyond the existing dominant structures, to include a range of

perspectives in the NHS can be attained. Therefore, I argue that a social approach based on the examination of cultural totality offers new potential avenues for future policy development.

7.9.   Future application of this research

The study reported in this thesis is independent, however, it does represent the opportunity to replicate the study in different contexts, e.g. city, suburban or rural contexts, and there are multiple options stemming from this approach which could focus on similarities and differences – this could lead to an area of social political development and equally be explored in policymaking.

Any future development of networks of doctors, nurses and managers in the NHS should enable them to recognise each other's diverse opinions, and working to build good mutual communication and trust in the management of change is crucial. Perhaps one approach might be to work with groups of doctors, nurses and managers across different areas of the NHS, asking them to design 'the future' as a group, leaving the past behind as reflections. These groups should be more concerned with what they can achieve as a diverse group together, asking the question: if this agenda is not accepted, why not?

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NB: For all eBooks that do not appear in the same format as the written version the pagination is given as location %, and cited in the reference list as a download.

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Appendices

Appendix A   Participant Consent Form

Royal Docks
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School Office

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East London

CONSENT FORM

Centre No: **Study No:**

Participant Identification Number for this study:

Research Title: Strategic policy, inter professional behaviour and service performance delivery in primary care setting in NHS

Investigator and Interviewer: Sue Truman

Please initial box

1 I, the participant, confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions which have been answered satisfactorily

2 I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason without my legal rights will being affected

3 I understand that my interview notes and data collected during the study, may be looked at by individuals from Trust or regulatory authorities and I give permission for these individuals to have access to my records

4 I agree to take part in the above study

5 I agree to the interview being audio recorded

6 I agree to the use of my anonymised responses in publications

7 I agree that my data gathered in this study may be stored (after it has been anonymised) and will not be used for future research

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Investigator & interviewer   Date   Signature

Appendix B   Master Table of themes

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
Rokh 1/54	Their approach to managing patients is different because they have a framework not a protocol they work to and that framework is much more flexible than a protocol.	Nursing and managers are climbing professions too now and doctors do not automatically accept this. This seems to be a major source of conflict in the NHS. Blair's initiative as part of the DoH Modern and Dependable (1997), followed by Making a Difference (1999) which was known as MAD. Traynor (1999), 'Managerialism and Nursing: Beyond Oppression and Profession' p. 64 describes nurse training as a calling with strict adherence to orders passed through female hierarchy.
Robert 2/10	Doctors have variations; managers have variations, nurses numerous variations. That is the sort of area I would focus on.	
Colin 3/47	Attention to the diminishment of motivation and quality of work in a re-org.	
Jill 4/6	…It ALMOST reinforced the role of the GP being the lead as they were generally…the money had	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	been paid to practices, to principle GPs and ermm, it had, the GPs had always had the final say…	
Jill 5/10	…and it, it, the GPs were livid at the time and I think that they really felt that they had lost something.	
Jill 6/13&14	Ermm, well I think that it did have quite a profound effect on the nursing team dynamic, and the GPs felt, at that point, ermm… it, it was very symbolic in a way that actually GPs don't control how the nurses work, the nurses outside the GP surgery, the nurses are now being presented in a different shape, different level of qualifications and there is not much that you can do about that… So I think that it did have, you know, an effect on the close working relationship what ermm, I think that the nurses probably liked it, because it raised the game for them professionally, but the GPs didn't like it because it probably meant that they were now outside of their control, they lost control and also it meant that their patients were seen by less qualified	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	doctors, more often than they were before.	
Jill 7/15	Yeah, but ermm… generally speaking it sort of settled down and as with all things, you know, it passed and things moved on. [Interviewer: what about the managers?]	
Douglas 8/45,46	If they had any problems they dumped it off to you or off to the acute ermm….they didn't actually do anything meaningful and I've still yet to see any real trade in that, I see some movement that way, more recently but I think they have all realized their jobs are under threat.	
Douglas 9/47	Specialist nurses but yeah they were completely a waste of space.	
10 Jill 10/20	Junior receptionist, ANSPAR diploma and then an MBA culminating during fundholding…and so I was quite lucky, in that I was aware that other practices didn't quite feel the same. Even now, I still hear some practice managers saying, "I can't do that because the doctors won't like it…"	
Frankie 11/22-23	So, in doing this you were, you were saying we need	No real management pathway – Griffith

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	the clinical thinking, but actually there is a group of people who may have been clinicians or may not have been…Who began to develop and carve out this professional manager role…	implemented with a surge of management already established in the private sector but on from that no obvious mandatory qualifications for management – numerous management programmes that were nice to have but no essential stipulation on management qualifications. Frankie was excited about the opportunity
Jill 12/23	I think that the biggest change in the relationships was between doctors and their hospital colleagues and you know, it used to be the joke that the GPs used to send the consultants the Christmas card and ermm… that sort of revised as you saw the consultants sending presents, and you know, and the cards at Christmas, erm… trying to attract business back in.	Fundholding creating GP emergence of power over the consultant for the first time.
Jill 13/40	… and I think that they also become much more conscious that these HUGE policy changes that we have seen over the last 20 years are, are so politically driven, and it is almost like, because one lot does this, then the new lot says that on principle they are not going to do it and vice	Ref: to political interference causing instability.

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	versa and so we are not going to do it.	
Jill 14/41	Bit of a game in that respect and I think that also the fact that PCTs have never settled for longer than two or three years without some kind of reconfiguration is viewed by some as evidence that the PCT haven't got it right, so they are also most standing back and waiting for it to settle.	(et) Reorganization costs – draining the NHS Management Consultant cost.
15	Griffiths Report 1983 I think prior to that we worked very much on the word administrator and I didn't notice any resistance to this; no recollection of any turbulence but clinical thinking is still there but not necessarily managed by clinicians – maybe or maybe not. And so a mixture of clinical and non-clinical began to carve out a role as a professional manager.	**ST This is interesting for the following reasons – who carved out the role as a professional manager, was it the administrators of the past? Were they qualified enough to make this transition and, if not, was this the beginnings of a build-up of resentment from the clinical staff and the management were not of the calibre as with the Audit Commission Report?** Thatcher government was in and she did use a lot of ideas from US, along with de-industrialising and moving to a retail based economy (research here).

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
		Care plans and the beginning of a lot more paperwork. **Ford and Walsh (1994, p. 58) discuss the paradox of change in nursing especially post Griffiths and cite the possible authoritarian, hierarchical nature of the NHS helps to explain the apparent rapidity with which management – imposed change occurs while the enthusiasm and bright ideas of clinical staff are frequently dashed to pieces by the apathy or discouraging attitude of others (but who are 'others'?).**
Frankie 16/?	Ermm and because we are talking about purchase and provider, I think the acute play games with the provider with regard to internal referrals and tertiary referrals – and they just build up their invoicing to the PCT. Ermm and part of it is like giving them a blank cheque really.	
Carol18/6	… at the time of Griffiths and beyond there was a move to specialism…'firms' grew up in the hospital, for	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	example the urology 'firm' and the concept of the clinical director also.	
Frankie 19/27	Nurses, too, were taken away from the old 'Hatty Jakes' view of the matron. And it gave nurses a parity with the high echelons of decision making.	
?21	Or you just happen to be my husband, wife, daughter, son…	The variations in practice management standard. Management in general no fixed career path in primary care other than an AMSPAR diploma – **desirable but not essential.**
Robert 22/38	May or may not have the skills you need, this is being edited I trust (laughs).	As above.
Robert 23/39	Managers in practice, I have a practice manager and he is there to make the practice run efficiently, he's there to hopefully make it easier for me to do my job efficiently.	Arrogant view of non-clinical management role.
Douglas 24/51	If you are talking about a reorganization then a lot of people think you have got three years, because you have got 18 months lead up to reorganization and 18 months lead out, so at the moment, where we are at the moment we are going	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	into 'cluster' with another PCT, and people doing a job, I am doing a job that a lot of people working in the organization – a lot of people who are thinking, well am I going to be here in six months' time – do I need to bother?	
Colin 25/47 ?	It's the people, the detail that cause the problems because if you have 8,000 practice managers in England getting them all to move in the same direction, when skill levels within those practice managers range from people with, ermm, degrees down to I'm a receptionist, I'll be a practice manager now.	
Robert 26/3	And ermm...they have got no concept of nursing and looking after the patient and they are sitting around the nurses station, chatting basically, chatting about their boyfriends and what they've seen on the television the night before.	
Colin 27/28	The sister in charge said, "Did I think I was going to be a doctor? And she didn't agree with it at all."	Carol is upset and emotional and felt frustrated at the time that she was never going to get around the problem of

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MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
		being shuttered in by the senior nursing staff.
Carol 28/2 28/3 28/4 28/5	But I think one of the most profound changes was the way that nurses were trained back in the…ermm probably the late '80s early '90s was ermm..that we used to have ermm a group of ermm, for example DNs and then there was another group, there was the RGNs and they were registered, ermm they used to have more practical nurses, I can't remember what they were called now [interviewer – SENs]. But we used to have DEN, a district enrolled nurse who was incredibly practical, ermm and 'fully flying' DN, you know without this sort of background stuff.	
Jill 29/8	No nothing we just you know…it all stood still, ermm, I think a lot of the problem from our point of view, a lot of the nursing stuff went on completely without imput from GPs ermm – used…So that the PCT spent huge amounts of money on nurses for this, nurses for that, I've got no problem, but they were all facing the wrong direction and they weren't	Issue around integrated working as the cultural.

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	communicating with the GPs, so they were absolutely no use to us.	
Douglas 30/40 31/41 Douglas	I wish the same extended to PCT managers, all you feel is they are ermm, nit picking, scrutinising ermm, and usually not flexible ermm, so that errm, it's looking at where we want to get to and how we get there and they say no you have to jump over this hurdle and that hurdle, so we can tick this box rather than actually get a successful outcome or the standard care.	Control of the way organization was run.
Douglas 32/51	Every time we have reorganization we have a whole batch of consultants come in to tell us how to do it ermm…and whole new ermm, tranches of time taken up with clinicians attending these workshops.	
Douglas 33/66	Tend to, you know, be a bit repetitive over the years oh this is what we should do and they are talking the same stuff again and again.	Audit Commission Report learn lessons from financial failure (2006)?
Douglas 34/67	Am I sounding cynical err, but err, you know we work with what we have got and yes I go along, I contribute to the workshops ermm yes, I go along and talk	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	fairly bluntly about the way I can see it going. I have to put it in reasonable terms otherwise I am just looked on as renegade or I won't be given a voice at all.	
Douglas 35/68	So nursing as a profession is not as strong as GPs and that's probably the reason why, I think because we don't stick with each other.	Discuss being left on one's own to sort things out when it goes wrong. The collegial relationship is not as strong. Goes back to Macdonald and Abbott and discussions around the development of patriarchal group and Weber's professional project and social closure.
37 Carol – 3	We tend to, we tend to, you know, if anybody goes off and goes xyz, then we go hum just get back here and see what happens to you, well I didn't think about that.	Carol was upset, and felt held back by the senior nurse on her ward. The organization was at odds with itself by implementing changes to the status quo it was creating resistance, and resistance for quarters that you would imagine would be pro a particular change were in fact against - **look at the dynamics of gender and how women are capable of holding back other women.** **Also assess the language of recollection to see if this holds something.**
38 Carol 5	So, there were only about three of us within the	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	training and it was consultant led and he was very proactive and forward thinking and thought this was the way to go.	
39 Brenda 2	It was much that when I first started which was in 1977 that nurses had their role and it was quite dictatorial, so you had your nurse tutors you had your ward sisters, you didn't talk to the ward sister unless she spoke to you. You did not know anything about strategic things in those days.	
40 Brenda 7	…sort of 1981,so ermm, things were beginning to change at that stage as I had a different role too. A lot of ideas started coming in from America and we didn't do care plans at first but this was now being asked and before it was basically task orientated until care plans came in. After the 1980s nurses were getting involved in drug trials etc things that they had not been involved with previously such as ordering and more meetings.	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
41 Lilly 2	There was still very much a traditional hierarchy of ward sisters being terrifying, they weren't modern matrons then they were nursing managers, matrons by another name, and were even more terrifying.	
42 Lilly 3	House officers were scared of ward sisters and students not wanting to talk to anybody above a staff nurse because they were scared.	The ward sisters were in charge and this may have a bearing on JR comment about not being discouraged to develop by senior nurses in the same profession – see also Wellcome study.
43 Lilly 5	Even more before you, patients came first ermm, ward sisters were very protective about their patients ermm, very protective (0.4) not against doctors, but you know you have your junior housemen who actually know less than the ward sister, but the ward sister has been here for 100 million years, the houseman has just come out of medical school and doesn't know anything. So, she is very protective, or was very protective, of her patients.	
44 Lilly 14	So, the relationship maybe isn't the same as it would be during the week, it's a lot more familiar there's not quite so much hierarchy	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	ermm, not always a good thing I don't think.	
45 Lilly 15	It feels to me like a lack of respect, from what was there previously, but maybe that's just being old fashioned.	
46 Lilly 18	There are times when I feel there is an awful lot of sitting around the desk and not an awful lot of interaction with patients.	
47 Lilly	Ermm (laughs and looks around) so you know that is a bit of a broad… the overall feeling I get working in the hospital now is that patients don't come first, whereas they used to.	
48 Lilly 22	I'll probably get struck off for saying things like that, but that's my personal feeling that it's not as it used to be.	
49 Lilly 25	So, there is still that sort of delineation, I suppose, ermm I don't think that GPs are very good working in a multidisciplinary team, I think the reason they became GPs is probably a lot to do with the fact they like working on their own, they like the autonomy, they don't like having to	Lilly is cold about this she has seen it all before and knows that she will still have to work under doctors regardless of whatever happens or she feels. This is how they work and this has to be accepted.

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	discuss their reasoning with other people.	
50 Lilly 91	As with all these NHS restructures they halve the people, but double the workload, so at Castle Point and Rochford, I had 27 practices I think, South East Essex, I had 70 odd.	
51 Lilly 93	So, you lose it to a certain extent, there has been loads in the press about how NHS managers are rubbish, we should get rid of them, there is a need for them, but I think there is a need for us to work in a different way.	
52 Lilly 94	I don't think it's that there are too many of us, in some respects there is not enough of us, but I think it needs a complete overhaul and a complete rethink.	
53 Lilly 102	I would say probably most managers in the PCT have never had management training.	
54 Lilly 8&9	So the people who are taking on a lot of these roles used to work on the front line and don't necessarily have management training or any education in management.	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	Have taken on these roles and it makes it quite difficult to work with them because they don't grasp what role or which hat they are meant to be wearing at that time.	
56 Paul 28	I mean if you look at the reams and reams now of paperwork that's there to be satisfied and the amount of staff needed to keep that going before the patient is even seen it doesn't seem (0.4) it has enhanced a service provision it may well have enhanced service audit.	
57 Lilly 79	Also when fundholding came in, I think GPs went, hang on a minute we need somebody with these sorts of skills, rather than you know in the olden days it was purely an admin job, in that you were counting numbers and were doing your staff do you know what I mean it was that sort of thing.	
58 Ajam 42 43	Ermm, in the good old days you used to, after graduating you become a house officer and became an SHA for about 18 months, and after that you had to do some postgraduate qualification	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	and then become a registrar for at least three years followed by five to eight years as a senior registrar before you could even think of becoming a consultant.	
	In Tony Blair's time this changed, you immediately became an SHO and within six months you became a SPR, which was Specialist Registrar, and after three years of that you could become a Consultant. So you can imagine the stepladder to the profession, how quicker one could become a Consultant… Obviously, the experience wasn't there, the confidence wasn't there and so the quality was not there.	
Lilly 50 27	I think you find the people, especially the older GPs that went into GP land are more the sort that actually don't want to be doing those multidisciplinary things and so then they find it hard to work in a multidisciplinary err, team.	
55 Lilly 87	I don't know, it felt as though it got worse as we have got bigger, that you become more distant from patients, the bigger the	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
	organization so when we were, I wasn't around for PCG, but I was there when the PCT was formed.	
56 Stuart 3	I think there are multiple hierarchies in the NHS because of the professional bodies, obviously part of one professional body nurses are another, managers usually aren't part of the professional body, but some of them may be doctors and nurses ermm, so I think there are parallel hierarchies that can make things ermm, difficult.	There is no identified structure for professional managers in the NHS – the obvious applies – MBA and membership of CMI etc but no formal mandatory prerequisite as is the case for medicine and nursing.
57 Ajam 12	There were no managers, nowadays in hospital wards the nurses have changed to managers! and deputy managers, and there are more managers than the nurses…	
58 45 Beth	Ultimately the power comes back to the PCT.	
59 28 Betty	Ermm, they didn't have much control over what was going where and we could put tighter reins on it you know and we did that exercise with mental health and we did that exercise with other providers and consultants and we actually…	

MASTER TABLE OF THEMES		
X ref	Abstraction of themes	**Initial comments**
Beth 60 58	They are getting all the power completely, which is what they want, like I said, some of them are trying to almost flaunt that, we can go up to the PCT laughing saying we have **all** the power.	
Rokh 61 92	It is vice versa as well, you can have a conversation in a room with managers and clinicians together and if you ask them what they are going to do about the situation, you will get different answers.	Rokh seemed at the time of the interview to be troubled. He is passionate about the issue and feels that this is a particular problem with clinical and non-clinical staff; that they will never agree and refuse, almost as a form of snobbery, to agree. But Rokh has no real evidence only what he observes.

Appendix C   Participant Pack: The Research Question Hand-out

<u>Please read the question below before we meet</u>

This is the only question I will ask during the interview.

I would like you to talk for one hour about your thoughts, experiences and feelings connected with the strategic milestone contained within the question below.

Research question

How has successive strategic policy implementation in the NHS since the introduction of the internal market in the 1980's and more recently, the introduction of integrated working in the 1990's impacted on inter-professional behaviour between doctors, nurses and professional managers and also service performance delivery in the NHS?

Sue

Appendix D Participant Pack-The Participant Information leaflet

Royal Docks
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PARTICIPANT INFORMATION SHEET

Title of the Research: Strategic policy, inter-professional behaviour and service

performance delivery in primary care in the NHS.

Sponsor: The University of East London Royal Docks Business School.

Study approved by: The University of East London Graduate School.

Investigator: Sue Truman, MPhil/PhD research student

I would like to invite you to take part in a research study, but before you decide please let me explain why the research is being done and what it will involve for you as a participant.

The aim of the study is to understand how successive strategic policy implementation in the NHS since the introduction of the internal market in the 1980's, and more recently, with the introduction of integrated working in the 1990's, has impacted on inter-professional behaviour between doctors, nurses and professional managers and also service performance delivery in the NHS.

Your participation will involve taking part in a one to one, tape recorded interview with the researcher for one hour to discuss how you feel about strategic change in the NHS and what impact, if any you feel this has had on how you interact with colleagues in medicine, nursing and management in the NHS, and whether this has had any impact on NHS service performance. The recorded interview will be transcribed by me the investigator and then verified with you, where you will have the opportunity to correct any part of the recording that you feel does not provide an accurate transcription of your views.

No significant risks have been identified to a participant other than being prepared to sit for an hour in discussion. In the unlikely event that any discussion topics prove stressful, the subject will be immediately changed to save the participant from any continued distress.

Permission has been granted by the Chief Executive Officer, Mr Andrew Pike, that the interviews can be held at the SW Essex PCT during normal work hours in a room of the participant's choosing where it is comfortable and not overheard. Alternatively interviews can be held away from PCT premises, I am more than happy to organise a room at the Murree Medical Centre instead.

An obvious gain from participating is that you will have a chance to contribute your views and opinions on NHS performance and government strategic implementation. It is also hoped that participation in the research will contribute to new theory about the relationship between strategic implementation, resulting inter-professional behaviour and possible impact on NHS performance.

It is important to stress that you do not have to take part in the study and that it is completely optional. It is also important to stress that even after you do decide to take part, you are free to withdraw at any time without giving a reason and any information already gathered will be destroyed immediately.

All information gathered via audio tapes and transcription notes and will be stored in an anonymous and secure format using a number coding system. No Information that is published will be recognisable and no direct quotes will be used. No information will be provided to anyone who is not directly involved in the study. The transcribed, anonymous data will be stored for 5 years in a secure environment and then destroyed.

The research interview process will follow ethical and legal practice and all information about you will be handled in the strictest confidence, Although it is important to point out the standard research process limitations to confidentiality and anonymity in an extremely unlikely event where there is an exception to the confidentiality and anonymity rule, where there is a disclosure of the information made 'in the public interest' or where there is a legal compulsion to report to the police,

When the study is finished I will write to each participant to thank them and to offer a copy of the completed research for their interest.

If you have any questions please do not hesitate to contact:

Sue Truman
The   Medical Centre

Thank you for taking time to read the information sheet.

Appendix E   Superordinate and Subordinate Themes Table

AC15 =SUM(AC13:AC14)

SUPER-ORDINATE THEMES Table 8.1

A	Colin - non clinical manager	Ajam - Doctor	Jill - non clinical manager	Betty - non clinical manager	Frankie - clinical manager	Ben - non clinical manager	Claire - clinical manager	Robert - non clinical manager	Dennis - clinical manager	Janice - non clinical manager	Paul - Nurse	Carol - Nurse	Douglas - Doctor	Malik - non clinical manager	Brenda - Nurse	Beth - non clinical manager	Chris - non clinical manager	Stuart - clinical manager	Dave - non clinical manager	Tracy - non clinical manager	Lilly - clinical manager	Kelly - clinical manager	Franz - non clinical manager	Rosh - clinical manager	Jillani - Doctor	Sue - Nurse	Sean Doctor	theme occurrence count total
Epochal Analysis (EA) - Super-ordinate theme																												
Subordinate themes																												
Awareness of Dominant culture (D)	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0			2
Awareness of Residual culture (R)	1	1	0	1	0	0	0	0	0	0	0	2	0	0	0	1	0	0	0	0	1	0	0	0	0			7
Awareness of Emergent culture (E)	1	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0			4
Total	2	3	0	1	1	1	0	0	0	0	0	2	0	0	0	1	0	1	0	0	1	0	0	0	0			13
Structure of Feeling (SOF) - Super-ordinate theme																												
Subordinate themes																												
Changes of Presence (CoP)	1	1	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0			4
Differentiated structures of feeling to differentiated classes (Dsoftdc)	3	0	0	0	0	0	0	0	0	0	1	0	1	0	0	1	0	0	0	0	1	0	0	1	0	0		8
Total	4	1	0	0	0	0	1	0	0	0	1	0	2	0	0	1	0	0	0	0	1	0	0	1	0	0		12

Appendix F   Transcript extracts demonstrating wengraf (2001)

notion of Intervew Interventions (II)

so it is ermm ...	
I have noticed, I have noticed in the past, since starting in the NHS it has got better errmm, yes, ermm yes it has got better than it was...	
Now we are not ( ) particularly.... (hissing with self-contained laughter – slightly manic) I start the point that err...(again bursting into contained mischievous laughter)	
(interviewer, laughs too, and says that it could be an issue with management? Taking into consideration the key milestones, what do you think has happened, do they all see each other as professionals? Or are their different views on this? What do they all see each other as?	K m in m in c
Ermm....err... I, I think, I think, I think that everyone sees themselves as 'professional' and I think that that is part of the problem, you know what is someone professional in errmm....	
And its around what we have had problems with within this PCT, is that we have had issues where we have by managers feel that they know more about some clinical stuff than clinicians do...	Ir is m d k is
And I think that starts to...starts to introduce risk ermm... into the compos motions ermm that will obviously get the clinicians 'backs	

out completely the psychology, mental, social aspect of it and just applying err err just like the kiddy toys you put the shape through, fit the shape you're in, never mind if that's actually what you need	
(Interviewer – so do you think that affects quality?)	
I think it does affect quality.	
(interviewer – pitching these two as separate training schemes together, expecting them to dove tail?)	
I think it is because what you are doing is is is the two roles are complimentary ermm and don't get me wrong, I don't think all doctors are perfect and I don't think all nurses are perfect, but what you need to do is recognise each strength.	
Now, ermm so in in that sense I think this issue of integration hasn't worked as well as it ought to and definitely a different view depending on whether you are in a hospital setting to if you are in a GP setting.	
Hospital setting a lot of consultants think their nurses are absolutely brilliant, trust them completely, leave them to it.	
If you look at the way the tariff is set up, that predisposes towards that because the tariff for a service is set with the consultant leading the service, if you get a nurse leading the service it makes more money for the hospital.	
Be honest if you are a consultant, ermm you have got to a level where you don't have to do the mundane boring stuff, you what interests you and the other stuff that's that's more predicable is less (0.4) interesting or	

Appendix G   Transcript example

Line/ box no.	Non clinical	Words	012 Carol
		Interviewer: I would like you to tell me what your views are about the research question:	
		Research question:	
		How has successive strategic policy implementation in the NHS since the introduction of the internal market in the 1980s	
		and more recently, the introduction of integrated working in the 1990's impacted on inter-professional behaviour between doctors, nurses and professional managers	
		and also service performance delivery in the NHS? I won't say anything but I will only repeat the question if you prompt me too.	
1	27:40	[Interviewer – so what did you think in the 80s where were you in the NHS?]	II
2		Ermm 1980s I… I had just qualified in 1979, 1980s I got my first sister's post on an acute ward in cardiology, ermm…	
3		The reason I got that post was that, ermm, I'd decided I'd go off and do a course in cardiac care, but the nursing officer at the time felt that it was totally inappropriate for a nurse to go and do extra training.	
4		'Did I think I was going to be a doctor?' And she didn't agree with it at all.	
5		Anyway, I went off and did this training and there were only about three of us, ermm and it	

		was a totally new thing to do, before that you just went and did your SRN training and did your nursing and didn't specialise in anything.	
6		(D) So there were only about three of us and within that training, a consultant led the course and he was very proactive and forward thinking and thought this was the way to go,	Nurse participant commenting on career development in the 1980s and what is most interesting is the surprisingly negative attitude from a colleague (sister in charge) and the supportive attitude from the consultant leading the course. This is a contradiction in terms as empirical literature points to the opposite view.
7		although I must admit some of his nurse colleagues felt a little bit disgruntled that this sort of new type of nurse was coming forward.	

8		So, coming back to my old hospital, ermm, all of a sudden it was the thing to do to go and get training and I was the only nurse in the hospital to have done this, so ermm, I soon got promoted at a very young age, at 23 I was a night sister.	
9		Ermm, and from then on I felt that ermm, other nurses looked to me because I had done that training and this was when courses after basic training started really.	
10		[Interviewer – and how do you think, how did the doctors react to that, this training?]	II
11	Felt Doctors supportive of Nurses doing extra training	I think they were yes, they were very supportive actually yes and they felt I was on par with themselves because I had that extra bit of knowledge in specialist care.	
12		The junior houseman with a trained nurse did tend to look at them for help and support in a way.	
13		The consultants really were above all that and weren't particularly concerned so long as they had a trained nurse on the ward.	
14		But the registrars, the senior houseman ermm, they really took it on board and encouraged you into their conversations and continued teaching you.	
15		I should imagine the doctors that were eight to ten years older were also proactive in thinking that this was the way forward for nurses.	
16		[Interviewer – so they were supportive?]	

17		Yeah, yeah.	
18		[Interviewer – do you remember what the managers were doing then, can you remember management, were they very peripheral or were they…?]	II
19		The managers that we dealt with were basically the nursing officers.	
20		[Interviewer – oh they weren't non-clinical, they were clinical?]	II
21		They were clinical, ermm didn't have any ermm, interaction with any other management at that time, we just had to report to them.	
22		Basically, they kept away from the wards, but knew what was going on, they didn't, ermm, relay any information going on, ermm, above their level so, ermm, it was a bottle neck really ermm, I felt they took information away from the ward, fed it to higher management and then didn't relay back what we needed.	
23		So, ermm, I can see why the nursing officers didn't continue in a way, ermm, perhaps they were threatened with their job because they were changes, they were the older generation and they were changes a foot.	
		So, I don't know but within my time working as a sister I saw the demise of the nursing officers they were gradually, ermm, got rid of one way or another, normally for silly reasons.	
24		[Interviewer – what ranks were they, was that the matron?]	II

25		Yeah, I would say it would be equivalent to a matron, you know, then you would have the senior nursing officer who was in charge of the hospital.	
26		Generally, I felt the ermm, senior nursing officer was more on a par with the nurses on the ward than the middle management.	
27		They disappeared.	
28		[Interviewer – do you know why they disappeared?]	II
29		No, because you weren't ever involved in the politics of it all, us on the wards weren't allowed to.	
30		[Interviewer – yes, interesting, so it just changed?]	
31		Yes, yes, so ermm, you know, so yeah, we weren't told.	
32		[Interviewer – and what replaced them or did they have a gap or did something replace them?]	II
33		You tended to have the senior sisters then, it was junior sisters and senior sisters and we had the senior sisters, ermm, doing (0.4) they reported to ermm, a manager that was in charge of managing wards, I can't remember the names now.	
34		This was coming towards my end of time in the hospital and this was when they were looking at closing hospitals as well, centralising into bigger hospitals	
35		This was 1988–1990 the big cuts.	

36		[Interviewer – so then you came out of there what prompted you to do that?]	II
37		Ermm, lots of reasons, well a couple of reasons really, they were getting rid of the local hospital that was Orsett and it would have been Basildon and I couldn't drive and had two small children.	
38		Also, the manager in charge of the medical unit was very, very unsympathetic if you had children ermm, and ermm, my grade got lowered and I had to go back as a staff nurse.	
39		[Interviewer – was the manager a nurse?]	II
40		She was a nurse, ermm a spinster, and she told me that, ermm, no way was I was right for nursing after having children.	
41		So this was 1990, so I wasn't capable of continuing and I had been working as a senior nurse for ten years, but looking further into it I was one of the highest paid night sisters.	
42		[Interviewer – so you feel it could have had a bearing?]	II
43		Yeah, so I left the hospital which I had started training at when I was 16, I left at 30, ermm very upset, ermm, and decided that I'd go into community care with the insight that I am sitting here watching people destroy their lives with heart disease.	
44		There was the education information out there about healthy lifestyles, but it wasn't seen as appropriate if they were in like (0.4) looking at what causes the disease.	

45		I thought, *well, I can do something about this in my little way* and ermm, that's when I went into practice nursing in 1990.	
46		My colleagues in the acute side thought that ermm, that was a dismal way to go because all I would be doing was washing out ears and giving injections and I'd be in a cupboard somewhere.	
47		[Interviewer – and were they right or wrong?]	II
48		I was in a cupboard (laughs) had no equipment ermm, cause 1990 was the beginning was the beginning of practice nurses, just before then was when it all developed.	Felt 1990s was the beginning of practice nurses
49		[Interviewer – this is interesting, tell me more about that; how did that develop then, so you went into it, it was a new thing. What had they used before practice nurses then?]	
50		They hadn't, they used to really, the surgeries, from what I gather, used to employ enrolled nurses and nurse/receptionist or I would imagine they had some receptionist doing the basic nursing duties, but weren't there specifically for nursing duties.	
51		There were no protocols, no guidelines, no, ermm and it basically there was a group of us in Thurrock who got together and thought, *this isn't the way nursing should be* and ermm, and formulated our nurse forum because we were aware we were working in isolation.	

52		We really felt the GPs didn't know ermm, how we should promote our skills or…	
53		So we made this forum and we decided we'd make our own procedure manual, ermm to give us some sort of governance.	Nurses forum started which helped bonding between nurses
54		So, and then that all caused a great deal of bonding between local practice nurses ermm, and this was sort of ermm, identified by the, was it health authority at the time, HAS? Yeah, it was and encouraged.	
55		So we had an awful lot of support from the health authority.	
56		[Interviewer – but you kind of built your own environment?]	
57		Yeah, we nurtured ourselves I think and supported ourselves and I am afraid I think that has all gone now to a point.	
58	Nurses felt unable to work with doctors; felt separate entity	I think comparing then we didn't feel we could work with GPs, GPs had their own work to do and we were a separate entity, but now I feel that nurses and GPs are more integrated, ermm more aware of their work load and hopefully a lot more GPs are a lot more supportive of their nurses.	
59		I think they realize ermm how important it is to have a practice nurse whereas in the 1990s you were an added bonus.	
60		[Interviewer – and what was their attitude then the doctors, you say they worked separately, but obviously there had to be	II

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		some sort of communication, what was that communication like?]	
61		It was, I felt, when I started it was very much through the practice manager, ermm, and it was up to the individual nurse to even make herself known to the doctor and ask questions and ermm, advice and all that sort of thing.	
62		My practice manager at the time, everything had to go through her to ask the doctor, because the doctor was always too busy doing jobs that practice nurses do now, like smears and ear syringing.	
63		[Interviewer – so what did you do then, what work was it?]	II
64		I think it was very basic stuff like dressings or helping with minor ops, assisting, but a lot of it was, ermm, doing these hypertension clinics you know, ten blood pressures so doctors could get payments basically and the smears, that was about the same time nurses started doing cervical smears.	
65		[Interviewer – how did you think the doctors got on with that at first were they happy with it? Was it their idea?]	II
66		I was lucky because I went into a surgery that the senior doctor was also a registrar when I was a nurse so he knew my capabilities, he knew me before.	
67		The new doctor that started there it took maybe two years, before he felt confident in allowing me to do other jobs.	
68		In fact, when we had to do lots and lots and lots of courses and	

		I remember I went off to do the asthma diploma and he was very, very good at teaching me ermm, but he would not let me do the asthma and see to the asthma patients for a good 18 months afterwards till he felt it was appropriate.	
69		At the time you come back with all the ideas of what you can do and how you can change it, but on retrospect, I can now appreciate how he felt he's going through an experience that you learn what you should, and shouldn't, be doing and you shouldn't be guided by text books for what is seen as the gold standard, because that doesn't really relate to giving best patient care.	
70		So, although it is a bit protracted I can see why now because he just felt so responsible for his patients and didn't want some nurse coming in and messing up all the medication.	
71		But now, oh my goodness me, it's 20 years later, I just get on with it all, same doctors we have all grown together.	
72		[Interviewer – do you remember the PCT before PCGs, can you remember their influence or lack of – what were they doing in amongst all this?]	II
73		They, it was not so much influence I think it was involvement more, they were very much smaller commodities then and we had the local offices in Grays and it was a case of you could nip in there if you had a problem and ermm, you know, they used to come	

		and do their visits once a year to see how we were.	
74		It was very much on first name terms and, yeah, it was nice, quite reassuring really, to go to them like that.	
75		Now, it's someone on the end of the phone, you don't get your problem sorted out there and then like you used to.	
76		[Interviewer – how has the relationship worked between non-clinical management and the clinical people, was there any conflict about that or was…?]	II
77		Oh yes, oh yes, I think ermm, from a clinical perspective they didn't like someone just down the road that could pop in, ermm, but again relationships grow and people knew each other and then after a while they weren't bothered…	
78		For a long time it was very much behind closed doors what doctors wanted to do because it was their business at the end of the day.	
79		From the nursing perspective and, perhaps, the practice manager's perspective, was in a different light, ermm, because then we were aware it was changing, evolving times and we needed to know what was going to be happening so we could plan.	
80		[interviewer – when you say it was a changing, evolving time, can you remember what was going on, what happened to change that set up?]	II
81		I think it was going from working from ermm, disease	

		management to health style management and public health issues, ermm, I think that's where basically things were evolving.	
82		Perhaps the GPs at that time didn't think it was anything to do with them because they were there for the sick patient, hands on bit.	
83		That's all I can surmise really from my situation, obviously every situation is different and when I compare to now (0.4) nothing's really changed.	
84		There's enough work for the doctors to do the hands on stuff, ermm, and there is still need to give holistic care and lifestyle health, although doctors are aware that the service is out there and perhaps bring it more into their conversation.	
85		I wouldn't say that they refer on, just give them the information within the surgery.	
86		[Interviewer – where do you think your profession changed, because obviously it has changed, can you remember that pivotal time when it changed and how it changed?]	II
87		Err, (0.6) no, I just think it has evolved.	
88		[Interviewer – you haven't sort of felt a change. Since you have been in the community, you say it is different to the early days to now, what made it different, why?]	II
89		I think, yeah, I think now it's different because we have the community nurses involved and whereas we worked in isolation, ermm, now our role is turning	

		that we work with our community colleagues more.	
90		Perhaps are more of a sign poster, where we didn't have that before.	
91		[Interviewer – how do you get the rest of the nurses, are they just as happy as they were or different?]	
92		It's ups and downs and has been all along, it's sort of testing the waters, as your nursing colleges come in really.	
93		I found I have to be very much aware of the stresses and strains they are under, especially with the situation at the moment and what their work involves and I think this is where we will need to work together more in the future to understand each other's roles.	
94		Because I should imagine it was about five or six years ago ermm, that it was seen could take the practitioner could be taking over the district nursing role they felt really quite threatened about that.	
95		That didn't do us any good at all, I think then everybody went off in their own little teams and silos.	
96		[Interviewer – do you think that affected quality?]	
97	People more concerned for their jobs rather than benefit of patient	Definitely, yeah, because you know you've got in mind communication talking to each other for the benefit of the patient, but that wasn't happening, well, everyone was concerned about their jobs.	

98		Yeah, but ermm, yeah, it did make a difference.	
99		[Interviewer – they went quiet and you couldn't actually work together to treat the patients, why weren't they discussing the issues why do you think?]	
100		Well they were reporting back to their bosses ermm I think it's a time where protocols, guidelines whatever, got really silly, ermm, you know they had to talk to their line manager who probably didn't have a clue what was happening in the locality.	
101		The line manager wouldn't be talking to the GP or anyone out there ermm, and I think ermm, the nurses are probably quite frightened to think laterally to go and talk to their colleagues in the community.	
102		I would say that happened, I should about six or seven years ago, ermm because, before that, we were very much aware of the district nurses coming in seeing the doctors, talking about the patients.	
103		Then that all seemed to be taken away and it is only really quite recently because ermm, of commissioning and GPs are saying we want to know our nurses we want to work together that all of a sudden they have been allowed, ermm, to come and…	
104		[Interviewer – so do you think the latest strategy ermm, proposal is going to be a good thing, is it going to improve quality, how are people going to work with that, you know the three non-clinical, clinical and management, how do you think	II

		they are going to get on with that?]	
105		I think it has potential to work well together, ermm but, it's got to be gradually and slowly, if it changes too quickly ermm, then obviously problems will occur.	
106		People will go back and hide behind the guidelines or report to the managers again.	
107		[Interviewer – is that what happens with people when they feel threatened?]	
108		Yeah definitely, ermm, you've got to feel comfortable haven't you in where you are working and you know we are not just sort of thinking about the patient here, as professionals you are thinking of your registration (laughs)…	
109		If you haven't got your line manager on board with you, ermm and something happens they are going to say what why did you do that and why didn't you report to me.	
110		So that's why it's got to be taken slowly, because if you do do something with the patient it has to be in agreeance with someone and you need the GP on hand because, as I say, the line manager is probably in a building somewhere at a meeting.	
111		So they are not going to be aware of the situation at the time.	
112		[Interviewer – what about the non-clinical managers, how do you think they are going to get on because, you know, if everything changes, what do you think the dynamic will be	

		there remembering what they were like before, in recent times and back further?]	
113	Worried re non-clinical management feels okay if been in job for years but not if just coming into NHS!	Ermm non-clinical management err (0.4) I think the experienced ones who have seen the changes before and learnt ermm, that'll be fine, but ermm, still going to people up and coming in management who have been ermm taught ways, business strategies ermm that cannot pertain to the NHS because it is so diverse.	
114		The same mistakes will be made again.	
115		[Interviewer – do you think they were mistakes then, do you think they had ideas that didn't fit with the organization?]	II
116		I think so, I think…I think they were just again ermm, given this agenda and followed it to the best they had been taught.	
		As I say, it is so diverse in the NHS and so much history and you need people with the experience to say we did this 20 years ago, it didn't really work.	
117		People get disillusioned and move on, ermm so just take things slowly.	
118		[Interviewer – when the managers tried to do that who told them to do that who gave them the agenda?]	II
119		It would have been from the DoH basically.	
120		You can still perhaps work that to your way of thinking.	