

THE PROFESSIONALISATION OF AUDIOLOGY

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**Thesis submitted to the University of Nottingham
For the degree of Doctor of Health Science**

June 2019

Abstract

While it is generally accepted that the professions enjoy a special status within modern western societies, it is increasingly recognised that new models of public management reform, with their slant on cost containment, pose challenges to the professions, especially those in the public sector. The purpose of this thesis is to explore professional development in UK audiology in the context of public health management reforms between 1997 and 2016.

A chronological case study design informed by methodologies for studying elites was used to examine a range of data including one-to-one interviews with professional elites; and secondary materials including policy documents and trade press articles, to explore professional development.

The findings of this study demonstrate that Audiology was considerably influenced by the state between 1997 and 2016. Models of public management reform, especially New Public Management, were used by the state to improve access to hearing healthcare in the UK. Undoubtedly, the professions' relatively small size and low status made it more responsive to state intervention as compared to archetypal professions such as medicine. The role of elites within the profession was to negotiate and reconcile the demands of the state and public with their own desires. Achieving social closure and status was a primary objective for elites, even in an age of austerity. This study reveals that the public was also an important stakeholder in professional development, having co-produced the Modernising Hearing Aid Programme in the early 2000's, which saw the introduction of a digitised infrastructure and new clinical processes for fitting hearing aids in the National Health Service. Latterly there

were indications that the profession was adopting a new role in mediating the excesses of cost containment, which threatened to reduce access to quality hearing healthcare.

Exclusionary tactics aimed at social closure and increasing status continue to be primary objectives for professions like audiology, although the role for professions as mediators between state and public should not be underestimated, and this raises questions around themes of 'new professionalism'. This thesis supports the role for professions as mediators between the state and public and makes practical suggestions for how this might conceivably, be achieved.

Archetypal professions such as medicine and latterly nursing continue to dominate the professions literature. The originality of this thesis rests on its focus on a relatively small healthcare profession which may be of interest to other small professions outside of audiology.

Acknowledgements

I want to thank the many people who have contributed to this work in one way or another over the last decade:

My current supervisors Professor Stephen Timmons and Dr Fiona Moffatt who have supervised me for the majority of my studies and have shown great patience with me. I thank them particularly, for their unwavering commitment to seeing this project through. Their ideas and suggestions have significantly improved my work.

The nature of this project required a deal of networking with leaders in the field of audiology. I want to thank all the participants for their time and insights as well as their interest in this project. I am struck by your collective commitment to the development of our profession for the betterment of the patients we serve.

Next, I want to thank Jonathan Butler my friend and colleague. As well nurturing my career, you have also been a great sounding board for the many ideas and concepts discussed in this thesis.

Also, I would like to extend my thanks to all my friends, old and new for your encouragement and patience. A special thanks to Richard Bazire for your handy IT skills.

Finally, I want to thank my immediate family. To my brother Simba, you set the standard for hard work and dedication. To my mother Bernice, for the many sacrifices you have made to ensure I reached this point, thank you.

List of abbreviations

AoHL	Action on Hearing Loss
AQP	Any Qualified Provider
BAA	British Academy of Audiology
BAAS	British Association of Audiological Scientists (superseded– now BAA)
BAAT	British Association of Audiological Technicians (superseded– now BAA)
BSA	British Society of Audiology
BSHAA	British Society of Hearing and Audiologists
BSHT	British Society of Hearing Therapists (superseded – now BAA)
CCG	Clinical Commissioning Group
CSO	Chief Scientific Officer
DH	Department of Health
ENT	Ear Nose and Throat (Otorhinolaryngology)
HCPC	Health and Care Professions Council
MSC	Modernising Scientific Careers
NDCS	National Deaf Children’s Society
NPM	New Public Management
OECD Development	Organisation for Economic Co-operation and Development
PA	Public Administration
PCHI	Permanent Childhood Hearing Impairment
PMR	Public Management Reform
RCCP	Registration Council for Clinical Physiologists
RHAD	Registered Hearing Aid Dispenser
RNID	Royal National Institute for the Deaf (superseded– now AoHL)
UK	United Kingdom
US	United States (America)

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Chapter 1: Introduction and background

I will begin my thesis with a reflective account of how I came to be interested in this research.

1.1 Reflection on my motivations for this study

My interest in the professionalisation of audiology dates back to my time as an undergraduate audiology student. While I had a general interest in the sciences, what attracted me the most about audiology was the way in which it was marketed as an exciting career opportunity. The newly formed bachelor's degree was marketed as evidence of the general aspirations of the profession. Indeed, seeking social closure and status through credentialing is a critical strategy for professions who seek to exclude undesirables from practice (Wilensky, 1964; Larson, 1977; Freidson, 1970; MacDonald, 1995). I came to learn that the state had invested in a modernisation programme in NHS hearing services and as a result, there was a shortage of audiologists. Not only did this mean a guaranteed job after graduation but it also meant significant opportunities for career development.

However, a significant consequence of modernisation was a substantial increase in the demand for NHS hearing aid services. In practice, we faced the daily challenge of having to inform our patients of waiting times for digital hearing aids up to three years. The same picture was reported nationally (The Health Committee, 2009), and faced with seemingly endless waiting lists, the work was monotonous and almost exclusively focused on hearing aid assessment and fitting to national protocols and recommended procedures. The variety of

work and the opportunities to develop a career were more difficult to attain than was initially indicated. I did not realise at the time that protocol-based care had been enshrined in public policy as a way of making healthcare more efficient and cost-effective (Department of Health, 2000).

I felt the situation was worsened by the decision of some strategic health authorities to put their NHS audiology services out to tender, and this was part of a more comprehensive state initiative to drive efficiency and increase capacity for hearing aid provision in England (Department of Health, 2000; 2004; 2010). Through various communication channels such as email, trade press and regional meetings, audiological leaders made regular efforts to reassure the profession that they were doing everything in their power to speak up on our behalf to the state. They were often critical of the state, particularly the Department of Health, for their intrusion in our professional affairs. However, despite all their rhetoric and their reassurances, many NHS departments in the UK, including my own, lost work to independent companies through tendering processes.

For the patients involved, this meant that they had a greater choice of service provider, although sometimes the NHS departments they had come to rely on were no longer open to them. I found this particular aspect quite challenging. My patients were being made into 'consumers', free to choose from a range of providers, except their usual NHS services where many had built long-term and meaningful professional/client relations. I felt that what the NHS was offering was a deceptive form of choice (Kuhlmann, 2006). In the few years after qualifying and securing my first permanent position as an audiologist, I became disillusioned. I was disillusioned with the state, which I

thought was undoing the gains it made through investment and reform into modernisation, and with our professional leaders whom I saw as being ineffective in the wake of endless policy reform aimed at intruding on professional matters.

Encouraged by my then service manager, I decided to attend the 2008 British Academy of Audiology (BAA) conference and use my time there as a networking opportunity with the purpose of figuring a way to advance my career and make a difference in our profession. I spoke with many audiologists, but mainly managers and professional leaders about my concerns. Interestingly many of them felt that audiology had reached a crossroads and they advised that for the profession to raise its status we required more audiologists with postgraduate qualifications like masters and doctorates. While this advice appealed to my interest in further study, I did not agree that credentialing was necessarily the only answer to ensuring better patient care. I have come to learn that this forms a gendered strategy aimed at social closure (Witz, 1992).

In 2009 I was accepted by the University of Nottingham to study on the Doctor of Health Science (DHSci) course. Many of my early supervision meetings involved documenting the various challenges facing audiology in the UK. Through the supervision process, I was encouraged to explore literature relating to the sociology of the professions. Research in this field allowed a way of organising and critiquing the professionalisation process in audiology. However, it was also apparent that the literature was largely informed of studies on established professions like medicine and nursing, and that there were gaps that a study in audiology could fill (Larkin, 1983). During

the early stages of my doctoral studies, I formed some questions, many of which I will rearticulate later. They included:

- What is the nature of the profession/ state relationship for small professions like audiology compared to larger established professions like medicine?
- What is the reach of the power of our professional elites?
- How can sociology inform future practice?

1.1.1 What I have learned from my studies

Almost a decade has passed since I began the DHSci course, and in the past few years my career has advanced to the point that I now lead an audiology service. Through my studies, I have been able to reflect on my initial frustrations and constructively reframe them. The topics I have discussed so far; the professions' aspirations, career prospects, professional elites and credentialing, are all related to notions of professionalisation. Whereas, issues of state involvement in professional affairs ranging from modernisation to patient choice and quality are part of a broader initiative under public management reform. There is a growing interest within sociology of the effects of public management reform on professionalism and professional development. However, as stated, much of what we know about professionalism in healthcare is formed from studies on medicine. Therefore, the professionalisation of audiology, a relatively small profession, is of interest to the sociological canon, as it is to other small health professions (particularly those now classed as the healthcare sciences).

Of the many lessons learned, the most important for me is that professional development is not unidirectional. The profession is

afforded many opportunities for growth, and this can be through the encroachment of other professional work (typically taking unwanted jobs from ENT), expanding the market for professional goods and services, and academic training (Abbott, 1988; Kuhlmann, 2006). Secondly, successful professional development relies on a rhetorical strategy aimed at reconciling the needs of different stakeholders in hearing healthcare, for managers, this includes the needs of staff, patients and hospital Trusts. For professional elites in the public sphere, the stakeholders include the profession, public and state. While at first, this may seem obvious, the ability for professions to put their interests (social closure and increased professional status) before those of the public and state should not be underestimated (see Larson, 1977; Timmons, 2010).

In the remainder of this chapter the topic of public management reform, professionalisation and professionalism are introduced. Following this the scope of the audiological profession, including facts and figures and the historical development of the profession are discussed. I conclude with reasons why a more comprehensive study of audiology is warranted before setting out a plan for this thesis.

1.2 Introducing public management reform, professionalism and professionalisation as a topic for study

Over the past twenty years or more, the neo-liberal management of public health services, particularly in the UK, has sparked debate about the changing nature of the healthcare professions and professionalism (Bezes et al., 2012). Neoliberalism has spawned a range of public management reforms aimed at making the state more efficient. The net effect of these reforms has seen an increase in bureaucracy and the introduction of quasi-markets for healthcare

(Hanlon, 1998; Freidson, 2001; Evetts, 2009). Latterly, new forms of governance have been introduced to make the state more accountable to the public (Kuhlmann, 2006). It has been observed that market and bureaucratic logics are increasingly being adopted into professionalising discourse leading to new forms of professionalism (Fournier, 1999; Evetts, 2011; Moffatt et al, 2014).

With regards to the health professions, medicine, in particular, has received the most attention from sociologists studying the professions and professionalism. The hallmark of medical professionalism, that is, the way it controls its work, is generally monopolistic and highly autonomous (Freidson, 1970). Medicine has been able to effectively capture the state which grants it legal state licensure to practice in such a way. Although public management reforms may have eroded aspects of its status and autonomy, medicine is still able to resist change, unlike other smaller healthcare professions such as audiology (Freidson, 2001; Kuhlmann, 2006).

Our understanding of professionalisation, that is, the way in which professions develop, maintain and defend their jurisdictions of work, is also limited to studies of a small number of archetypal professions. The process of professionalisation is played out through a rhetorical process, which is specifically located within the elite strata of the professions (Larson, 1977). The challenge of professional elites is to reconcile the different needs of the profession, the state and the public (Kuhlmann, 2006; Abbott, 1988). Apart from the fact that the subordinate healthcare professions seek to expand their territory, we understand very little about how these different needs are reconciled (Kuhlmann, 2006).

Furthermore, a decade of austerity following the 2008 global financial crash has played a vital part in the professionalisation process. Austerity can result in radical public management reforms aimed at cost containment, and this, in turn, can affect patient care (Pollitt and Bouckaert, 2017). In hearing healthcare, austerity has resulted in disinvestment, and so an examination of professionalism and professionalisation is timely (AoHL, 2012, 2015b; NDCS, 2017). There is an opportunity to learn from sociology and make a contribution to the broader professions' literature. However, before setting out a plan for this thesis, some basic facts and figures about hearing healthcare are presented.

1.3 Hearing loss – facts and figures

According to the World Health Organisation (WHO, 2017), 466 million people in the world have a disabling hearing loss, and this is due to rise to over 900 million by 2050. It is estimated that 34 million children have a disabling hearing loss, however, in 60% of these cases, the cause of such loss is preventable. The majority of hearing-impaired children live in developing countries where access to hearing services are limited or non-existent (Jauhiainen, 2001). Furthermore, the profile of aetiologies varies considerably between developed and developing countries regarding the proportions of ototoxicity, neonatal infections, otitis media and genetic factors (Jauhiainen, 2001; Clark, 2008).

In the UK, 11 million people have hearing loss, and this accounts for approximately 1 in 6 people (AoHL, 2015). Due to population growth and specifically an increasingly aged population, it is possible that the number of people with hearing loss in the UK will rise to 15.6 million people or 1 in 5 of the population by 2035 (AoHL, 2015a). It is

estimated that in 2013, the UK economy lost £24.8 billion in potential output because people with hearing loss were unable to work (AoHLA, 2015).

In England, about 1000 (1.6 per thousand) babies are born each year with a permanent childhood hearing impairment (PCHI), and in 40% of these cases, the hearing loss will be severe to profound (Department of Health, 2008). A further 600 children develop or acquire a PCHI by the age of ten, and this may be the result of congenital or genetic factors that become manifest after a period (Department of Health, 2008). 30-40% of children with hearing difficulty have additional needs, and there is evidence to suggest that these children are more likely to experience mental health problems or be abused. Furthermore, otitis media with effusion (OME), or glue ear, is the most common childhood illness and a common cause of temporary hearing loss (Department of Health, 2008). OME may fluctuate and be prolonged, and when it is more persistent, it may lead to educational, language and behaviour problems.

Unaddressed hearing loss poses a global cost of around US \$750 billion per year and interventions aimed at prevention, identification and amelioration are cost-effective and bring great benefit to individuals. Nevertheless, in developing countries, the struggle to meet basic health demands such as providing clean water, housing and dealing with malnutrition means that hearing impairment remains a low priority (Jauhiainen, 2001).

There are many personal and social costs associated with hearing loss (AoHL, 2015). These include social isolation which often leads to problems with depression and other mental health problems. Hearing

loss can affect a child's educational attainment and may contribute to difficulties in adults securing and maintaining employment (NDCS, 2017). According to the RNID, adults with severe or profound deafness are more likely to be unemployed than the general population (RNID, 2007). Therefore, hearing healthcare plays an essential role in solving the personal and societal costs of hearing loss and deafness, and audiology is the identifiable profession responsible for this role.

1.4 A brief history of the profession of Audiology

Audiology is one of some fifty healthcare science professions practising in the National Health Service. Like many other professions subsidiary to medicine, it grew out of burgeoning technological and social developments in healthcare after World War II, and like its counterparts, it bears the common characteristics of professionalisation, that is, through the development of institutions and practices, it seeks to develop, maintain and defend a heartland of work (Abbott, 1988). Audiology has a profile of high technology for equipment and hearing instruments and requires highly trained and qualified expertise of different professionals, and this means that it is a luxury of the countries with well-funded health, social and educational frameworks (Jauhiainen, 2001).

It is believed that many 19th and 20th-century German scientists and otolaryngologists (Ear, Nose and Throat – ENT) laid the groundwork for the profession through their use of tuning forks for diagnosing hearing loss (Jerger, 2009). The most famous of these were Ernst Weber (1795-1878) and Heinrich Rinne (1819-1868). Respectively, they are famous for the Weber Test for differentiating unilateral conductive from unilateral sensorineural hearing loss, and the Rinne

Test for differentiating conductive from sensorineural loss (Jerger, 2009). Of course, these tests are still in use today, though importantly, this fact highlights the close relationship between the profession of audiology and otorhinolaryngology (ENT).

Rehabilitation is an equally important aspect of audiological work. Primarily its development can be traced back to the need to rehabilitate deafened war veterans after World War One and Two (Baguley et al., 2006; Jerger, 2009). This situation was also a significant driver for the development of hearing aid technology (Baguley et al., 2006). In Australia, a rubella outbreak in the 1940s caused an increased number of children with hearing loss, and this was a significant impetus in professional development there (Byrne, 1994). Nearly all of these children were born to normally hearing parents, and so the demand for aural/oral forms of habitation was high (Byrne, 1994). The development of increasingly sophisticated technologies for the assessment and treatment of hearing and related conditions fed the demand for hearing services globally. In the UK and USA, this combination of factors led to the new profession of audiology (Baguley et al., 2006).

It is not exactly apparent when audiology became a discipline (Baguley et al., 2006). However, it is generally accepted that the words 'audiology' and 'audiologist' were coined in the USA between the 1930s and the 1950s to represent *"a developing professional speciality dealing not only with the medical aspects of ear disease but the propagation and transmission of sound to the ear, the processes involved in its perception and the psychological aspects of its interpretation leading to the reaction of the listener"* (Jerger, 2009; 12-13).

Over the last century, a more significant translational interface has grown between audiology and basic science, namely physics, biology, modelling and medicine, but to name a few (Cacace et al., 2016; vii). In the UK and USA, the main activity of the profession is the non-medical diagnosis and treatment of hearing, tinnitus and balance disorders. In UK practice, the diagnosis and treatment of hearing, tinnitus and balance problems require a multidisciplinary process, consisting primarily of audiology and ENT. Nevertheless, the relative status of audiology compared to professions such as medicine or nursing is debatable.

1.5 Audiology education and practice – an international perspective

As discussed, audiology has evolved from a range of related expertise in different health economies, and therefore there is a broad diversity of education and practice in the field (Goullos and Patuzzi, 2008). While audiologists are increasingly becoming the primary contact for the non-medical management of hearing, tinnitus and balance disorders, many other professionals are also involved including, audiometric technicians, hearing aid acousticians, teachers of the deaf, and speech pathologists. These various types of hearing healthcare professionals represent a broad diversity in the audiological curriculum internationally as well as within countries (Goullos and Patuzzi, 2008).

In English speaking countries, the Americas, Asia and the Pacific countries, audiologists are strongly represented. In Central and South America and South Africa, hearing healthcare professionals obtain a dual qualification in audiology and speech and language therapy. In

most European countries, including Austria, Croatia, Denmark, France, Germany, Italy, Norway, Poland, Slovakia, Slovenia and Switzerland, audiology is a specialisation after professionals complete their ENT training. The European countries have a more significant number of other professionals undertaking a narrower range of clinical activities, and their titles are closely linked to clinical practices; ENT technicians, hearing aid acousticians and audiometrists (Goulios and Patuzzi, 2008).

1.6 Defining Audiology as a profession

Having sketched out the development of hearing healthcare, including the effects of hearing loss, historical development, and education and practice from an international perspective, it is worth refining the definition of Audiology as it stands in the UK. Different theoretical vantage points argue that defining a profession is a 'sterile exercise', however, more recently there has been a resurgence in the taxonomic approach because it helps us understand what professions are and how they operate (Saks, 2012; 1). That there is an identifiable occupational group called Audiology, is perhaps the most significant clue that it is a definite profession (MacDonald, 1995).

In the UK, the main activity of the profession is the non-medical diagnosis and rehabilitation of hearing and balance disorders from birth. If Audiology in the UK has a protected heartland of work, it is the assessment of hearing thresholds and the fitting of hearing aids. Audiology is differentiated from ENT and Audio-vestibular Medicine, which deals with the surgical and medical management of hearing conditions, respectively (otology). Audiology then belongs to the set of 'para-medical' occupations as described by Larkin (1983; 2), that has sought to exclude doctors and organise as a profession. It is still

debatable how successful the so-called para-medical professions have been in their claims to complete jurisdiction (For example, Etzioni, 1969; Larkin, 1983; Abbott, 1988).

As Abbott (1988) discusses, while professionals aim for full and final jurisdiction, many, particularly in healthcare, will settle for subordinate jurisdiction, where Medicine still retains overall control over aspects of hospital work. Indeed, the proliferation of subordinate professions is thought to have created complicated and fuzzy jurisdictions which extend the dominance of professions such as Medicine (Abbott, 1988; 72). Abbott (1988) argues that this results in a profession having incomplete jurisdiction over aspects of its work, meaning the profession exists in a precarious state of jurisdictional flux.

It is common for audiologists to identify themselves by specialism or area such as adult, paediatric, vestibular and tinnitus. Audiologists primarily work in NHS departments, or within multinational high street companies. A smaller number of Audiologists work as independent practitioners and are mainly involved in the sale of hearing aids. The fact that Audiologists have different work sites across public and private sectors is a common feature of UK healthcare professionals, including Medicine and Nursing, and a growing plurality of provisions thought to rise from modern PMR (Hanlon, 1998). However, on its own, this facet of Audiology is not enough to define it as a profession in its own right.

Entry into the profession is through the completion of a recognised university course. The majority of audiologists complete a three-year Bachelor's degree. In the NHS, career progression can be achieved

by the completion of further training and qualifications (credentialing) as part of the Modernising Scientific Careers Programme, and this may include a three-year Scientific Training Programme (STP) resulting in a Master's degree. Completion of a five-year Higher Specialist Scientific Training (HSST) programme results in a Doctorate in Audiology. While MSC is the preferred route to career progression in the NHS, there is no evidence yet of the effectiveness or widespread use of the programme in Audiology career progression.

Many theoretical approaches consider a claim to distinctive knowledge and expertise as a definitive hallmark of professionalism (Freidson, 1970; MacDonald, 1995; Wilensky, 1964; Larson 1977; Abbott, 1988). However, it can be argued that not all learned occupations are necessarily professions because a claim to knowledge may be seen as part of a socio-political interest that supports a credentialist strategy (Saks, 2012). In other words, credentialing may be seen as part of a credentialist ideology linked to professional projects but may have no substance behind it. Indeed, Audiology in the UK has spent considerable effort incorporating the MSC programme into its professionalising strategy. The justifications for this are discussed in Chapter 4, Results and Discussion of this thesis.

There are three leading professional associations and societies for Audiology in the UK. They include the British Academy of Audiology (BAA), British Society of Audiology (BSA) and the British Society of Hearing Aid Audiologists (BSHAA). Functionally BAA and BSHAA are analogous, in that they represent the administrative interests of their membership. On the other hand, the BSA represents the scientific interests of Audiology in the UK. The formation of associations and societies are typical for professions wishing to organise their work

(including qualifying arrangements) and raise their status (Millerson, 1964; Wilensky, 1964). Associations and societies may form different functions as either administrative or knowledge arms of a profession as in the case of BAA and BSA, respectively (Freidson, 1994).

Does audiology bed classical marks of professionalism? Considering the few points discussed here, an identifiable occupational group, with a degree of specialised knowledge, and organisational structure aimed at supporting professional interests, then yes. However, it will become apparent throughout this thesis that Audiology has achieved nothing of the status or closure of archetypal professions such as Medicine. Furthermore, while it plays a subordinate role within otological care within the NHS, Audiology is also subject to a great deal of state intervention.

1.7 Why study the professionalisation of Audiology?

Since 1997 there have been significant transformations in audiology education and practice in the UK that are directly linked to state reforms aimed at making hearing healthcare more efficient and accountable. In brief, these transformations include:

- Modernising Hearing Aid Services (MHAS) – the introduction of digital hearing aid technology and corresponding infrastructure and training to the National Health Service
- The formation of the British Academy of Audiology – this represented the amalgamation of three associations and societies representing audiological technicians, audiological scientists and hearing therapists

- Modernising Scientific Careers (MSC) – the wholesale restructuring of the career pathway for the healthcare science professions including audiology
- The introduction of competitive quasi-markets for adult hearing aid work – achieved through the Any Willing Provider and Any Qualified Provider schemes in England

As discussed, medicine is still the focus of the sociology of the professions, meaning that there is still a lack of comparative case studies within the field (Larkin, 1983). While professional affairs are driven mainly by the state, audiology still bears the classic hallmarks of professionalisation through activities aimed at social closure and increasing status, including, the restructuring of its academic training, market expansion and encroaching on medical work (UK Health Departments, 2010; Department of Health, 2010; NHS improvement, 2010). Furthermore, the profession has a noteworthy relationship with the public, as evidenced by the co-production of large-scale projects such as Modernising Hearing aid Services, and this is of particular interest to the sociology of the professions as evidence that the public are critical stakeholders in professionalisation (Murdock and Lamb, 2009; Abbott, 1988; Kuhlmann, 2006; Kuhlmann et al., 2009).

As part of an abductive approach, the opportunity to study audiology in the UK is twofold (see Blaikie, 2007). Firstly, the sociological literature may support professional interpretations of the consequences and opportunities of contemporary public management reform. Secondly, the fact that audiology is a relatively small, self-contained and aspirant profession means that it is feasible to present as a case study on professionalisation

1.8 Thesis plan

Four chapters make up the remainder of this thesis; Literature review, aims and objectives (chapter 2), Methodology (chapter 3), Results and discussion (chapter 4), and Conclusions (chapter 5).

With a specific focus on the profession/ state relationship, the main aim of the literature review is to introduce the concepts of public management reform, professionalisation and professionalism. The literature review begins by introducing the broad concept of public management reform and specifically references New Public Management (NPM) and governance. Following this, the concept of professionalisation is discussed as a useful way of understanding how professions evolve. Next, the concept of professionalism, that is the way the way in which professional work is controlled, is discussed. Contemporary knowledge of professionalism focuses on a discourse of control, and instead of being eroded by public management reform, it has the potential to transform. The idea of new professionalism is discussed. A striking feature of the literature is that it draws from empirical studies on archetypal professions, and this forms a central reason to study audiology.

In the methodology, a reflective approach is used to discuss the chronological case study approach used to explore the professionalisation of audiology from 1997 to 2016. The epistemological and ontological foundations are discussed at the outset and are based on the notion that professions are socially constructed through the discourse of professional elites. Multiple sources of evidence inform this study, and they include documentary evidence and one to one interviews with professional elites. As such, several methodological issues are discussed, including the reasons to

study professional elites, the value of single case study design, and how, as part of an abductive analytical strategy, social theories and perspectives can help us understand the actions and accounts of professional elites.

The professionalisation of audiology between 1997 and 2016 is discussed in the results and discussion chapter, and this takes the form of a chronological narrative which examines the discourse of professional elites, state and public in light of the extant literature. The chapter is divided into early, middle and late phases covering four themes of development, which include; modernisation, independent sector involvement in hearing aid provision, Modernising Scientific Careers (MSC), and extending patient choice. Each phase of development is associated with an aspect of public management reform since 1997. A series of challenges and opportunities for the profession are summarised before turning to the conclusions chapter.

While the limitations of the study and recommendations for further research are addressed, the main aim of the conclusions chapter is to present some suggestions for practice. The fate of professional trust and ethics is discussed before suggesting opportunities for the profession to act as a mediator between state and public. Some examples from existing practice are presented.

Chapter 2: Literature review, aims and objectives

In this chapter the sociology of the profession's literature is discussed. Like most social concepts, our understanding of the professions owes much to classic social theorists such as Marx, Durkheim, Weber and more recently Foucault. Reference to these theorists is limited because it is not within the remit of this thesis to necessarily expound on these.

2.1 Identifying gaps in knowledge

Identifying the gaps in knowledge around audiology, professionalism, and public management reform was informed by an iterative literature search process. For seminal insights into professionalism, professionalisation and public management reform, critical texts by scholars such as Magali Larson, Eliot Freidson, Andrew Abbott and Ellen Kuhlmann, and Christopher Hood, Christopher Pollitt and Stephen Osborne were consulted. This reading was followed by searches of journal databases such as Web of Science, using keywords such as 'audiology', 'healthcare science', 'professionalism', 'professionalisation' and 'new public management', it was ascertained that there were no studies relating to audiology or other healthcare science professions. Most healthcare studies in this genre typically focused on medicine or nursing. Indeed, scholars in this field acknowledge the paucity of evidence of smaller healthcare professions (For example, see Larkin, 1983 and Timmons, 2010).

Given the length of this study, it was essential to keep abreast of emerging and developing literature. Knowledge and awareness of literature were maintained in several ways. Primarily, the literature search described above was repeated at regular intervals during writing and editing process of the thesis, and this is because the preparation of each new chapters and section offered the opportunity to search and revise emerging and developing literature. Also, the author subscribed the Professions and Professionalism Journal, an open-access, internet-based, peer-reviewed and English-language journal which focuses on the study of professions and professionalism primarily in Europe. It was set up in 2011 and is published three times per year. The author received and reviewed updates on the latest articles.

2.2 Organising the literature

Several attempts have been made to organise the profession's literature, and each attempt reflects the changing theories and perspectives in sociology (Abbott, 1988; Macdonald, 1995; Evetts, 1999; Dingwall, 2008). Abbott (1988; 3-9) categorises existing sociological work on the professions and substantive views on professionalisation in order of functionalist, structuralist, monopoly and cultural theories. Macdonald (1995), separates functionalist and interactionist alternatives. Evetts (1999) suggests that the professions can be understood in terms of conceptual schemes including professional dominance (Freidson, 1970), professional project (Larson, 1977), jurisdictional competition (Abbott, 1988), and patriarchal closure (Witz, 1992). References to many of these theories will be made in this chapter.

With contemporary developments that take into account the increasing role of the state in professional development, a more useful way to organise the literature is to separate the so-called demand and supply theories of professionalism (Dingwall, 2008). Traditionally, professions were presented as well-organised social groups that seized on the opportunity to capture the legislative process by seeking state licensure to secure a monopoly for their work (for example Hughes, 1958). Legally backed licences related to the demand for professional services. However, not all well-organised professions had successfully managed to secure a legally backed monopoly, such as in the case of pharmacy (Denzin and Metlin, 1968). Instead, state licensure was only granted when the profession's claims matched the wider state interests. Dingwall (2008) suggests that sociologists should look more closely at the circumstances under which states choose to supply monopoly licenses.

This literature review aims to explain the concepts of professionalisation and professionalism, and how they are being transformed in light of contemporary public management reform. It is assumed that the introduction of managerialism and the expansion of large professional employing organisations are the strongest correlating factors for changing notions of professionalism (Bezes et al., 2012). However, a possible decline in trust, relating to high profile (medical) negligence and malpractice scandals has also been suggested as another causal link to changing professionalism (Freidson, 2001; Evetts, 2009).

The chapter begins with an historical view of the sociology of the professions, before discussing the central tenet of this thesis,

professionalisation. Following this, the concept of public management reform is discussed as an important factor in the development of the profession/ state relationship. While public management reform has sparked collective action against managerial and bureaucratic forms of control, contemporary literature suggests that professionalism is being transformed, and therefore different forms of professionalism are discussed. As discussed, the most significant gap in the profession's literature lies in the absence of studies on smaller healthcare professions. This chapter concludes with a set of aims and objectives for the study of the professionalisation of audiology in the UK.

2.3 A historical view of the sociology of the professions

The first systematic attempts to analyse the professions came in the twentieth century as a result of the rise of the social sciences and the fact that there was a significant change in the professions themselves (Abbott, 1988). As Abbott (1988) states, the nineteenth century saw the first development of the professions as we know them today.

2.3.1 Functionalist views of professions

Early on, functionalist writings on the professions considered two methodological characteristics, combining naturalism and typology (Abbott, 1988). Early articles on the professions would summarise the life history of particular cases, review the-then current essential traits of true professions, and decide whether the profession was a profession (Abbott, 1988). While work in this genre rapidly built up a stock of case studies and compared them to a list of essential traits, this approach failed to recognise the natural variation and individuality of different professions (Abbott, 1988).

Structuralist attempts at explaining professionalisation incorporated the natural variation and individuality of professions. For example, Millerson (1964), recognised that the trait approach used by functionalists could be used politically to exclude certain cases from being called professions. He avoided this by identifying only very general traits of professionalism, for example, organisation, education and ethics, and permitted wide variation between them. Others, such as Wilensky (1964), accounted for variations by assuming that professional status was something that few occupations had yet achieved, and that diversity would disappear as these groups obtained the hallmarks of true professions (such as medicine and law). Wilensky's (1964) answer to this was professionalisation (discussed later), which he explained as a regular sequence of events. Nevertheless, the functional assumptions of the characteristics of professions were thought to be guaranteed by various intuitional forms such as associations and licensure (Hughes, 1958; Abbott, 1988).

2.3.2 The monopolistic tendencies of professions

In the 1960s, theorists began to reject the functional assumptions of professionalism and professionalisation and instead focused on the monopolistic tendencies of professions (Johnson, 1972; Freidson 1970; Larson, 1977). For Johnson (1972, 41), the emergence of specialised occupational skills created a relationship between social and economic dependence. That is, the state and the public became increasingly dependent on professional goods and services. Paradoxically, this dependence created relationships of social distance, as professions imposed both the definition of needs and the manner of services on their clients. Thus, Johnson (1972) highlights that professionalisation served the interests of professions rather

than those of the client, and this leads Freidson (1970) argues that dominance and autonomy were the hallmarks of true professionalism.

Larson's, *The Rise of Professionalism* (1977) is perhaps the most influential thesis in the monopolistic genre (see Macdonald. 1995). While it has been characterised as Marxist in its outlook because of its focus on professionalism and material reward, Larson draws equal insights from the work of Weber.

"Weber, in particular, defined the ability to command rewards in the marketplace as a function of both property and skill, and the possession of skills may be seen as a typically "modern" form of property." (Larson, 1977; xvi).

For Larson (1977), professions are typical products of modern industrial society. Even though occupational professionalism is being eroded (discussed later), it is her view that individual professional status is still undeniably middle class because it represents the typical aspirations of a socially mobile working class (also see Johnson, 1972). Larson's view is that professionalisation is an attempt to maintain a monopoly by translating special knowledge and skills, which are themselves scarce, into economic rewards.

2.3.3 Jurisdictions in flux

A review of the profession's literature would not be complete without mentioning Abbott' (1988) valuable contribution, *The System of Professions* (1988). For Abbott (1988), the success of professions is linked with how successfully they can make claims about their work, that is, claims of jurisdiction. These claims are made to audiences; notably, the state and public. The concept of jurisdictions leads Abbott

(1988) to analyse professions as existing in a system. In other words, professions are inevitably interdependent so that one profession can both influence and be influenced by another profession (Abbott, 1988). The significance of Abbott's work is that it offers an alternative to professionalisation (discussed later) and accounts for idiosyncratic developments in individual professions without invoking a social trend (Macdonald, 1995; 15).

2.3.4 Gender, professionalism and professionalisation

While feminist accounts of professionalism and professionalisation do not inform the overall thesis, it is worth highlighting such accounts given the gender make up of Audiology in the UK. In a BAA survey conducted in 2014, it was observed that within the NHS, the ratio of female to male staff is 4.5:1 (Beckman, 2014). There is also a significant majority of female staff in the private sector, while the genders are balanced within academic settings (Beckman, 2014).

In her thesis, *Professions and Patriarchy*, Witz (1992), states that the relationship between gender and professionalisation is a neglected one. The notion of professions are gendered because they take the successful projects of class-privileged males to be the paradigmatic case for all professions (Witz, 1992). The hegemony of maleness within professional ideology is supported by others such as Connell (1987), Riska et al. (1995) and latterly Kuhlmann et al. (2008). The overemphasis on medicine as an archetypal profession within the sociology of professions is perhaps a good case in point.

By developing a Neo-Weberian model for the study of gender and professionalisation, Witz (1992) summarises that throughout the history of professions, women have been excluded from the division of labour, or have had work demarcated from them by dominant male

professions. In the past, excluding women from routes of access to skills, knowledge, entry credentials, or technical competence, was the main exclusionary tactic used by men, and this has led Witz (1992) to conclude that credentialing is a gendered exclusionary tactic. The demarcation tactics involved the creation and control of occupational boundaries based on gender. In other words, women were circled into particular occupations such as nursing, teaching, and so on. Typically, these bound occupations were subordinate to male professions such as medicine (Witz, 1992).

While Witz (1992) provides a historical account of the development of gendered professionalising strategies, it is still evident today that gender plays a significant role in professional life. With a specific focus on the UK healthcare sciences, Bevan et al. (2012) summarise that women are lower paid, are valued less for working part-time or on temporary contracts, and gain salary progression and tenure more slowly than men. By examining discourse, Bevan et al. (2012) demonstrate subtly damaging masculinist discourse that promulgates taken for granted patterns of behaviour, beliefs, symbols and identities. Through empirical discourse analysis, they explain how men support men, men do not do support work, and men exclude women. Outside of the micro arena of worksites, Kuhlmann et al. (2008) discuss the impact of state policy on perpetuating gender imbalances within professions. By reference to General Practitioners in France and Britain, they demonstrate how policy leads to differing obstacles in the way of the female workforce. In other words, the issues faced by women are mostly dependent on differing state policies worldwide.

The historical concepts discussed here, have importance for understanding contemporary issues in professionalisation and professionalism. The development of sociological frameworks, from functionalism to interactionism, is illustrated well in the following discussion about professionalisation.

2.4 Professionalisation

The concept of professionalisation is contentious within the sociology professions. It generally refers to a series of processes by which occupational groups become professions. Wilensky (1964) is widely credited with first describing a typical process of professionalisation and observes that the labour force as a whole, in one way or another is becoming professionalised. Indeed, professionalisation is seen as a desirable pursuit for many occupations wanting to achieve exclusive technical competence, a service ideal and supporting norms of professional conduct (Wilensky, 1964). In many ways, professionalisation aims to achieve the kind of status enjoyed by archetypal professions such as medicine and law. There is a consensus that professions desire professionalisation (Haug, 1972; Abbott, 1991; Evetts; Noordegraaf, 2007; Timmons, 2010)

To describe a typical process, Wilensky (1964) studies the professionalisation process of eighteen occupations in the United States. These occupations included established professions (law and medicine), marginal occupations (nursing and school teaching), new occupations (city management and hospital administration) and doubtful occupations (advertising and funeral direction). Many of the professions considered were considered semi professions at the time (see Etzioni, 1969). Wilensky (1964) summarised the following sequence of professionalisation:

1. Start doing the thing that needs doing (the work)
2. Establishment of training school
3. Combine to form a professional association
4. Political agitation to win the support of law
5. A formal code of ethics

However, Wilensky (1964) noted several barriers to professionalisation. The first barrier is organisational complexity and bureaucracy. Secondly, the nature and structure of the professions' knowledge base is a threat to exclusive jurisdiction. If the knowledge base is too broad or too narrow, it risks codification, making it vulnerable to encroachment by outsiders (also see Haug, 1972; Abbott, 1988). The range of organisations that professions find themselves can make it difficult to follow a career path, as each organisation will set different rules and regulations. Lastly, the internal power structure of the profession may also determine the overall professional control.

"If the marks of a profession are a successful claim to exclusive technical competence and adherence to the service is ideal, the idea that all occupations moved towards professional authority- this notion of the professionalisation of everyone- is a bit of a sociological romance." (Wilensky, 1964; 156)

If the professionalisation of everyone is, as Wilensky (1964) describes, 'a sociological romance' then Haug (1972) takes this idea further by suggesting an alternative hypothesis, de-professionalisation.

2.4.1 De-professionalisation

Haug (1972) states that professions are increasingly located within or linked to bureaucratic organisations that force compliance with legal or quasi-legal rules and regulations for the benefit of clients. Like Wilensky (1964), Haug (1964) summarises that bureaucracy threatens professional autonomy and authority and goes on to assert an alternative hypothesis to Wilensky (1964); that de-professionalisation is a trend of the future. The idea of bureaucracy as an opposing logic to professionalism is discussed later (also see Freidson, 2001).

“De-professionalisation is defined as a loss to professional occupations of their unique qualities, particularly their monopoly over knowledge, public belief in their service ethos, and expectations of work autonomy and authority over the client.” (Haug, 1972; 197)

However, how does bureaucracy lead to de-professionalisation?

Haug (1972) observes several different trends. The first being the increasing use of computer technology that has the potential to codify data. The second is an increase in the general educational attainment of the general population, twinned with increasing access (through IT systems), will lead to the demystification of professional knowledge. Thirdly, the rise of so-called ‘para-professionals’, will challenge established professional boundaries (Haug, 1972). Indeed, the proliferation of new healthcare professions since the 1950s has been a particular challenge to medical dominance (Larkin, 1983). Finally, bureaucratisation which favours accountability, challenges the autonomy of professionals. What is clear, is that bureaucracy,

through some disparate trends, has the potential to challenge the knowledge base of professions. While the de-professionalisation thesis has been challenged, the sociological literature at least supports the hypothesis that bureaucracy is the most challenging logic for professions (Wilensky, 1964; Freidson, 2001; Evetts, 2003; Noordegraaf, 2007).

2.4.2 The role of elites in professionalisation

The role of professional elites in professionalisation is mostly overlooked within the profession's literature. In many cases, their role is only implied. However, Larson (1977) makes this role explicit by clarifying their paradoxical relationship with rank and file members of a profession. She states;

"The story of professionalisation is largely that of the aspirations of the rank-and-file professionals, as interpreted and organised by their leaders." (Larson, 1977; 84)

Therefore, a profession is almost always defined by its elites. It is they, who in Abbott's (1988) terms, make claims of jurisdiction on behalf of their profession to the public and legal spheres. Thus, elites speak to outsiders for the 'whole profession' and must maintain an image of solidarity, and this is typically achieved by projecting the achievements and identity of the profession (Larson, 1977). The projection of solidarity has two aims:

1. To maintain social control over professional work.
2. To control the rank-and-file members of a profession.

The first aim relates to maintaining social closure and the legal protection to control specific tasks for material reward (Larson, 1977). The second aim is part of a means of professional socialisation. However, the elites that are visible to the outside are not necessarily the same ones that wield internal power, neither do they originate from the same internal positions (Larson, 1977). While professions are considered homogenous groups to the public, internally, they may be very diverse (Abbott, 1988). Therefore, elites will originate from either the administrative or scientific arms of the profession (Freidson, 1994).

The projection of solidarity is also used to maintain control of the rank-and-file members of a profession (Larson, 1977). This is part of the profession's socialisation process. Thus, the standards that are defined by the elites are made part of each rank-and-file's subjectivity. Elites then control the material rewards (power or income) as well as the kind of esteem that counts. Conferring esteem is more straightforward to dispense than material reward. In this case, esteem counts for a promise to rank-and-file members; that is if they adopt a career in the chosen profession that they will one day achieve power and influence (Larson, 1977).

Because professions are ideologically constructed, then one will enter the profession by calling, or at least by choice (Larson, 1977). The expectation of a career is an influential factor of conformity and draws on the ideas of Wilensky (1964) that careers adopt a long-term view that defers immediate gratification for a later payoff. Thus, the paradox is complete; an individual's commitment to a career epitomises their self-involvement in professional work and this, in

turn, confers legitimacy of their elites on whom their future depends (Larson, 1977; 229).

However, this assumes 'successful' professionalisation, and two factors threaten this (Larson, 1977; 228). If the ideological nature of 'calling' is eroded, that is, if the just rewards of esteem are lessened, then the powerful element of social control (as used by elites) will also be eroded. The existence of 'alternative elites' is also tied to this in that they can diminish the control over an individual's self-esteem. However, this does not necessarily mean that the 'overall' control of the profession is diminished as collectively elites may share the same basic standards of professionalism. According to Larson (1977), the commonality of basic standards amongst the different elites is what maintains the control of the profession.

The value of Larson's (1977) treatment of elites is that it makes explicit what is generally only implied within the sociology of professions, that elites are essential in the professionalisation process and that their roles are inextricably linked with the careers of rank-and-file professionals.

2.4.3 Critics of professionalisation

The concept of professionalisation is not without its critics. Firstly, Evetts (1999) notes some substantial contextual differences between the US and other countries in the way that professionals are produced. While most professional associations share similarities, the exclusionary and licensing arrangements of different states can be very different.

The second criticism of professionalisation is aimed at its functionalist foundations (Johnson, 1972). Johnson (1972) takes issue with a notion of professionalisation that aims to reach ideal-typical professionalism. By true professions, Johnson (1972) is referring to archetypal professions such as medicine and law. Furthermore, ideal-typical professionalism is supported by functionalist models which stress the functional value of professional activity but ignores the power of the different professions within society (Johnson, 1972). In other words, a profession may exhibit signs of ideal-typical professionalism, but that says nothing about its power, its precise occupational control or professional activities. Johnson (1972) states that the functionalist approach is unlikely to provide a means of analysing variations in the organisation of occupations within different contexts. Johnson (1972) concludes that;

"The concept of professionalisation itself is a straight-jacket imposing view of occupational development which is uniform between cultures and unilinear in character. As a concept, it does not provide the means by which we might identify the structural basis for variations in occupational control, except in so far as they are deviant from expected progression towards professionalism." (Johnson, 1972; 87-880)

Thirdly, in developing a theory of professional development Abbott (1988) criticises the assumption that professionalisation is uni-directional. As Abbott (1988) notes, some professions stalled, died and even amalgamated with others. There is a body of evidence to show that particularly small professions are dependent on more traditional ones in the professionalisation process (Abbott, 1988).

Modern healthcare professions have relied on medicine in their professionalisation process (See Larkin, 1983).

Challenging the assumption that social structure and cultural claims of the profession are more important than the work professions do, is perhaps a defining feature of Abbott's (1988) thesis. This feature renders it amenable to studying the division of work within and between professions. Abbott, (1988) challenges the assumption that professions are homogeneous units, and like Johnson (1972), Abbott (1988) asserts that professions have their internal differentiation that contributes to external differences in interprofessional prestige, locations at work and access to professional power.

Abbott (1988), credits Johnson (1972) and Larson (1977) with bringing to attention the increasing involvement of the state and the general drift towards bureaucratic practice is reshaping professionalisation. Indeed, much of the contemporary literature discussed later confirms the view that professionalism is changing due to the state and bureaucracy. It also explains why terms such as de-professionalisation and the concept of semi-professions have passed out of contemporary use (see Haug, 1972; Etzioni, 1969).

Abbott (1988) rejects the concept of professionalisation in favour of the concept of professional development, and methodologically this balances the contrary imperatives of positivists who attempt to reduce cases to coded independent variables and theorist who delineates the mechanisms at play within lengthy cases. Nevertheless, despite proving that professions move in many directions, the concept of professionalisation has survived, and it endures for several reasons (Abbott, 1991). Firstly, it is assumed that

professionalisation focuses on the structural form of professions rather than the work they do, and this is generally acceptable when jurisdictions of work are uncontested or readily available. In this situation, regular processes of development may be observed (Abbott, 1991). Secondly, the belief that there is a process of strengthening occupational control may have partial truth. Abbott (1991; 356) suggests that professions have periods in which they move towards a given cultural model of "*how to be a profession*". Whether or not such periods produce a regular pattern of professional development is a matter of debate. While Wilenky's (1964) test of strict professionalisation is seriously flawed, (Abbott, 1991) concedes that it still warrants study and concludes that;

"My most important conclusion is therefore that the professionalisation process, if it is to be seen at all in changing professions, be recognised as the multilevel, contagious, complex social process that it actually is. Professionalisation is not a simple collective action by a cohesive group, and we cannot discuss it as if it were." (Abbott, 1991; 380)

While this poses issues for the generalisability of professionalisation (discussed in the methodology chapter of this thesis), the concept of professionalisation, in its loosest form, informs the central observation in this thesis; that audiology in the UK seeks to strengthen its occupational control and status. However, the role of other stakeholders in this endeavour, particularly the state, cannot be ignored.

2.5 Public Management Reform: Public administration, New Public Management and Governance

Over the latter half of the 20th century, there has been a reconceptualisation of the role of the state in professionalisation. Contemporary literature has tended to focus on the consequences of public management reform (PMR) and changing notions of professionalism (Bezez et al., 2012; Kuhlmann and Saks, 2008; Evetts, 2009). While the nature of PMR is contested, empirically, observers of public management policy have noted a shift towards the utilisation of managerial and consumerist ideals (Hood, 1991; Pollitt and Bouckaert, 2017).

It is widely acknowledged that public policy implementation and public service delivery have evolved across three regimes over the past century; from a longer pre-eminent Public Administration (PA), through to New Public Management (NPM), and latterly governance (Osborne, 2010; Pollitt and Bouckaert, 2017). These regimes represent the changing PMR. PMR can be defined as the *"deliberate attempt to change the structures, processes, and/or cultures of public sector organisations with the objective of getting them (in some sense) to run better."* (Pollitt and Bouckaert, 2017; 2).

PMR embodies a different field of sociological and organisational study to that of the professions. However, its inclusion into this review is important because the concepts of PMR are increasingly being adopted into the sociology of professions as a way of explaining transformations in professionalism (discussed later) (Bezez et al., 2012). The intention here is to provide simple definitions of the three regimes mentioned above. The three models of PMR are summarised in Table 1. While the definitions follow the broader historical utilisation

of the different regimes in modern western states, they can be used simultaneously (Pollitt and Bouckaert, 2017).

Model	Core Claim	Most common coordination mechanism
Public Administration	The dominance of the 'rule of law'. Policy creation and implementation	Political science and expertise and incremental budgeting. Central role for bureaucracy in implementation
New Public Management	To make government more efficient and more responsive to consumers by injecting business like methods.	Market-type mechanisms, performance indicators, targets, competitive contracts, quasi markets.
Governance	To make government more effective and legitimate by including a wider range of social actors in both policy making and implementation.	Networks of partnerships between stakeholders. These bring different skills and resources to address complex problems.

Table 1: A comparison of PA, NPM and Governance (Adapted from Osborne, 2010 and Pollitt and Bouckaert, 2017).

2.5.1 Public Administration

In the 1950's and 1960's PA differentiated significantly from the forms of public management we have today. PA was generally treated as a technical or legal matter, involving simple organisational or procedural changes, rather than a political or economic concern (Pollitt and Bouckaert, 2017). It was primarily a national or sectorial matter, where each nation or sector made reforms based on their circumstances, history and constitutional laws, and this meant that there was a great deal of differentiation between nations. Furthermore, international forums such as the Organisation for Economic Co-operation and Development (OECD) Public Management Committee or United Nations Public Administration Network, which became influential 'talking shops', did not exist (Pollitt and Bouckaert, 2017; 6).

However, a spread of global economic disturbances in the 1970's led to the growing belief that governments had become overloaded (Pollitt and Bouckaert, 2017). Increasingly, the Western welfare states had become unaffordable, ineffective and overly constraining on employees and citizens alike (Pollitt and Bouckaert, 2017; 6). This led to a growing desire to make government more business-like by saving money, increasing efficiency and acting more responsively to citizens. This trend was widely felt amongst several OECD countries including the UK and USA, whom all launched significant reform programmes during the 1980's. Components of these reforms came to be known collectively as New Public Management (NPM) (Hood, 1991).

2.5.2 New Public Management

NPM was coined as a generic label, intended to cut across the particular language of individual projects or countries and relates to several changes in public sector accounting in the OECD countries beginning in the 1980's. Hood (1991) lists the doctrinal components of a group of ideas known as NPM:

1. Visible, hands-on top management in the public sector.
2. Explicit, formal, measurable standards and measures of performance and success.
3. Greater emphasis on results, where resource allocation is directly related to performance.
4. Shift to separating/ unbundling the public sector into corporatised units which are organised by product of service.
5. Shift to internal markets, more contracts-based competition and fixed/limited term contracts in the public sector.

6. Stress on private sector management styles or tools in the public sector.
7. Stress on greater restraint in resource use and cost-cutting.

While nation-states have adopted various elements of NPM, there is no straightforward way or conceptual framework to judge its success (Pollitt and Bouckaert, 2017). Policy makers and scholars alike have tended to form a strong commitment to being either pro or anti-NPM. Nevertheless, Hood (1995) notes some particular criticisms of NPM.

The advent of 'new' managerialism has changed little, apart from the language that senior public managers speak in public (Hood, 1995; 9). NPM is criticised for being a rhetorical form of control, however underneath, the old problems and weakness of management remain. There is also a growing criticism that NPM has damaged public services and has failed to deliver on its central claim to lower costs. Critics have noted aggrandisement of management and growth of middle-level bureaucracy aimed at implementing and maintaining reporting systems; put simply, the growth of the performance indicator industry (Hood, 1995; 9). Critics assert that this, combined with tight budgetary controls have weakened essential competencies on the frontline (Hood, 1995).

Another common criticism is that NPM is a self-serving movement designed to promote the career interests of an elite group of managers and officials, rather than the mass of the public or low-level staff, and therefore NPM cannot claim to be for the public good (Hood, 1995). The assumed universality of NPM is criticised because different administrative values create different implications for the fundamental aspects of administrative design. Overall, NPM is seen

as a self-serving movement of rhetorical control that has the potential to damage public services. For some, governance is viewed as the reform of the future as it aims to deal with the limitations of NPM by making the state more accountable (Osborne, 2010).

2.5.3 Governance

Since the late 1990's, governance has become a popular term with both academics and practitioners and appears in almost as many versions as there are writers about it (Pollitt and Bouckaert, 2017). That there is a noun 'governance' is undoubted, but precisely what it means is contested (Hughes, 2010). However, a lack of definitional clarity may not be that unusual in the social sciences when one considers that definitions for 'justice' or 'democracy' require some explanation or qualification when they are used (Hughes, 2010). One point of agreement amongst commentators is that 'government' and 'governance' now have different meanings (Hughes, 2010). In short, a government is the formal apparatus of society, and it is about control, authority and ordered rule (Hughes, 2010). However, the manner, methods and systems by which a society is governed encapsulates the term governance (Hughes, 2010). Governance is not an alternative to the government because the government remains as one of the principal constituent elements (Pollitt and Bouckaert, 2017).

Common to all definitions is the notion that steering society or making policy requires the active participation of actors in addition to the government itself. The different actors may include business corporations and civil society associations. It is also thought to be a move away from hierarchical forms of organisation, such as those used in PA and NPM, and from a jurisdictional point of view, authority

is being progressively devolved to organisations from the centralised state (Bellamy and Palumbo, 2010). Governance emphasises a shift away from hard law to more flexible forms of soft law. It can be thought of as a product of and a response to the increasingly complex, plural and fragmented nature of public policy implementation and service delivery (Osborne, 2010). However, this broad thought alone is not entirely new and does not adequately explain the recent attractiveness of the term and the concept has come under criticism from some who see it overblown and static (Pollitt and Bouckaert, 2017; Osborne 2010).

It is important to reemphasise that governance is not being posed as a normative policy or as a better way because in practice it invariably coexists with PA and NPM (Osborne, 2010; 414). Instead, it is offered as a conceptual model to help understand and evaluate the reality of contemporary public policy and service implementation. It is debatable whether it is a genuinely new regime, but it is argued that it is a reality in the modern fragmented public policy and public service delivery (Osborne, 2010). Like NPM, governance has also attracted some strong criticism not least because, the broader literature lumps together competitive systems, collaborative working, strategic alliances and lobbying coalitions, and this results in conceptual confusion and empirical errors (Bellamy and Palumbo, 2010; Pollitt and Bouckaert, 2017). As for whether governance works, like other PMR regimes, the variations in definitions means that no definite answer can be given (Pollitt and Bouckaert, 2017).

Nevertheless, PMR has caused sociologists to reconsider the profession/ state relationship. The concepts of mediation, countervailing powers and governmentality are discussed as possible models to explain the interaction between professions and the state.

2.6 Professions and the state

It is accepted that the state plays a decisive role in professionalisation (MacDonald, 1995, Harrison and Macdonald, 2008, Kuhlmann, 2006). As discussed, professions are credited with having an exceptional status in modern Western societies in that while monopoly is generally deemed unacceptable in Western culture, professions still seek it (Macdonald, 1995). Monopoly is thus dependent on state recognition, and it is achieved when a regulative bargain is struck between profession and state (Larson, 1977).

Acknowledgement in the form of regulation confers status and moral authority on the profession. As such, important questions arise about the nature of the relationship between professions. Three critical concepts are considered, mediation (Johnson, 1972), countervailing powers (Light, 1995) and governmentality (Johnson, 1995). This debate marks a turning point in the sociology of professions from demand to supply led theories of professionalisation (see Dingwall, 2008).

2.6.1 Mediation

The concept of mediation, a demand theory of professionalisation views the state as an all-powerful institution and the professions as an instrument of delivering services on its behalf. Mediation is summarised:

"Mediation arises when the state attempts to remove from the producer or the consumer the authority to determine the contents and subjects of practice." (Johnson, 1972; 77)

Johnson (1972) attempts to explain mediation as the primary form of state control. It is defined as the means by which the state intervenes in professional affairs which include its relationship with the client, their needs, and the manner in which the needs are catered. In striking a regulative bargain, the state becomes the active employer of all practitioners and will seek to ensure an even distribution of professional services (Johnson, 1972). As the state also defines who is to receive services (eligibility), agencies are required to supervise the manner in which services are delivered. The significance of this control is that it guarantees clients for the professional services (Johnson, 1972). However, the guarantee of clients negates the need for continuous colleague contact (a feature of professionalism). Clients become less defined by their social characters and more by their unique availability (Johnson, 1972).

2.6.2 Countervailing Powers

Light (1995) discusses the decline in medical dominance in Europe and the US and provides a framework for explaining professions in transition. The countervailing powers thesis suggests that states go through 'phases of harmony and discord' and this is because professional dominance produces excesses and creates imbalances and alienates the broader public (Light, 1995; 25-27). The time frame by which a new balance of power is struck is measured in years or decades. Thus, excesses create inefficiencies and in turn market failures.

For Light (1995), countervailing powers are a potential solution aimed at making the system more efficient although he concedes that the framework needs further development (Light, 1995; 39). As Kuhlmann and Saks (2006) state, the approach provides limited

opportunity to reflexively explore changes within professions and society at large. Furthermore, Kuhlmann et al. (2009) criticise the approach for underestimating the capacity for professionalism to transform itself by including a variety of professional projects.

2.6.3 Governmentality

In recognising changes in the politics of healthcare in Europe and the US, Johnson (1995) reconsiders the profession/ state relationship in light of Foucault's (1979) concept of governmentality. Foucault (1979) rejects the notion that the state is '*...a coherent, calculating, subject whose political power grows in concert with its interventions into civil society*'. Instead, it is viewed as '*an ensemble of institutions, procedures, tactics, calculations, knowledges and technologies*' (Johnson, 1995; 8). In other words, Johnson (1995) demonstrates that the profession/ state relationship has been misconceived as one existing between two distinct subjects, and thus analysis that continues to think of 'autonomy/ intervention' (meditation) are also flawed.

In this sense, professions are viewed as a critical resource in government because through them the objects of politics are formed, and this happens because professions identify new social problems and construct the means to solve them (Johnson, 1995). Furthermore, they provide staff in the organisations that are created to solve them (Johnson, 1995; 23). Like the countervailing powers thesis, governmentality can be thought of as a supply led theory of professionalisation (Dingwall, 2008), as such, it has more concordance with much of the contemporary professions' literature because of its focus on governance, discussed later.

2.7 Public management reform: A means to punish the professions

The rise of PMR, in particular, NPM, has sparked protest and collective action by professionals working in the public sector who see it as a threat to their autonomy (Bezes et al., 2012). Despite this, there is evidence, particularly in the UK that there is little sign of policymakers becoming immune to the attractions of NPM as it continues to spread like a 'virus' through public services (Hyndman et al., 2016; 405). Nevertheless, this collective action is a global phenomenon represented by activities such as the creation of committees, demonstrations and strikes against budget and staff cuts (Bezes et al., 2012).

The UK is viewed as the state where NPM reforms have been implemented most widely. However, as Ackroyd et al. (2007) demonstrate, the changes brought on by NPM have been far less radical than many assume and are dependent on the particular sector. While many of the reforms directed at the NHS have been resisted (particularly by medics), in other sectors such as housing, they have been received well (Ackroyd et al., 2007). However, the resistance of public sector professionals working in the NHS has been more extensively analysed than other sectors (Ackroyd et al., 2007; Bezés et al., 2012; Currie et al., 2012; Moffatt et al. 2014).

Professions in the public sector have assumed a peculiar form of professionalism compared to the classic professional model. The main difference is that public sector professions are less interested in status as they are occupational closure (Bezes et al., 2012). In the literature, the opposition to NPM reproduces the discourse of those professions

involved in the conflicts, sustaining the notion that professionalism is opposed to managerialism and consumerism Bezes et al., 2012).

In *Professionalism: The Third Logic*, Freidson (2001) attempts to present occupational professionalism as a distinct and conflicting logic to markets and bureaucracy. He presents an ideal-typical market as a world where individuals are free to buy and sell anything they choose, compete to buy at the lowest price possible and where sellers sell for the highest price possible (Freidson, 2001). Ideal-typical bureaucracy is presented as a world in which the production and distribution of goods and services are planned and controlled by the administration of large organisations (Freidson, 2001; 1).

In the context of these competing ideal-typical logics, Freidson (2001) examines the fate of medicine in the US by comparing the present status of the profession to its 'golden age' in the 1950s. He concludes that the market and bureaucratic logics that have increasingly been used by the state has resulted in an 'assault' on medicine and the professions (and specialised knowledge) in general. Overall, Freidson (2001) laments that occupational professionalism has failed to defend itself as well as the logics of markets and bureaucracy. He states several consequences for professions, including the fact that all professions have suffered a loss of public confidence and trust and that many have come under pressure to reduce the cost of their services to consumers and the state.

For Hanlon (1998), the rise of NPM is associated with the growing reaction against the power, privilege and cost of public sector professionals. Hanlon (1998) states that professions are under attack from powerful actors such as the state and large-scale capital because

they no longer trust the professional ethos to deliver cost-effective and competitive services. The public is increasingly encouraged to question professional expertise, which in turn undermines the professions (Hanlon, 1998; 51). The overall view is that NPM is just a means to punish the professions (for example, see Dent, 2006), and can be observed impacting five core areas within general public sector organisations:

1. Business environment and strategic objectives
2. Organisational structures and processes
3. Performance management systems and measurement systems
4. Management and managers
5. Employees and corporate culture (Diefenbach, 2009; 893).

Business environment and strategic objectives can be divided into outside and inside orientations. Outside orientations include the commodification of services under the slogan of value for money, meeting the objectives and policies of strong influential stakeholders such as the state, and service delivery from a customer's perspective. Inside orientations are defined by increased efficiency, effectiveness and productivity as measured in functional and technological terms, and by cost-effectiveness which means reduced costs, downsizing, competitive tendering, outsourcing and privatisation (Diefenbach, 2009; 894-895).

While these ideas can be convincing, they turn out to be questionable endeavours in the hands of their proponents who portray them as a historically inevitable force (Diefenbach, 2009). Public sector organisations are obliged to accept NPM doctrines and the fact that

no alternatives exists. As Diefenbach (2009; 895) points out, only ideologies refer to 'laws of nature' that can neither change nor resist. A significant consequence of this ideology has been the marginalisation of other public service values such as impartiality, social equality, integrity, equity, communication values and the qualitative dimensions and uniqueness of each case (Diefenbach, 2009; 895). Overall, cost orientation reduces organisations to reduce costs, services, quality, and a concentration on 'cash cows' and the deletion of activities that are not seen as profit-making, and this has caused some to speculate that the NHS is being privatised from the top down (For example, see Pollock, 2005).

Concerning the effect of NPM on organisations, there has been an effect on their internal structures and processes, although it is worth stating that public institutions such as NHS hospitals have been profoundly and thoroughly colonised by professionals, particularly medics (Ackroyd et al., 2007). Nevertheless, PA, which was thought to protect market shelters through over formalised, slow, compartmentalised and inefficient bureaucracies, has been replaced with decentralisation, which is aimed at creating more flexible and less hierarchical structures. However, decentralisation from PA has been demonstrated to create more centralisation or hardened structures. Organisations tend to centralise power to a few areas in strategy and policy setting, finances, performance measurement and information systems (Diefenbach, 2009). This has direct consequences for front line departments within organisations that devote considerably more time to administrative tasks. For example, social workers must now devote considerably more time to paperwork (see Kirkpatrick et al., 2005).

Performance management and measurement systems usually accompany NPM strategic objectives and organisational structures. Such measures include (and are not limited to), benchmarking, league tables, inspections, quality assessments, and staff appraisals (Diefenbach, 2019). It is thought that these systems are fairer than old systems of either no performance measures at all or collegial networks. However, there appear to be both methodological and psychological consequences for people working under such systems. Methodologically, intangible assets, core capabilities, or values are reduced down to quantitative, absolute, and relative results. Intangible and traditional values such as skills and knowledge, fairness, dignity, equality, justice, quality of life, security, freedom representation, participation, commitment, trust, creativity, and others, are deliberately neglected (Diefenbach, 2009; 900, also see Freidson, 2001). In some instances, they are devalued, discredited, and portrayed as being unimportant, and in others are treated as constraints and obstacles for organisations to overcome.

Psychologically, performance management systems define the frameworks by which people act and think within by defining what they strive for, how they behave, and what they become. However, as Diefenbach (2009; 901) goes on to say, people in social or institutional systems learn very fast to 'play the game';

"People learn how to deliver the information required by 'the system', how to cope and deal with objectives, deadlines, and indicators, how to give the right impression, and how to manipulate the system."

As discussed, a significant criticism of NPM is the emphasis on the primacy of management above all other activities and groups of people (Hood, 1995). Managerial concepts, methods, skills and competencies are portrayed as superior or more important than professional competencies and credentials. There is a noted distinction between those who work (the frontline professionals), and those who plan, organise, coordinate and control work (managers). There is a perception that managers are concerned with their status, influence and aspirations (Diefenbach, 2009). Within organisations, management values carry a certain prestige associated with advancing career prospects and higher salaries. However while some see management values as a rejection of occupational professionalism (Freidson, 2001), others have noted a particular trend for professions to include management style techniques by becoming 'hybridised' professionals (McGivern et al., 2015, also see Currie et al., 2012; McDonald et al., 2009; Noordegraaf, 2007; 2013). Moreover, hybridisation does not necessarily result in either loss of occupational values or increased reward (McGivern et al., 2015).

The overall negative impacts of NPM discussed may have less favourable effects on rank-and-file employees of large organisations. Diefenbach (2009) asserts that NPM is less about the empowerment and more about the infantilization of frontline staff. NPM typically leads to the additional workload by increasing obligations for routine administration, monitoring and communication. There is empirical evidence that the additional workload is implicated in the rising stress levels of organisational employees (Kirkpatrick et al., 2005). Senior management are often at pains to talk about strategic change initiatives in a positive light; however, employees feel that they are merely paying lip service.

Frontline staff may become disillusioned, demoralised and cynical in management strategies when faced with ongoing issues of, inadequate staffing, reduced job security, and redundancy. Paradoxically, stressed and demotivated workers fit well into the ideological framework of NPM because such aspects underline the necessity for more policies and procedures, more systematic performance measurements, more monitoring and more leadership (Diefenbach, 2009; 904). Resistance and dissatisfaction are yet another reason and justification for more managers and more change initiatives. In this way, managers are seen to secure and sustain their position by rubbishing the workforce as short-sighted and self-interested.

The view that PMR is a threat to the professions and professionalism is only one way of analysing the current situation. The increasing focus on professionalism as a discourse of control marks a significant turning point in the sociology of the professions (see Fournier, 1999). Through the examination of discursive strategies aimed at controlling work, sociologists are observing that professionalism is being gradually transformed.

2.8 Public Management Reform: Beyond opposition and new professionalism

The argument so far is that PMR, that is the introduction of managerial and market logics into practice, challenges professional autonomy, and professional discourse sustains the notion that professionalism is diametrically opposed to managerialism and consumerism. In some ways, these ideas link to the concept of de-professionalisation, previously discussed (see Haug, 1972). However,

this approach increasingly fails to stand up against newly accumulated knowledge from the sociology of professions and research on neo-managerial changes. It is recognised that opposition can only be a starting point (Bezes et al., 2012). For example, such is the opposition to NPM, that power struggles and collective battles have tended to be frozen in time, and historicising such moments provides an insufficient way of analysing longer-term changes especially as new managerialism is not stable doctrine and tends to change over time (Pollitt and Bouckaert, 2017; Hood, 1995; Bezes et al., 2012). Furthermore, the interaction between managers and professionals, organisations and professions and the extraordinary variety of professional dynamics cannot simply be analysed in terms of managerial aggression (Bezes et al., 2012).

Latterly, there is a growing body of literature that challenges the broad opposition to PMR, by suggesting that through a discursive process, professionalism is being transformed, rather than eroded (Fournier, 1999, Moffatt et al, 2014). While the nature of this 'new professionalism' is contested, there is general agreement that professionalism is contingent (Evetts, 2011).

Professionalism is a difficult concept to explain because it has a chequered history of use and misuse within the professions' literature (Evetts, 1999). The development of the concept of archetypal or occupational professionalism is synonymous with the methodological construction of ideal types based on medicine and law, notably during the interactionist or power phase of the extant literature associated with Magali Larson, Terrence Johnson and Eliot Freidson.

The methodological construction of ideal types was an essential characteristic of Weber's work and can be thought of as the conceptual arrangement of related, but sometimes unclear and confused historical events into describable consistent systems (Morrison, 1995). Ideal types capture features of empirical reality by separating essential from the non-essential features of historical events (Morrison, 1995). Ideal types do not serve as a description of concrete reality; instead, they are used to explain the features of historical reality. Furthermore, by introducing developmental sequences, ideal types can be used to explain shifts that are taking place in a given society and can lead to some theoretical conclusions about the prevailing conditions of that society (Morrison, 1995). In some ways, the concepts of NPM and governance discussed earlier are ideal types of public management reform.

Four models of professionalism are presented; occupational, organisational, hybridised and inclusive. Each form considers the increasing trend for professions to be located within large organisations and different forms of public management reform. Multiple forms of professionalism may be operationalised at the same time.

2.8.1 Occupational Professionalism

It is generally agreed that the professions and professionalism arose out of the class-based struggles of the industrial revolution (Larson, 1977; Johnson, 1972). While the rise of professionalism is associated with the organisation of markets for professional services, Larson (1977) defines professionalism as an ideological construction aimed at concealing the existence of class and the basic structures of exploitation (Larson, 1977; 156). Larson (1977; 66-80) states that professions employ old stratification structures within their

organisational structures and construct ideological 'anti-market' principles which are associated with a sort of noblesse-oblige (gentlemanly or aristocratic character and disinterested in markets) and notions of professional ethicality legitimise this ideology. Moreover, it is generally agreed that having an ethical code of conduct is one of the hallmarks of professionalism (MacDonald, 1995; Freidson, 2001).

Freidson (1970) focuses on the medical profession and the organisation of healthcare and concludes that professions make ideological claims, have monopolistic privileges, and create and sustain authority over clients, other occupations and even the way the public thinks about deviant or undesirable behaviour. Essentially, professionalism is a way for professions (rather than the free market, individual consumers or mediating organisations) of controlling work (Johnson, 1972).

Professionalism is said to exist *"when an organised occupation gains the power to determine who is qualified to perform a defined set of tasks, to prevent all others from performing that work, and to control the criteria by which to evaluate performance"* (Freidson, 2001; 12). However, the link between a profession and tasks is complex. They are typically human problems that are amenable to expert services but more importantly, they have some degree of abstraction, and the degree of abstraction is related to the knowledge base of the profession (Abbott, 1988; Macdonald, 1995; Freidson, 2001). Indeed, the knowledge base of professions is a crucial attribute of professionalism as professions have been defined as occupations which are knowledge-based and achieve years of higher education or vocational training (Evetts, 1999).

2.8.2 Organisational professionalism

Historically, nation-states have been instrumental in the development of monopolistic forms of professionalism through regulative bargaining with the professions (MacDonald, 1995). Nowadays governments are reluctant to strike regulative bargains with professions because monopolistic ideals are no longer acceptable in modern western societies and new forms of governance increasingly devolve the states responsibility to large organisations (Muzio et al., 2011; Bellamy and Palumbo, 2010). Therefore, professionals increasingly find themselves working in large-scale organisations, where the discourse of professionalism is constructed 'from above' (Evetts, 2011; 408).

As Evetts (2011) states, organisational objectives seek to define the professional/ client relationship and set achievement targets and performance indicators. Sometimes, organisational objectives are political, and this may be truer of educational institutions, primary care practices and NHS hospitals in the UK (Evetts, 2011). When a discourse of professionalism is constructed from above, it is often imposed as a disciplinary mechanism (Fournier, 1999) aimed at facilitating rationalisation and encouraging autonomous individuals to exercise appropriate conduct (Evetts, 2011). A loss of occupational discretion is what undermines the main difference between organisational professionalism and occupational professionalism (see Table 2). Nevertheless, the misleading discourse of dedicated service and autonomous decision making is part of what makes this form of professionalism attractive, especially to aspiring occupational groups because it is perceived as a way of improving the occupational and individual status and rewards (Evetts, 2011; Fournier, 1999).

Occupational professionalism (Archetypal)	Organisational professionalism
Discourse constructs within professional groups	Discourse of control used increasingly by managers in work organisations
Collegial authority	Rational-legal forms of authority
Discretion and occupational control of work	Standardised procedures
Practitioner trust by both clients and employers	Hierarchical structures of authority and decision-making
Controls operationalised by practitioners	Managerialism
Professional ethics monitored by institutions and associations	Accountability and externalising forms of regulation, target setting and performance review
Located in Durkheim's model of occupational communities	Links to Weberian models of organisation

Table 2: Occupational and organisational professionalism (Evetts, 2009; 263).

While the Evetts (2011) version of organisational professionalism is useful for understanding the role of large-scale organisations in controlling work, it is not without its problems. The focus on organisational control does not explain how medicine, for example, has retained its pre-eminence, especially in large NHS hospital trusts that employ many doctors (Larkin, 1983; Freidson, 2001; Kuhlmann, 2006). Although she concedes that the situation is highly complex, variable and changing, Evetts (2011) presents a dichotomy between organisational and occupational professionalism and does not account for the reflexivity and involvement of professions as crucial stakeholders in the discursive strategies taking place to control work (Hanlon, 1999; Kuhlmann, 2006; Noordegraaf, 2007).

2.8.3 Hybridised professionalism

While Evetts (2009) delineates organisational from occupational professionalism, Noordegraaf (2007) presents an alternative form of hybrid professionalism. For Noordegraaf, pure professionalism is a form of 'controlled content', where the content is related to the knowledge and skill base of a profession, and the control is linked

with professional associations that accord special privileges and determine who is in and who is out. Content and control reinforce each other and aim to achieve social closure.

As discussed, there is pressure for many occupations to imitate the classic strong professions (Noordegraaf, 2007; Wilensky, 1964), however, in the public sector, strong forms of occupational closure are hard to attain because substantive and institutional strength are difficult to establish. Societal changes, as discussed, constrain professionalism and professional powers. This means that, apart from established archetypal professions, new occupations wanting to establish strong forms of occupational closure will struggle.

Instead, Noordegraaf (2007) suggests that a number of different occupations have shown a deal of reflexivity in utilising different forms of professionalism simultaneously and asserts that professionalism can no longer be seen as a matter of occupational or organisational control. Instead, professionalism should be seen as a reflexive control. In other words, it is a reflexive search for the professional use of professionalism (Noordegraaf, 2007). It is achieved through focusing on making new and meaningful connections between work, organisational action and outside worlds. This is a form of hybridised professionalism.

"Hybridised professionalism offers new opportunities for maintaining the notion of professionalism in times that weaken the notion of professionalism." (Noordegraaf, 2007; 775)

For Noordegraaf (2007), hybridised professionalism is especially relevant in the public sector because this is where professionals must

deal with a variety of ambiguity. However, the limitation of Noordegraaf's (2007) thesis is that it does not deal directly with the inclusion of service users and new forms of governance in remaking professions. Khulmann (2006) poses yet another interpretation of new professionalism, based on a study of the German healthcare system, that includes strategies of exclusion and inclusion.

2.8.4 Inclusive patterns of professionalism

New professionalism is understood as a reaction to public management reform and contemporary health care policy. However, according to Kuhlmann (2008), professions do not just react to health policy, they can also enhance change by following interest-based strategies and new pathways that are not entirely under the control of the state. Occupational forms of professionalism, as discussed earlier, value autonomy and social closure, and Kuhlman (2006) is also keen to point out that it perpetuates the gendered division of labour within the healthcare workforce. There is evidence for a rise of new professionalism in the wake of new governance and changing concepts of citizenship (Kuhlmann, 2006; 220), and these new forms are known to advance cooperation, make boundaries within and between professions more permeable, and enable more contextualised identities (see Table 3).

Exclusionary patterns of professionalism (Occupational/ Archetypal)	More inclusive patterns of professionalism
Hierarchical, bureaucratic patterns of self-regulation and self-administration	Networked governance, and more active participation in the self-regulatory bodies
Striving to market closure	Cooperation
Tribalism and occupational closure	Networking and more permeable occupational boundaries
Claims for autonomy and self-determined decision-making	Inclusion of managerialism, standardisation of care, EBM
Quality of care based on individual qualification	Quality of care based on formalised procedures and performance indicators
Identity construction based on belonging to a professional community	More contextualised and permeable identity constructions
Gender division of the healthcare workforce	Changing gender relations within professions
Expert lay divide	Improved information, inclusion of users in regulatory bodies
Professionalism restricted to the medical and other high status occupational groups	Health occupations refer to professionalism to upgrade occupational status

Table 3: Exclusionary and inclusive forms of professionalism (Kuhlmann, 2006; 221).

Within medicine, in particular, public participation does not only act as an external force, but it has been adopted as part of its professionalisation strategy (Kuhlmann, 2006). For example, links between the woman's health movement, the development of health consumer groups formed by patients and carers and the capacity of some groups to build political alliances with professionals to counter or expand government policies has led to structural changes in the health system particularly in midwifery and complementary and alternative therapies (Kuhlmann et al., 2009).

The emergence of managerialism, networks, and more contextualised professional identities demonstrates that the professions are beginning to combine classic exclusionary patterns of professionalism with more inclusive forms (Kuhlmann, 2006; 2008). However, given its size and power, it is the medical profession that has the greatest ability to flexibly combine these different forms (Kuhlmann, 2006; 2008). The key areas where medicine is changing includes the

improvement of coordination through networks, more participatory bottom-up structures of decision-making, quality management, coordination of provider services and patient information (Kuhlmann, 2006).

However, the relationship between exclusionary and inclusive patterns of professionalism is tenuous because they oppose each other. As Kuhlmann (2006) states, they do not simply coexist, but professions use these patterns in different ways, sometimes overlapping them to promote their own interests, and this supports the notion of continuities and changes in professionalism as discussed by Evetts (2009). Overall, the different ways in which professions use these different patterns leads to a greater diversity of professionalism and of course professionalising strategies. Overall this supports Abbott's (1991) conclusion that professionalisation is multilevel and diffuse.

Concerning other healthcare professions, a discourse of professionalism is spreading, however, their ability to transform is somewhat limited by gendered tactics of organisational professionalism such as credentialing and patterns of state regulation that promote forms of market closure (Kuhlmann, 2006; Also see Witz, 1992 for gendered strategies of professionalisation). However, the patterns of state regulation in the UK differ to that on Germany (Kuhlmann et al., 2009) and more evidence is required to demonstrate the ability of other healthcare professionals, such as audiology, to transform.

2.9 Understanding the impact of reforms on small professions: a gap in the literature

As discussed, over the past century, an extensive literature has developed on the subject of professionalisation and professionalism in modern western societies. However, empirical work in this field is usually limited to archetypal professions, especially medicine (Larkin, 1983). The proliferation of specialisms, explosion of different paramedical occupations and the aspirations of lower status personnel to the rewards of doctors is situated in the critical importance of medicine to sociologists (Dingwall, 2008). Furthermore, healthcare provision requires a political and economic interest in containing premature death, disease and therefore medicine is a matter of public concern in a way that no other professions are (Dingwall, 2008; 7-8). This is further compounded by the fact the public perception of healthcare is limited to knowledge of doctors and nurses as though they are homogenous groups (Abbott, 1988). In other words, the public is generally disinterested in the different specialisations and the internal tensions that exist between them.

This view obscures the case that medicine is more successful than other healthcare professions in resisting factors that transform professionalisation and professionalism (Freidson, 1994; Kuhlmann, 2006). One factor that makes medicine more resistant to change is that the elimination of occupations and/ or the control of newly emergent professions was at the core of the evolution of modern medicine, and this is why occupational closure is now deemed an essential trait of archetypal professionalism (Freidson, 1970; Larson, 1977; Larkin, 1983; Abbott, 1988).

Historically, while medicine could be broken down into composite skills, like all work processes it remained a labour-intensive service that was less amenable to mass production. However, the development of medical technologies, the expansion of the middle classes in the industrial revolution, and the emergence of a new more extensive demand provided the conditions for the employment of 'auxiliaries' to ease the burden on the medical profession (Larkin, 1983; 4). Importantly, the growth of a division of labour between doctors and others provided an essential channel for delegating devalued or unpleasant work. It is true now that the professionalisation of any speciality may depend on the success in such delegating stratagems and this is why innovative groups in healthcare often commence with low status (Larkin, 1983).

However, with increasing calls for flexibility and teamwork, those planning and providing healthcare services rarely think about the tensions of the resulting division and re-division of labour and the effect these have on professional practice (Larkin, 1983; Abbott, 1988). Furthermore, new forms of PMR, have the potential to transform professionalisation and professionalism in ways that were inconceivable twenty or thirty years ago. Despite several transformations in the state apparatus to govern, medical dominance persists, and interprofessional dynamics remain weak because states fail to set up structures that better coordinate the entire healthcare workforce (Kuhlmann, 2006). Thus, the wholesale restructuring of the healthcare career frameworks by the UK state in nursing, allied health, healthcare science and medicine, makes the absence of other healthcare professions in the sociology of the profession's starker.

While professionalism has the flexibility and power to transform itself, the way in which different professions change is related to their relative power within the medical division of labour. Kuhlmann (2006) concludes that medicine has the most strength to transform itself, whereas other healthcare professions such as physiotherapy (and perhaps audiology), which accept subordination to medicine, focus on market expansion, academic training and bypassing medical control. At the lower end of the power spectrum, other occupations such as receptionists refer to professionalism but lack resources and their overall gender identity clashes with the typically male dominant forms of professionalisation strategies (Kuhlmann, 2006; 123; also see Witz, 1992 for feminist perspectives of professionalism).

2.9.1 Filling the gap: The professionalisation of audiology in the UK.

As discussed in the introduction and background chapter, audiology in the UK is one of many scientific professions to have emerged after the second world war. Furthermore, it is undergoing an era of immense transformation aimed at making hearing healthcare more efficient and professionals more accountable. All of these transformations, which are aimed at the healthcare sciences in general, are directed by the state through a range of policies. A simple evaluation of this situation might overestimate the role of the state in mediating professional interests. However, the literature discussed suggests that the relationship between the state and profession is more complicated, not least because of the ability for professionalism to transform itself, and this should be evident in the professionalising discourse of professional elites. Furthermore, as previously indicated, Audiology has a close association with the public through charities, such as AoHL and the NDCS, who are stakeholders in the

professionalisation process and certainly further the development of clinical practice.

Because Audiology is a relatively small and self-contained profession, it is amenable to study its professionalisation strategy in light of public management reforms. Furthermore, the sociology of the professions may be used to explain the actions of the various stakeholders in the professionalisation process. The aims and objectives of this study are as follows:

2.9.2 Aims and Objectives

The Doctor of Health Science degree aims to produce high-quality research which contributes to the theoretical and knowledge base of healthcare with an ultimate focus on promoting practice improvement. In other words, the core aim of this study is to contribute to practice improvement. However, the concept requires clarification due to its frequent use throughout the rest of this thesis because it has many possible meanings.

As previously discussed within the literature review, there is a refocus on professionalism as a discourse of occupational control (Fournier, 1999), where professional elite maintain control through a rhetorical process that emphasises professional solidarity (Larson, 1977). In this sense, the professional practice can be understood in terms of a rhetorical discourse as used primarily by professional elites in Audiology.

For this study, improvement is primarily defined by a change in the direction of the professionalising strategy, as defined by the rhetoric of elites. As alluded to within the literature review, transformations in

professionalism associated with inclusion, have the potential to improve inter and intra-occupational relations, increase quality of front-line practice, and empower service users through forms of regulatory inclusion (Kuhlmann, 2006; Also see Evetts, 2009 and 2011; Osborne, 2010; Pollitt and Bouckaert, 2017). Therefore, it is reasonable to suggest that improvements in the direction of the professionalising strategy should be associated with rhetoric that supports new or inclusive forms of professionalism discussed. The aims and objectives are as follows:

Aims:

- To use professional development in Audiology to explain a version of professionalisation.
- To use knowledge of the sociology of professions and public management reform literature to explain professionalisation in Audiology for practice improvement.

Objectives:

- Gather evidence on professional development in Audiology
- Use this evidence to describe professionalisation.
- Interrogate the sociology of professions and public management reform literature to explain professionalisation in Audiology.
- Discuss this version of professionalisation and consider alternative directions for improving practice.
- To discuss similarities to other healthcare professions.

In the next chapter, the methodology is discussed.

Chapter 3: Methodology

In the previous chapter, the sociology of professions literature was discussed, and a study of the audiological profession in the UK proposed. With a focus on large archetypal profession such as medicine, there is a paucity of evidence to explain how small professions like audiology develop in the context of evolving public management reform. In this chapter, I will discuss the methods used to explore professional development in audiology since 1997.

Despite being an empirically based study, my objective is that this chapter is an open and honest discussion about what happened during my research. This reflective approach follows the examples set by qualitative researchers who study elites (see Moyser and Wagstaffe, 1987, Hertz and Imber, 1995 and Aguiar and Schneider, 2012). The choice to use a case study design is informed by a tendency for sociologists to use this technique when studying the professions (For example, see Denzin and Metlin, 1968; Larkin, 1983; Kuhlmann, 2006, Freidson, 1970, 1994 and 2001, Fournier, 1999).

This chapter is divided into four sections. In the first section, I discuss the choice of research design, that is, a case study informed by methodologies for studying elites. The second section begins with a brief description of the method used followed by an in-depth discussion of the data collection process. The third section is concerned with how I analysed the data using a broadly abductive research strategy. In the fourth section, I discuss some of the

inherent shortcomings in the design and analysis and how they might have influenced the findings.

3.1 Design

As discussed earlier, audiology in the UK is a relatively self-contained profession with clear boundaries of work. It is one of over fifty healthcare science professions which developed in the UK over the latter half of the twentieth century and like its counterpart occupations, has been subject to a wholesale state-sponsored restructure. The purpose of this study is to explain the professionalisation of audiology since 1997. 1997 marks the beginning of this case because many of the developments in practice were as a direct result of New Labour policy. Given the paucity of studies relating to smaller healthcare professions, there is an opportunity to explore how audiology reconciles contemporary public management reforms with developments in practice. Furthermore, it is envisaged that the pattern of professionalisation may be of interest to other small healthcare professions which are subject to the same state interventions.

3.1.1 Why a case study design was chosen

Although not explicitly stated as such, case study research has been used in a variety of different ways within the sociology of professions. While Witz (1992) uses comparative case studies to explore patriarchy in professionalisation, Larkin (1983) uses a similar approach to examine the effects of medical dominance on smaller healthcare professions. Through the continued study of medicine, Freidson (1970, 1994, 2001), demonstrates how medical dominance is being eroded through the incorporation of managerialism and consumerism in medical practice. In a strategy more closely

resembling this case, Macdonald (1995), uses the extant literature to explore the professional project of accountancy worldwide. More recently, Fournier (1999) uses a single case study approach to examine the use of professionalism as a disciplinary logic. Kuhlmann (2006) uses a case study approach to study governance and the German healthcare system. Timmons (2010), uses a single case study approach to highlight professionalisation and discontent amongst Operating Department Practitioners. It is therefore clear that a range of single and multiple cases are used within the sociology of professions.

Dingwall (2008) suggests that detailed case studies are the only way to understand the broader structural and cultural features of occupational development. Therefore, the choice to use a case study design was a logical one based on the self-contained nature of audiology in the UK, the predominant use of case studies within the sociology of professions, and its ability as a research method to help answer 'how' and 'why' questions (such as how professionalisation occurs in the circumstances of evolving public management reforms) (Yin, 2018).

According to Yin (2018), the case study approach remains the most challenging of all social science endeavours. Yin (2018) describes the critical features of a case study in two parts. The scope of a case study:

- *investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when*
- *the boundaries between phenomenon and context may not be evident (Yin, 2018; 15).*

However, because the phenomenon and context are not always distinguishable in real life situations, other technical characteristics are required to define the case study. Yin (2018) goes on to explain that the case study enquiry:

- *cope with the technically distinctive situation in which there will be many more variables of interest than data points, and as one result*
- *benefits from the prior development of theoretical propositions to guide design, data collection, and analysis, and as another result*
- *relies on multiple sources of evidence, with data needing to converge in a triangulating fashion (Yin, 2018; 15).*

Yin (2018) demonstrates that case study research is an all-encompassing method and that there are several variations including single and multiple case studies and can include or even be limited to quantitative data. There are at least four different applications of case studies, the most important ones are as follows:

1. To explain presumed causal links in real-life interventions.
2. To describe an intervention and the real-life context in which it occurred.
3. To illustrate specific topics within an evaluation.
4. To enlighten those situations in which the intervention being evaluated has no set of clear, single set of outcomes (Yin, 2018).

From this point of view, professionalisation in audiology is a contemporary phenomenon that is clearly defined in terms of the professions literature. However, the effects of public management reform (the context) on professionalisation (the phenomenon) are not evident and remain contentious at best (see literature review). Nevertheless, the professions literature draws attention to other variables in professional development including the state and the public, thus indicating the need for multiple sources of data to illuminate the case.

In studying the professionalisation of audiology, the case study approach allows for the explanation of causal links between state intervention and practice. Furthermore, as professionalisation is an ongoing process (Abbott, 1991), the case study approach can at least enlighten any situations where there are no set of clear outcomes.

3.1.2 Single case study design

Yin (2008) suggests that there still exist some traditional prejudices against case study methodology. Case studies are particularly criticised for their potential lack of rigour, that they provide little basis for generalisations and that they take too long to develop. Furthermore, with a renewed emphasis on randomised trials, there is growing concern that case study research fails to demonstrate causal relationships in the same way. These criticisms are especially levied towards single case studies.

On dealing with single case study design, Stake (1995) states that case study research is not the same as sampling research and that we do not necessarily study cases to understand other cases. Our first obligation, according to Stake (1995), is to maximise what we can

learn. While the single case study might seem like an inadequate basis for generalisations, the case will be studied at length, and specific problems will come up again and again; thus, certain generalisations may be drawn. Nevertheless, it is seldom that new understandings are reached with single case studies; however, they can be useful for refining our understanding. Thus, the real business of single case study design is not generalisation, but particularisation, that is, we take a particular case and know it well (Stake, 1995; 8).

Yin (2018), proposes several rationales for adopting a single case study design. The single case study is appropriate under the following circumstances:

1. Critical case - This may be used when testing a formulated theory. The single case that meets all the conditions for testing the theory can confirm, challenge or extend that theory.
2. Extreme or unique case - Either of these situations commonly occurs in clinical psychology.
3. Typical case - The lessons learned from these cases are assumed to be informative about the experiences of the average person or institution.
4. Revelatory case - In this situation the investigator has the opportunity to observe and analyse a phenomenal case that was previously inaccessible to social science enquiry.
5. Longitudinal case - The theory of interest would likely specify how conditions change over time.

This case study does not just adhere to one of these rationales. As a single case, the profession of audiology meets the conditions for confirming, challenging or extending sociological knowledge of the

professions. Audiology is typical of a modern healthcare science profession and presented as a case study it may be of interest to other professions. Indeed, much emphasis is placed on the reader of such research, as it is they who potentially find generalisations in case studies (Stake, 1995 and Yin, 2018). Furthermore, audiology is being studied over time, and the social theories strongly suggest that evolving public management reform is challenging.

3.1.3 Why study up?

An integral feature of this study is the focus on professional elites. As discussed previously, Larson (1977), states that professional elites are public figures who speak to outsiders on behalf of the whole profession, maintaining an image of solidarity or projecting the achievements and identity of a speciality. In Abbott's (1998) terms, elites make claims of jurisdiction on behalf of the profession to the state and the public. Internally, professional elites may use images and projections of solidarity to maintain control over rank and file professionals (Larson, 1977). Fournier (1999) summarises that professionalism is a disciplinary logic used by leaders.

Research on elites is so rarely done because by their nature elites are difficult to penetrate because of the barriers they establish to set themselves apart from the rest of society (Hertz and Imber, 1995; see also Aguiar, 2012, Savage and Williams, 2008). Social scientists have tended to focus attention on the poor and disenfranchised in the hope of exposing their plights and empowering them (Hertz and Imber, 1995). However, Aguiar (2012) suggests that even if when studying the poor and disenfranchised, social scientists should consider the role of elites in managing and controlling social processes and phenomena, and there are several reasons for doing so.

Hertz and Imber (1995) talk of strategies in the study of elites. One strategy is to expose their reach of power in the hope of clarifying it for those who are subject to it. Another is to attempt to understand the functions and responsibilities of elites so that we can better understand how social policies are developed as they affect the government and the workplace. The study of elites also offers the opportunity to link contemporary empirical work with major historical transformations such as the public management reforms discussed earlier (Hertz and Imber, 1995). Another reason to study elites is that of the continuing growth in inequality between elites and the rest of society (Aguiar, 2012). For Aguiar (2012), elite studies should be used to unravel and undermine inequality and its reproduction. Indeed, Saks (2015) highlights how inequalities and marginalities within professions can be detrimental for the public who must use professional services.

As the concept of professionalisation is so broad, focusing on one aspect of the profession, that is its elites, limits the scope of the case study, thus making it more manageable. Professional elites act as an interface between state and practice, and the choice of using them can help illuminate how they regulate their public and internal discourses, understand their reach of power and highlight tensions within the profession.

3.1.4 The socially constructed nature of professions and professionalism

While positivism assumes that the world has an observable definable external reality, social constructionism posits that our knowledge of the world, including social actions, is a product of human thought,

language and interaction (Burr, 2018). The first use of the term social constructionism was used in Berger and Luckmann's book entitled *The Social Construction of Reality* (1967). Berger and Luckmann (1967) state that human beings create and sustain all social phenomena through social practices, and because we are born into a socially constructed world that pre-exists us, this world seems natural. (Berger and Luckmann, 1967; Burr, 2018). The role of language in the construction of human phenomena is particularly important to social constructionists because it has practical consequences for people (Burr, 2018). For example, Burr (2018; 8) explains that;

"...when a doctor declares that a person is suffering from schizophrenia, and "sections" them under the Mental Health Act, this has immediate and significant consequences for the person's freedom."

Therefore, the constructive and performative functions of language are of primary interest to social constructionists.

The socially constructed nature of professions is frequently implied within the literature (for example see Larson, 1977). Their status in society, the way in which the nature of their work is constructed and how their leaders use professionalism as a discourse of control demonstrate how professions are socially constructed. Functionalist interpretations of professions emphasised the special status of professions in modern western society (Macdonald, 1995). However, attempts to list the steps of professionalisation (Wilensky, 1964) or define professions from semi-professionals (Etzioni, 1969), proved futile because of the contingent nature of professional developments.

Abbott (1988) demonstrates how the maintenance of jurisdictions of practice is dependent on how successfully professions construct problems for work. For Abbott (1988), work has both objective and subjective foundations. The two are sometimes difficult to distinguish. Natural or technological imperatives give the objective foundations. The human body might constitute a natural imperative. Objective foundations can also be determined by their objective nature such as 'running a railroad'. Furthermore, the objective foundations resist reconstruction, whereby reconstruction is the process where professions use their knowledge to "*reduce the work of competitors to a version of their own*" (Abbott, 1988; 36)

Abbott uses the treatment of alcoholism in the early industrial world to further demonstrate how professions construct problems for work. Alcoholism has certain objective qualities as consumption (of alcohol) produces "*central nervous system depression with loss of fine and, ultimately, coarse motor and sensory function.*" (Abbott, 1988; 37) However, the objective qualities have been reduced to many things by different groups wanting to claim the right over its treatment;

"Alcoholism has been a biological disease, a nervous and mental disease, a personal problem, a moral deficit, a sin." (Abbott, 1988; 38)

Abbott (1988) states that the further reinterpretations are from the objective qualities, the harder it is to find public acceptance. Professions are also vulnerable if the objective characteristics of the task change. Nevertheless, it is evident how the objective qualities of alcoholism have continually been reinterpreted over time and this

demonstrates how professions, which are socially constructed, construct the nature of work.

Contemporarily, Fournier (1999) argues that the rules by which professions can establish their legitimacy have changed considerably over the last fifty years with the advance of liberal forms of governance. These transformations can be observed in the discursive strategies of professions. Through examining professionalising discourse in large privatised service company 'Teamco', Fournier (1999) demonstrates how notions of professionalism are being used as a disciplinary logic for controlling employees. This form of 'organisational professionalism', can be exploited in this way because it appeals to employees. The appeal is twofold; firstly, as logic, it puts the customer first while secondly, it rewards employees through the medium of developing skills and competence.

"Re-imagining labour as offering 'professional service' serves to construct an image of quality and reliability appealing to the allegedly increasingly discerning and demanding customer; it also opens up some imaginary space within which self-actualising employees can strive for continuous fulfilment and improvement." (Fournier, 1999; 299)

Thus, transformations in professionalism, aimed at keeping pace with advancing liberalism, highlight the constructed and political nature of the professions. Because this study takes a socially constructionist approach, an abductive research strategy was used.

3.1.5 The Abductive Research Strategy

This study uses a broadly abductive research strategy for understanding professionalisation in audiology. Blaikie (2007) states that the abductive research strategy is advocated as an appropriate method for theory construction in interpretive social science. In its basic form, this strategy involves constructing theories that are derived from social actor's language, meanings and accounts in the context of everyday activities (Blaikie, 2007; 89). The aim is to discover why people do what they do, and this is done by uncovering there largely tacit, mutual knowledge, symbolic meanings, intentions and values. As Blaikie (2007) describes, the abductive research strategy has many layers to it and can be summarised as follows:

Everyday concepts and meanings

Provide the basis for

Social action/ interaction

About which

Social actors can give accounts

From which

Social scientific description can be made

From which

Social theories can be generated

Or which can be understood in terms of existing

Social theories and perspectives (Blaikie, 2007; 90)

Some social scientists focus only on reporting social actors' accounts as they feel this is all that is possible or necessary to understand social life. Others turn these accounts into social scientific descriptions of life but would insist on keeping these descriptions tied closely to the language used by social actors. Nevertheless, once

these descriptions are produced, they can be understood in terms of social theories or perspectives. In short, in this case, the social actions and accounts of elite professionals we described and understood in terms of theories and perspectives relating to the sociology professions.

3.1.6 Epistemological considerations - Social constructionism

The abductive research strategy is associated with a social constructionist epistemology. Social constructionism posits that the phenomenon in question is a product of a particular society or similar societies, rather than something that is natural or inevitable. Therefore, we might find a particular role or practice in one society but would not expect it in every society (Crossley, 2005). According to Crossley, (2005), social constructionism can be used in several ways:

1. Where we wish to indicate that some part of the social world, a role, institution, practice, is better explained in social rather than biological or psychological terms.
2. Used in literature to illuminate the use of reified terms such as things, the state, the media and patriarchy.
3. Used in an epistemological vain to indicate how we come to know the world is shaped by social factors such as social linguistic categories and procedures and practices of knowledge production. (Crossley, 2005)

Furthermore, the notion of constructionism can be applied to the work social scientists as well as social actors.

"Social actors socially construct their reality. They conceptualise and interpret their own actions and experiences, the actions of others and social institutions. From the same perspective social scientists construct their knowledge of social actors realities, their conceptions and interpretations of the actions of social actors and social situations" (Blaikie, 2007; 23)

By rejecting the traditional attempt to establish scientific knowledge through the positivist process of verification and falsification, there are implications for the status of knowledge, in particular, the findings of this thesis. Primarily, the evidence presented for professionalisation in Audiology is not thought to represent some objective reality. Instead, it leaves space for multiple interpretations of the same process, whether that be taxonomic (functionist), interpretive, Foucauldian, feminist, and so on. Furthermore, this research not only represents a dialogue between the empirical evidence and sociological understanding of professionalism as a changing concept, but it is also left to the reader to make interpretations of the findings.

As Gergen (1985; 272) states, scientific formulation using a constructionist philosophy is not about the impersonal application of decontextualised methodological rules, but the responsibility of persons in an active communal interchange. This 'communal interchange' is perhaps best demonstrated by Abbott's (1988) thesis on the system of professions, wherein the conclusion, he acknowledges that the reader is permitted to interpret his findings as they require.

3.1.7 Ontological considerations

Social constructionism is associated with an idealist ontology which posits that the external world consists of representations of individual minds. Whatever we think is real is merely an idea that has taken on the impression of being real. Idealism provides an alternative to empiricism which is based on the idea that the use of our human senses produces knowledge or that knowledge comes from observing the world around us. However, a significant criticism of the idealist ontology is that it is relativistic and the idea that the world is entirely illusory, gets no respect (Stake, 1995; 101).

3.1.8 Dealing with the problem of relativism

Relativism is an issue for case study researchers and in particular those using an abductive research strategy because this strategy generally adopts a constructionist epistemology and an idealist ontology. As Stake (1995) states, qualitative researchers generally emphasise experiential and personal determination of knowledge, and therefore most are relativists. Opponents of this philosophical underpinning interpret this to mean that qualitative researchers consider *all* views and *all* interpretations with equal value. Stake (1995) asserts that while personal choices or political ideology may call for respecting every view, the rules of case study research do not. Every informant's personal reality is not equally important, and some interpretations are better than others.

Stake (1995), Blakey (2007) and Hammersley (1992) recognise that some social scientists generally acknowledge that an independent, knowable reality exists independently of the activities of researchers. Addressing the abductive research strategy Blakey (2007), advocates that social scientists adopt a subtle realist ontology to overcome the difficulties of relativism. Hammersley (1992), suggests that the subtle

realist ontology retains from realism the idea that research investigates independent knowable phenomena. However, the subtle realist ontology breaks with the idea that we have direct access to social phenomena and therefore we cannot claim to reproduce it in an appropriate way (Hammersley, 1992; 52). This is because correspondence of these reproductions cannot be tested because of our individual constructed interpretations or biases.

While Stake (1995) advocates a rationalist constructivist stance, the consensus is clear; that to avoid the relativism of a constructionist epistemology and idealist ontology, that social scientists adopt a naive view that an independent social reality exists, however, that it cannot be confirmed because of our individual biases. Nevertheless, by utilising good quality data, constructionism helps the social scientist justify lots of narrative descriptions.

In revisiting the epistemological foundations previously discussed, it is important to state that in order to avoid the issues of relativism, a naive view that an independent reality exists has been adopted, insofar that it is recognised that notions of professionalism and professionalisation have practical consequences for a range of stakeholders in Audiology (See Burr 2018.) For example, professionalisation in Audiology has particular consequences for access to hearing care services by the public.

This thesis does not claim to reproduce the professional project in an unbiased or complete way, and this is in part due to the specific focus on elites as the drivers of professionalisation, when it is well established within sociological literature that other stakeholders including rank-and-file practitioners also steer professional

development (see Abbott, 1988, Scarselltta, 1997; Bolton, 2005; Moffatt et al., 2014). It is also because other constructionist interpretations, such as feminism, were precluded in favour of more general understandings of professionalisation.

3.2 Data Collection Methods

Having discussed the epistemological and ontological foundations and suitability of the study design, the remainder of this chapter focuses on methods and issues faced in data collection and analysis. A chronological case study approach was used to explore the professionalisation of audiology between 1997 and 2016. With a focus on professional elites, a wide range of evidence was considered including publicly available documents such as public policy papers and trade press magazines. This evidence was supported by data collected through one-to-one, semi-structured interviews conducted between August 2012 and March 2013 with thirteen participants. As part of an abductive research strategy, professional development in audiology was arranged chronologically and explained in terms of the extant literature pertaining to the professions.

The remaining chapter is split into three sections covering data collection, analysis methods and finally some caveats about the study are discussed. In the data collection section, documentary and interview evidence are considered separately. In case study research, it is essential that the data provide up-close and in-depth coverage of the case (Yin, 2018) and so the various sources will be discussed in terms of how they were collected and used. In the analysis methods section, the use of computer aided qualitative design software and dealing with discursive strategies are discussed. Finally, a reflexive

account detailing how my subjectivity may have affected the outcome of the research and the strategies used to counter this, is considered.

3.2.1 Data collected

A range of publicly available documents were considered in developing a chronological account of professional development in audiology. I based decisions about the document search on my prior understanding of the roles that the public and state play in professionalisation. Therefore, I included documents that were generated internally in the profession such as trade press magazines, and those generated externally such as charity reports and policy papers.

3.2.2 Internal documents

With a focus on professional elites, only articles written by leaders in the profession were considered. The problem of identifying professional elites is covered in the section dealing with interviews. Nevertheless, professional elites were identified based on their credentials as either having public involvement with significant projects in audiology, or as national and international subject experts in audiology. An obvious source for such articles are trade press magazines of which four were considered for this study (the date ranges are the publication dates of the respective magazines):

1. British Association of Audiological Technicians (BAAT) magazine 1997-2004
2. British Academy of Audiology (BAA) magazine 2004-present
3. British Society of Audiology (BSA) News from 2000-2013
4. Audacity (replaced BSA news) magazine - 2013-present

Trade press magazines contain a range of articles written for professional consumption. Typically all magazines contain an introduction by the president or chairperson of the respective association in which they discuss contemporary issues of professional development. These articles plus some others of importance were included in the study. From trade press magazines, eighty-three articles were included. In addition, professional guidance documents produced by the BSA or BAA were also considered as evidence for triangulation purposes.

3.2.3 External documents

A range of external documents relating to important practice developments were also included in this study. For this, some prior awareness of key developments was required. As discussed in the Introduction and Background chapter, these included MHAS, MSC and AQP. The document search was conducted in order of importance. White papers detailing key policies were the most important followed by green consultation papers. State responses to Select Committee Reports were also a vital source of evidence as they contained transcribed conversations and written responses from the profession, state and public. Some NHS documents and Department of Health services specification in hearing aid, tinnitus, balance and paediatric audiology work were also included in this study as they detailed specific practice improvement programmes. Overall, twenty-three state-sponsored documents were included in this study.

As noted, the public play a vital role in professional development insomuch as they are audiences for professional claims (Abbott, 1988) and the state is increasingly co-opting them as part of new forms of governance (Kuhlmann, 2006). In audiology, charities such

as AoHL and NDCS publish reports on the state of services nationally. Four of these reports were included as evidence to this study.

3.2.4 Transcription of documents

Hard copy documents were electronically scanned using ABBYY® FineReader, a text recognition software for converting scans, images and PDFs into editable documents. Once all documents were in an electronic format, they were uploaded to NVIVO. NVIVO was used as a database only for search and retrieval purposes when constructing the chronological narrative. The analysis of the evidence is discussed later.

3.2.5 Issues in collecting documentary evidence

Documentary evidence plays a significant role in this case study. However, the collection and interpretation of documentary evidence pose methodological considerations. It is fortunate that the audiological associations and charities have generated a considerable collection of documents in the form of trade press articles, and while policies are superseded or developed sequentially over time, the state has a robust system for archival and retrieval of these documents.

Some issues were encountered in the document collecting phase of the study. Firstly, electronic access to certain documents was restricted through password protection. Overall, the number of these documents was low, and this was not particularly detrimental to constructing the overall narrative. Secondly, the national electronic archiving system changed in 2010 making document searches and retrieval more difficult. Thirdly, there was a tendency for charities to delete older reports from their websites. Given the longitudinal nature

of this study, it was important that documents were downloaded and stored promptly to mitigate the risk that they were lost.

However, a significant problem of the trade press is that it is not formally addressed to posterity (Moyser and Wagstaffe, 1987). This generates two issues. Firstly, trade press is seen as disposable and so obtaining copies of magazines can be extremely difficult. I was fortunate that a meticulous and almost complete set of magazines had been kept in the local audiology department library. Secondly, trade press documents can sometimes obscure as much as they disclose, and underlying motives maybe even hidden from the writers themselves. Nevertheless, this has not stopped scholars, dealing with the professions, from finding additional information or novel insights into historical discourse (for example see Witz, 1992).

3.2.6 Interviews

As previously discussed, interview data supported the documentary evidence. Issues of identifying elite participants, gaining access to them and maintaining their anonymity were major issues in this study.

3.2.7 Identifying professional elites

The term 'elite' has taken different meanings and uses over time (for a summary of its uses see Aguirar and Shneider, (2012). However today elites are considered to be the small minorities who make decisions on behalf of the majority (Hiller, 1996: 113), and as such, they are found in all parts of society including politics, economy, military, culture, sport, academia and so on (Aguirar, 2012).

In their volume about studying elites, Hertz and Imber (1995) define professional as different from business, community and political elites. They acknowledge that the study of professional elites is often subsumed under the sociology of work and occupations where law, medicine and the clergy, have been defined as the most prestigious of these professions. Thus, the sociology of professions literature should offer a more refined definition for use in this study.

As discussed, professional elites are public figures that speak to the state and public on behalf of the profession and maintain control over rank-and-file professionals. In another definition, Freidson (1994) considers the broader aspects of differentiated specialities, segments and circumstances of practices within professions (particularly medicine) and proposes that these internal differentiations are mirrored in separate associations and sections within. Freidson (1994) reduces these separate associations and segments to having either administrative or knowledge functions where administrative associations are devoted to political and economic interests, and knowledge associations are devoted to the advancement and communication of scientific and scholarly knowledge. Therefore, unless they have marginal roles or views, most elites sit within administrative or knowledge associations (Freidson, 1994).

Based on these loose definitions I defined professional elites as:

1. A minority who make decisions on behalf of the majority.
2. Generally, public figures who speak to the outside (public) on behalf of the profession.
3. Have roles in administrative or knowledge associations.

4. However, they can be invisible to the public and not always sit within association especially if they have marginal roles or views.

With that definition in mind, I created a list of potential candidates. Firstly, all past and present presidents or chairpersons of the BAA and BSA were included. These constituted not just the public facing figures but also those representing administrative and knowledge roles within the profession (as BAA and BSA are respectively the administrative and knowledge associations of the audiological profession). It was challenging to identify elites with marginal roles or views in audiology.

The second group consisted of administrative elites who had public involvement with national projects and transformations in audiology. Such projects included MHAS, MCHAS, MSC, NHSP, Quality, AWP and AQP. This group of elites were identified mainly through their publications within trade press journals. The third group of elites included national and international subject experts in the fields of hearing aid technology, cochlear implants, tinnitus and balance.

The list of potential candidates was generated and verified by two senior audiology colleagues. There was significant overlap of role and function of all the elites identified and given the small size of the profession, the total number of potential candidates was small (the final list consisted of 31 potential candidates). While allowances were made for snowballing, it did not yield any alternative participants.

3.2.8 Gaining Access

Gaining access is a principle methodological concern faced by researchers studying elites and is primarily achieved by gaining rapport with potential participants (Hertz and Imber, 1995). As the success of such research projects rely on gaining access, researchers sometimes must 'make do' with what they can and so projects arise as a 'product of convenience' (Ryan and Lewer, 2012; 75). Sometimes projects can be serendipitous and unplanned (Herzog, 1995)

Medhurst and Moyser (1987) present a case study of the Anglican episcopate. For them gaining access was relatively straightforward because of work they had already done and published in Church journals. This had had a legitimising effect for them amongst Church leaders. Initial interviews were facilitated by personal recommendations from academic theologians with links to ecclesiastical networks. Finally, the investigators could truthfully represent themselves not only as academic observers but also active members of orthodox Christian communities, helping to neutralise the idea that they could be in the business of mischief making or debunking (Medhurst and Moyser, 1987; 92).

Like Medhurst and Moyser (1987), it was important I could truthfully represent myself as a member of the profession and this may have helped to neutralise the idea that I was in the business of mischief making or debunking. Furthermore, being a rank-and-file professional may have demonstrated *my* willingness or capacity to empathise with the cause of the participants. Indeed, it was my expressed intention to use the social sciences to increase the professions' self-awareness and this is something that many participants appreciated.

Several participants expressed their desire for such research to be undertaken as they felt it was necessary for the profession to reflect on its developmental strategy in light of state intervention in professional affairs. Others were particularly interested in the fact that I was conducting a qualitative research project, something that is still entirely novel in audiology. For these individuals, there is a firm belief that the profession should adopt more innovative research strategies. While I wish only to demonstrate how my professional standing helped with access to the professional elites, there are of course dangers in such complicity.

Where possible, I informally approached candidates at networking events such as audiology conferences and courses, and this was particularly advantageous as it allowed for a degree of rapport building and for candidates to ask more about my study. This approach was particularly successful. Of all the participants that accepted to take part in the study all had been approached informally at network events beforehand. All the candidates that had not been approached in this way did not respond to formal invitations.

Candidates were formally approached via email, inviting them to take part in the study (see Appendix 1 for Participant Invitation Letter). A participant information document was attached which summarised the research and the requirements for participation and exit from the study (see Appendices 3 and 4). Subjects were required to respond by email if they wished to participate. Upon receipt of confirmation, I arranged interviews at times and locations that were convenient to the participants.

3.2.9 The Interview Process

Semi-structured, one-to-one interviews were conducted between August 2012 and March 2013. Eleven were conducted face-to-face in a convenient place for the participant, and two were conducted over the phone. My insistence on face-to-face interviews was sometimes problematic. I thought it was essential to meet participants in person to help build rapport. However, this made for some long journeys and given their busy schedules; participants were prone to cancelling appointments at the last-minute. As interviews were arranged several weeks in advance, I contacted participants a couple of days before the meeting to confirm that the interview was still scheduled. On one occasion the meeting was cancelled. On two other occasions, I arrived at a meeting only to find that the participants had double booked appointments and therefore I had limited time for discussion. Only one of the participants offered a second meeting.

Interviews typically lasted for one hour. An interview schedule was used to elicit a discussion regarding the past, present and future development of audiology in the UK (see Appendix 2 for the Interview Schedule). The attitude or stance of the researcher is particularly crucial in case study research and the conduct of interviews (see Stake, 1995). In this case, I adopted the stance of a naive interviewer because I thought it would help in the rapport building process. I hoped that participants would not feel threatened or judged by my sociological background. On a practical level, I felt most at ease being a naive interviewer by dint of being a rank and file audiologist myself.

Such is the effect of the socialisation process for professionals that as an audiologist I was naturally inclined to show deference to the professional elites. However, the major pitfall of this was that it was

difficult to ask deep, probing and controversial questions to people that I considered my superiors. These questions included:

- Why did the BAA not include hearing aid dispensers in the amalgamation process?
- What role does race and gender play in the professional project?
- Why do we fail to acknowledge the role of the public and professional development?

As Moyser and Wagstaffe (1987; 98) note about their adopted stance:

"It may be that interviewers, as well as interviewees, can be the prisoners of particular images or pre-conceptions and these may stand in the way of effective communication."

Nevertheless, with the permission of participants, all interviews were digitally recorded for later transcription. During the interviews, prompt and reminder notes were made to explore specific topics in more depth. Notes were also made as part of an analytic process after the interviews were conducted.

3.2.10 Transcription of interview recordings

The interview recordings were transcribed verbatim. Speech disfluencies were not included in the transcription process as they were unnecessary for this study. Anonymised transcriptions of the interviews were uploaded into NVIVO which was used as a search and retrieval tool to build a timeline of events.

3.2.11 Ethical Considerations

Ethical approval was sought to conduct the one-to-one interviews from The University of Nottingham, Medical School Ethics Committee (see Appendix 3 for Ethics Approval Granted letter). Multi-centre ethics was not required because professional elites were interviewed as part of their wider role in the profession and not their roles in their respective places of employment. Approval was formally granted in May 2012.

A volunteer information sheet was provided on contact with prospective participants that detailed the purpose of the study, methods and possible intended use of the interview data (see Appendix 4). Participation was entirely voluntary, and participants were informed that they were free to withdraw at any time and without giving a reason. No participants withdrew from the study. All interview data including the audio-recordings and transcripts were stored electronically on an encrypted and password protected NHS database. The transcripts were anonymised by assigning a number to each. In the data sections, participants are referred to as Participants 1 - 13. Nevertheless, maintaining the anonymity of the participants was still a significant issue.

In dealing with elite materials, ethical issues can emerge with considerable force, and this imposes important obligations on the researcher (Moyser and Wagstaffe, 1987). How information is presented, disseminated and stored is of interest to people involved in power, especially when the information is about themselves. Furthermore, Moyser and Wagstaffe (1987) state that wider audiences, media and the mass public are likely to have an interest in the deeds or misdeeds of elites.

How researchers maintain control of information once findings have entered the public domain is sometimes a complicated matter. When obtaining interview data, in particular, guarantees of the anonymity have to be given; however, elite information makes identification of individual names a straightforward matter. For example, By the definitions I have used to identify professional elites, it would be relatively easy for a researcher to create a similar list of potential study subjects to my own.

During the interviews, there was a tendency for participants to talk about other individuals and this was mainly in the form of 'off the record conversations'. While this demonstrates something about the trust and rapport that I built with the interviewees, these conversations were usually a precursor to being asked whom else I was interviewing for my study. In other words, several participants expressed a deal of curiosity about the potential subjects for this study. In all cases, I declined to reveal anything about the people I was interviewing.

Nevertheless, through these off the record discussions, participants were attempting to influence my thoughts and feelings about particular individuals and thus introduce certain biases into my research. I found this particularly problematic when participants were critical of another person. I reflected on each conversation and resolved each time to put aside biases, believing that there are two sides to every story. Overall, this situation also revealed something about the network of elites in audiology. It is a relatively small group of people with diverse experiences and views about professional development, and this diversity can sometimes create tensions

between them. However, without a doubt it was clear that all participants were committed audiologists and have a great concern for the future of the profession.

3.3 Analysis of Data

An overview of the analytical strategy is presented in Figure 1 as a set of steps from immersion in the data to explanation building using social theories and perspectives. In the following section, I present a more detailed description of the data analysis process and some of the issues raised in the process.

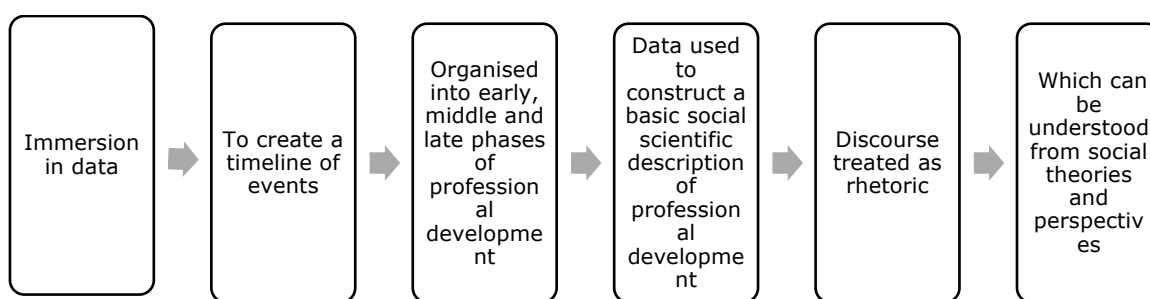


Figure 1: Analytical strategy: Chronological case study design and adapted abductive research strategy.

3.3.1 The use of Computer Aided Qualitative Design Analysis Software

NVIVO software was used for storage and retrieval purposes, and it allowed for searching the data using keywords. Searches extracted all sentences containing keywords (and similar words if required). As the data was inputted in chronological order, the extracts could be aligned with corresponding phases of professional development. This strategy was also useful for triangulating data as it was easier to view how different data sources linked together. For example, a search for 'private sector' revealed extracts from public policy, trade press magazines and charity reports and all occurring within the early phase of professional development.

3.3.2 Immersion in data and creating a timeline of events

It is perhaps apparent by now that a significant amount of raw data from multiple competing sources was collected for this thesis. The first issue was how to combine and integrate the data into a coherent narrative of professional development. Following the production of a draft timeline of events from memory, I reorganised the data into an approximate chronological order. From my knowledge of the sociological literature, particularly Abbott's (1988) work on the system of professions, I divided the data set further into professional, state and public materials, in effect, leaving me with three opposing views of professional development.

The process allowed me to review all the data and reflect on the content, and this was important because much of the story of professionalisation was closely related to my career trajectory, and so the data could be viewed through my newly acquired sociological knowledge of the professions. I discovered that I had a tendency, at first, to overestimate the importance of certain events, mainly because I had experienced them (or effects of them) first hand. The lack of empirical evidence about these events underlined their insignificance; however, where necessary, I filled in gaps by refocusing my search for evidence. In some cases, inconsequential or significantly incomplete data were excluded from consideration altogether. Nevertheless, rearranging the data allowed me to revise the timeline of events continually. The reviewed timeline is detailed in Appendix 5, and it details critical policy updates and significant transformations in practice.

3.3.3 Reorganising the data into early, middle and late phases

It was in the writing process that I was able to learn more about my research topic and data. Indeed, writing can be considered a useful method of inquiry (Richardson et al., 2008). Following the production of a basic timeline, I began focusing on developing a written description of professional development. At first, the focus was purely on crafting a description of professionalisation based on the professional materials (trade press magazines and interviews). It became apparent quite quickly that writing chronologically was confusing to write and read. Professionalisation was multifaceted and incorporated so many different topics as diverse as public engagement, private sector involvement in hearing care, Modernising Scientific Careers, and so on. It was necessary to divide professionalisation further, effectively creating a series of overlapping phases. Following the convention of chronological case study design as detailed by Yin (2018), I divided the timeline into sections concerning the early, middle and late phases of professionalisation and included the following sections:

1. Modernising in audiology services.
2. Independent sector involvement in NHS hearing aid provision.
3. Modernising Scientific Careers and professional status.
4. Extending choice and cost containment in NHS hearing aid provision.

It is common for audiologists to refer to the period leading up to today's formation of the BAA as the modernisation era. Modernisation was synonymous with the New Labour policy of the time and was associated with the introduction of digital infrastructure as part of the

Modernising Hearing Aid Services programme. Modernising scientific careers, the rationalisation of the education and career pathways, had its antecedents in the modernisation period. However, the project took several years to realise; hence, this is the reason why it follows independent sector involvement in NHS hearing a provision. Whereas, extending choice and cost containment can be seen as a direct consequence of austerity following the global financial crash in 2008.

3.3.4 Constructing social scientific descriptions

The reorganisation of the timeline into discernible phases allowed me to begin constructing concise social scientific descriptions of professional development in Audiology. Summaries of these phases are described in Table 4. By this stage of the analysis, I was looking to explain primary causal sequences. I had taken to reading and writing about professional development in a particular order, beginning with the state as the most powerful influence, followed by the profession and the public. This pattern of discussing professionalisation is evident in the data and discussion chapters that follow.

Nevertheless, reading and writing in this order helped in understanding the variations, contradictions and tensions of the professionalisation process. For example, competitive tendering could be understood in NPM terms, the professional resistance in terms of protecting market shelters, and the public in terms of widening access and participation. The causal sequences are evident when Table 4 is read horizontally. Through my knowledge of the extant literature, I rearranged the phases by stakeholder input: the three primary stakeholders being the state, the public and the profession. As a

result, three themes emerge from the description of professional development:

1. The state/ profession relationship is one where the state drives efficiency and cost containment in hearing healthcare.
2. In the case of audiology, through a commitment to reduce inequality and the personal and social costs of hearing healthcare, the public are instrumental in practice improvement.
3. Status and social closure, the hallmarks of occupational forms of professionalism, still appeal to contemporary professional projects.

Whether for explanatory or descriptive purposes, Yin (2018) advises avoiding giving disproportionate attention to the early events and insufficient attention to later ones. Much of the interest in a case study may be related to more recent events (Yin, 2018) and was true of this case which aimed to explain causal sequences in state policy and professional development which has led to increasing inequality in service provision. Based on Yin's (2018) recommendation, the final drafts of the case study were rewritten with the conclusions in mind and composed backwards from the late to early phases.

3.3.5 Dealing with discursive strategies

One significant issue was how to treat the discourse contained within the overall data. With an increasing focus on professionalism as a disciplinary mechanism (see Fournier, 1999), it was reasonable to treat this discourse as a form of rhetoric. Gill and Whedbee (1997) suggest that there is little consensus as to the meaning of rhetoric and scholars throughout history have redefined it. Rhetoric is

identified as many different things, including argumentation and expressive language and may include non-discursive activities and objects. Although definitions of rhetoric vary, Gill and Whedbee (1997) state that two themes occur with regularity;

1. The essential activities of rhetoric are located on a political stage.
2. Rhetoric is a discourse calculated to influence an audience toward some end.

The role of professional elites is now well defined, and we understand that they attempt to influence a range of audiences including state, public and rank and file professionals, on a range of issues including the right to certain types of work (See Larson, 1977 and Abbott, 1988).

While this is not a critical rhetorical study, the method outlined by Gill and Whedbee (1997) was considered during the analytical process.

"Initial experience with a rhetorical text leads a critic to ask questions of the text, questions that focus attention on particular aspects of the text, and how it functions. For example, among the most basic questions, the critic might ask are: what expectations are created by the context? What does the text present to the audience? What features of the text are significant?" (Gill and Whedbee, 1997; 160-161)

As a result of this focus on rhetoric, I focused my attention not on what was said, but why it was said. For example, as the role of the public in professional development became apparent, I began to ask

why professional elites avoided attributing professionalisation to them.

Importantly, an understanding of the sociology of professions literature informed me that this was because professions choose to portray images of solidarity for social closure. Therefore, as part of the abductive research strategy, I used social theories to construct social scientific descriptions of professionalising rhetoric in audiology. Thus, the sociology of professions helped me to explain the motives behind the rhetorical process used by professional elites, the state and the public.

3.4 Reflexivity

Reflexivity has a long history spanning at least the last century (Finlay, 2002). However, Pillow (2003; 176) states that most researchers use it without defining how they are using it, and as if it is something we all commonly understand and accept as a standard methodological practice for critical qualitative research. The misapplication of reflexivity has led some methodologists to explore some possible validated reflexive strategies (see Anderson, 1989; Finnlay, 2002; Pillow, 2003). In most cases, reflexivity involves the exploration of the researcher's subjectivity, how that subjectivity affected the research (from the design, being in the field and analysis of data), and how the researcher may have transcended their subjectivity.

My own research comes closest to what Finlay (2002) describes as a social critique. Social constructionist and feminist approaches often fall within this category because they are often interested in power

balances. In this case, I was interested in the reach of the power of professional elites in audiology.

"In reflexivity as social critique, it is naive, if not disingenuous, to pay lip service to the power dimensions by assuming a fixed knowable subject position." Finlay (2002; 226)

When I began the data collection, I was particularly aware of the power differences between myself and the participants. As discussed in the literature review, rank-and-file professionals are dependent on elites for the rewards of professionalism (Larson, 1977). In other words, I felt at that point that any of my participants could be my future employer. This idea is linked to the fact that this project represents my personal professionalisation project. This created two issues. Firstly, I feel that it restricted the level of probing when it came to uncomfortable subjects, for example, the problems of gender in audiology. Secondly, in deference to the power of elites, I was initially inclined to accept their version of professionalisation. For example, when asked about factors affecting professionalisation, almost all participants cited technology as the primary driver of development. None of the participants willingly talked about the importance of the public in practice improvement. As I have since learned, this is because professions are naturally socially closed, and therefore inclined to only project the achievements and status of the profession (Larson, 1977).

This case study has taken nearly ten years to bring to a conclusion, and from my point of view, it represents a significant sea change not only in my position but also that of the profession as a whole. As stated in the introduction to this thesis, I began my research because

I had become disillusioned and frustrated with my profession. This meant that I was initially inclined to analyse the prevailing professionalising discourse negatively.

The fact that it has taken nearly a decade to complete my thesis is probably advantageous, because as I have taken up numerous leadership roles, and so rhetorical strategies aimed at reconciling the needs of patients, organisations with my career aspirations, have become part of my subjective way of viewing professionalisation. Furthermore, while competitive tendering and the fragmentation of services for people with hearing impairment caused a great deal of upheaval a decade ago, today it has become commonplace and to some extent the accepted way of things. It is often difficult to advance professional interests in times of austerity, and to that end, I am more inclined to empathise with other professional leaders. The period between starting and finishing this thesis has meant that my analysis of the situation is more nuanced.

Also, my understanding of the extant literature pertaining to the sociology of the professions has grounded my analytical process. It has allowed me to explain professional development in light of established peer-reviewed empirical studies and sociological perspectives.

Chapter 4: Results and Discussion: The professionalisation of audiology between 1997 and 2016

In this chapter, documentary and empirical evidence are used to discuss professional development in audiology between 1997 and 2016. The purpose of this chapter is to:

1. Demonstrate professional development as a set of causal sequences linearly over time
2. Use the extant literature to explain a version of professional development to make practice improvement

As discussed in the methodology chapter, an abductive strategy is used to explain professional development. An abductive strategy uses a broadly constructionist epistemology to develop theories and elaborate them iteratively, and this is achieved through the production of a technical account of everyday lay concepts, meanings and motives (Blaikie, 2007).

Some challenges arise in constructing such an account. The first challenge is to take macro and meso levels of analysis (e.g. social systems, institutions and organisations) and relate it to the micro levels of professionalisation (e.g. professional practice). As Evetts (2009) states, micro and macro variations and complexities form different contexts for further analysis because some professionals

continue to operationalise occupational forms of professionalism (in their clients' interests), despite working in systems where forms of organisational professionalism are dominant. This account provides some pertinent examples, including the use of the independent sector for NHS hearing aid provision, where occupational professionalising discourse was used to counter increasing public management reform.

While the overall aim is to make recommendations for practice improvement, the second challenge is avoiding making assumptions about the precise outcomes of public management reform. As Pollitt and Bouckaert (2017) state, there is still no way of reliably evaluating public management reforms. Like Kuhlman et al. (2009; 514), this account focuses on the dynamic relationships between the profession, state and public rather than assuming which reforms may provide better quality or greater choice. The recommendations for practice focus on ways in which the profession and its elite could mediate the dynamic for the benefit of hearing healthcare in the UK.

The third and common challenge to anyone writing about the professions is limiting the timespan. In introducing *Occupational Monopoly and Modern Medicine*, Larkin (1983: viii) acknowledges that in limiting his analytical timespan from 1900 to 1960, he inevitably omits important proceeding events and inter-occupational rivalries. In a similar vein to Larkin's thesis, this account focuses on the emergence of a modern audiological profession within the context of contemporary public management reform, rather than focusing on an entire history which would probably demand another volume for adequate analysis.

Conventionally, this chapter is divided into descriptive narratives of early, middle and late phases of the chosen period of professional development (Yin, 2009). These narratives are arranged in the following chronological order:

1. Modernisation in audiology services (early phase)
2. Independent sector involvement in NHS hearing aid provision (middle phase)
3. Modernising Scientific Careers (MSC) and professional status (middle phase)
4. Extending patient choice and cost containment in NHS hearing aid provision (late phase)

The early phase covers 1997 to 2004, a period of modernisation in which the three professional audiological associations representing technicians, scientists and hearing therapists amalgamated and the NHS adopted digital hearing aid technology through the Modernising Hearing Aid Services (MHAS) programme. The middle phase, between 2004 and 2010 was defined by increasing market reforms in NHS adult hearing aid provision and reforms to education and career progression through the development and implementation of the MSC programme. Finally, the late phase covers the period between 2010 and 2016, in which market reforms were accelerated through the states' Any Qualified Provider (AQP) scheme and inequalities in NHS audiology provision intensified through cost containment.

Professionalisation is detailed as a rhetorical process in which professional elites set about interpreting policy for organising the rank and file professionals with the intention of increasing the professions' status. Other than professional elites, the state and the public are

considered integral stakeholders in professional development, as they both influenced and benefitted from the process, a point which corresponds to contemporary insights regarding professional development (for example, see Kuhlmann, 2006).

Some broad themes emerge from the data and allow for iterative sociological analysis. These themes include the profession/ state relationship, public involvement in professional development and the appeal of occupational professionalism. Recognising, as does Abbott (1991; 380), that professionalisation is a multilevel, contagious and complex social process, professional development is summarised in Table 4. A simplified timeline of professional development has also been included in Appendix 5.

	Modernisation in audiology services	Independent sector involvement in NHS hearing aid provision	Modernising Scientific Careers and professional status	Extending patient choice and cost containment in NHS hearing aid provision
State	The state invested widely in a programme of modernisation in the NHS service provision.	Initially the state supported independent sector involvement as a way of increasing capacity.	With skill substitution in mind, the state invested in the wholesale rationalisation of the healthcare science disciplines.	Latterly, the state has increased independent sector involvement principally as a way of reducing expenditure.
Theme 1: Profession/State relationship that drives efficiency and cost containment in hearing healthcare.				
Public	After leading a successful campaign which highlighted long waiting times and inequalities in service provision, the RNID co-produced MHAS.	The public supported independent sector involvement in NHS provision as a way of widening access and reducing social stigma.	There is no reported evidence to support public involvement in MSC.	The public have attempted to hold the state to account for cost containment. Evidence suggests that hearing healthcare services continue to be cut.
Theme 2: Public involvement and professionalisation to deliver equality and access to hearing healthcare and reduce the personal and social costs of deafness and hearing loss.				
Profession	Modernisation included the amalgamation of the public sector hearing professionals, adoption a bachelor's degree and implementation of a new clinical infrastructure.	Public sector professionals sought to exclude the independent sector from public sector provision of hearing aids fearing that it would destabilise NHS services.	The profession saw MSC as a way of raising its status.	Cost containment is having a deleterious effect on the profession and its ability to deliver inclusive hearing healthcare services. The profession is beginning to form alliances with the public that mediate excessive policies around cost containment.
Theme 3: Professionalisation as a quest for social closure and status.				

Table 4: The Professionalisation of Audiology in the UK: Horizontal themes and vertical narratives arranged by stakeholder interest.

4.1 Modernisation in audiology services

In 1997, audiology in the UK consisted of four occupations: Audiological Scientists, Hearing Therapists, Audiological Technicians and Registered Hearing Aid Dispensers (represented by their respective associations and societies BAAS, BSHT, BAAT and BSHAA). Much like today, the technicians (now practitioners) represented the largest occupational group. There was very little to distinguish between the four occupations as they all shared the same cognate discipline, however the hearing aid dispensers operated solely in the private sector whereas the rest were public sector professionals. Table 5 shows the four audiological occupations in 1997 arranged by worksite, professional association, minimum qualification and status of professional regulation.

Meanwhile, it was also a time in which there were significant inequalities for patients accessing audiology services. In 1999, the RNID published *Waiting to Hear*, a report on the findings of a national survey of hearing healthcare provision in the UK (RNID, 1999). It primarily reported on issues of access to hearing healthcare in the NHS which was because of long waiting times for hearing tests and hearing aids. The report also highlighted a significant variation between audiology departments in the NHS, where many were poorly funded, understaffed and often housed in inadequate facilities (RNID, 1999). Finally, the report emphasised the significant inequalities between the public and private sector hearing aid provision. Digital hearing aids were available in the private sector but at over-inflated prices, whereas the NHS could only provide analogue technology that was years out of date (RNID, 1999).

The election of the Labour Party in 1997 marked a decisive turning point in the reorganisation of audiology and hearing healthcare services in the UK. The White Paper, *The New NHS: Modern, Dependable* (Department of Health, 1997), set out the Labour Government's plan for a modern NHS. For the professions, a focus on quality meant establishing best practice through policies and strengthening professional development, and this would be achieved through substantial investment in new models of training, a national pay spine and strengthening existing systems of self-regulation. For patients, the paper set out a commitment to reduce NHS waiting times and expand public involvement in shaping the NHS. Resultant policy programmes related to the white paper, discussed later, include Modernising Hearing Aid services (MHAS) and Modernising Scientific Careers (MSC).

Occupation	Primary Worksite	Professional Association	Minimum Entry Qualifications	Professional Regulation
Audiological Scientists	Public *	British Association of Audiological Scientists (BAAS)	MSc (Audiology) Certificate of Audiological Competence (CAC)	None
Audiological Technicians	Public **	British Association of Audiological Technicians (BAAT)	BAAT part 1 & 2 ONC (MPPM)	None
Hearing Therapists	Public	British Society of Hearing Therapists (BSHT)	Certificate in Hearing Therapy	None
Registered Hearing aid Dispensers	Private	British Society of Hearing Aid Audiologists (BSHAA)	Hearing Aid Council Exams	Mandatory with the Hearing Aid Council (HAC)

*Clinical Scientists in Audiology

**Medical Technical Officers

Table 5: Audiology by occupational groups in the UK in 1997

According to Harrison and McDonald (2008), the Labour Party had never considered substantive health policy until six months before the general election of 1997. Instead, their winning manifesto was based on a rejection of the internal markets and long waiting lists passed on from the previous Conservative Government. Modernisation was initially coined to signify reform within the Labour Party and was used as a description of various facets of public policy, the term featuring prominently in many policy documents since 1997 (Harrison, 2002). Beyond a rhetorical term, the substantive elements of modernisation can be linked to contemporary PMR, in particular, governance.

As discussed, PMR aims to make the government more efficient by using free market type mechanisms, performance indicators, competitive contracts and quasi-markets (For example see Hood, 1991). Over the last couple of decades, PMR has also sought to make government more effective and legitimate, and this is achieved by involving a range of social actors and stakeholders in the policy-making and implementation process (Osborne, 2010, Pollitt and Bouckaert, 2017). Audiology specific projects such as MHAS, MSC and Any Qualified Provider (AQP) (discussed later), can be understood in terms of contemporary PMR and have consequences for both the profession and the public.

4.1.1 Taking advantage of the states' modernising agenda: The rhetoric of amalgamation and credentialing enter professionalising discourse

Public sector audiology professionals saw an opportunity to advance the profession and under the charge of the Department of Health's Chief Scientific Officer (CSO), began exploring the benefits of

amalgamating the various professional associations and establishing their career framework based on a system of credentials, namely a bachelor's degree.

"I have recently had a meeting with Dr Greenaway the Chief Scientific Officer at the Department of Health and with representatives of the British Association of Audiological Scientists (BAAS). Some days earlier I had had the honour of addressing the conference of the Audiological Scientists in Bournemouth. Both of these meetings come at a time when I sense that previously hard line attitudes to our respective professional positions are beginning to ease, and both sides are beginning to respect each other's position and contribution to our audiology service. This was certainly evident at the BAAS Conference and was re-enforced by the subsequent meeting in London. At that meeting it became quite clear that the Department of Health is seeking to regularise our position and that of our Scientist colleagues by having a root and branch review of scientific health service personnel as a whole. It is hoped that common ground may be found between the currently disparate groups so that common occupational standards may be brought in, leading to greater uniformity and higher standards. Clearly, we as Audiologists, can already begin to identify some commonality with our Scientist colleagues, and with further work may well be able to establish a common educational and grading tree." (Brown, 1998; 4)

The selected excerpt taken from the Chairman's Letter in *BAAT Magazine* illustrates the beginnings of a rhetorical process aimed at persuading rank and file professionals of an emerging professional

project. It was an attempt to balance the positions of the state and profession; on the one hand, the coercive state, with their wholesale approach to standardising the healthcare sciences and on the other, the harmonious and aspiring profession poised to reorganise its work and division of labour. Put simply, it was an attempt to portray occupational change as coming from within.

The '*hard line attitudes*' or tensions between technicians and scientists can be traced back to the early 1980s when discontent arose amongst technicians because they felt that they could not achieve their professional ambitions under the BSA (Wyke, 2004). Consequently, in 1984 BAAT was formed to further the professional interests of technicians in audiology (Wyke, 2004). It is evident that the tensions between the various audiological occupations carried on through the 1990s, as one informant, discussing her career states;

"In those days you had three disciplines in audiology – you had hearing therapists, audiologists (known as technicians) and clinical scientists; and they were a highly tribalised, the technicians resented the hearing therapists, and the scientists thought they were better than everybody else!" (Informant 2)

The notion that '*scientists were better than everyone else*' was said by this informant to arise from the fact they had a master's level qualification, the highest-level credential for audiological practice at the time. Furthermore, this notion continued to cause tension during the amalgamation process. In 1999, scientists were granted state registration, and this proved a catalyst for BAAS to leave negotiations. Parsons (1999; 8-15) reported in BAAT news that the scientists had been particularly "*disingenuous*" in negotiations, in that BAAS

consistently saw themselves at "*the top of the tree*" and whilst supporting the advent of a bachelor's degree in audiology, they saw it only as a feeder into their own education system. Furthermore, Parsons (1999) reported that BAAS did not consider that technicians who subsequently became heads of departments possessed the necessary skills, knowledge or competence to do so. Thus, the evidence suggests that scientists represented by BAAS attempted to carve out a role for themselves as professional leaders based on their credentials.

References to common occupational standards and greater uniformity link the government pledges, in the aforementioned White Paper, *The New NHS: Modern, Dependable* (Department of Health, 1997), to the foregrounding principles of MSC which are described later. Evidence shows that the Department of Health shared a draft schematic of the MSC career pathway with audiologists almost a decade before it was formally published in a Department of Health consultation *Modernising Scientific Careers: The Next Steps* (Department of Health, 2008) (see Figure 2). The proposed career pathway set out a pay spine and career grade based on a system of credentials. Importantly, it was proposed that entry into a career in audiology, starting as a practitioner, would be based on completion of a bachelor's degree, something that public sector audiologists welcomed as part of their strategy to increase professional status.

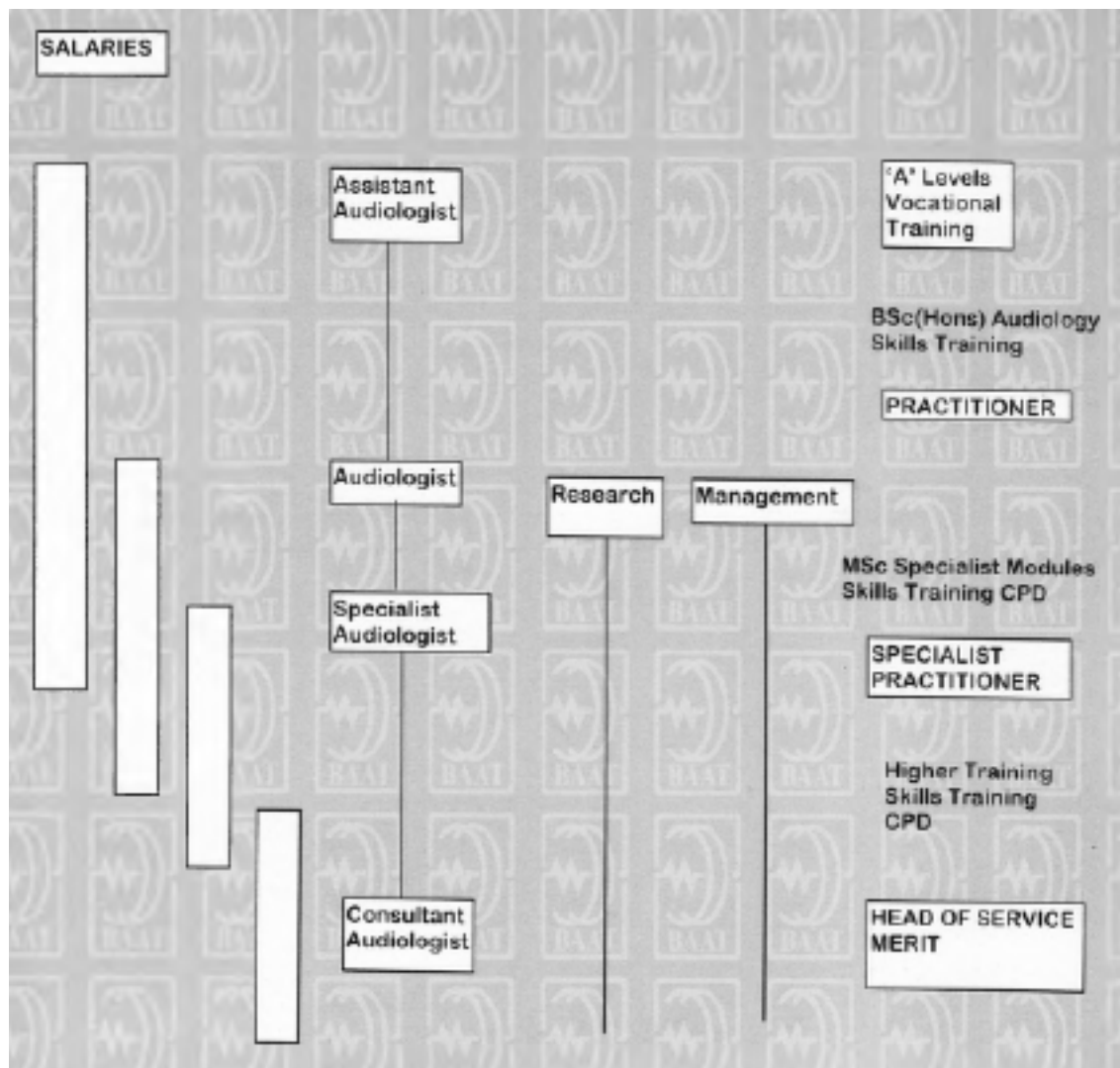


Figure 2: Early version of career framework proposed by the CSO and published in BAAT Magazine (Study Issue) in 1999 (Parsons, 1999;11)

It is worth mentioning at this point that the process of amalgamation described so far ignored the role of the private sector Registered Hearing Aid Dispensers (RHADs). While it is evident that they were represented at meetings with the CSO about amalgamation and developing a career framework, eventually they were excluded from the final process leading to the implementation of the bachelor's degree and formation of the British Academy of Audiology (BAA). In

short, it was neither in the private or public sectors' interest to amalgamate. As one informant discussed;

"I think we could easily be one big unit and we were very close to being, as part of those negotiations you just described, but they wouldn't have it in the end. They couldn't sell it to their management, that what we could have done is say, "Okay, by ____ [0:25:38], we'll make all of you RCCP registered and at a date set in the future, training will be at degree or whatever level, we'd all agree on it." That would have solved it completely. I think they were worried about what that would do to their market in terms of current NHS people deciding to go and operate outside of their borders." (Informant 8)

RHADs had their established system of training and their role in selling hearing aids was protected through mandatory state regulation. Essentially, had they agreed to amalgamate with the public sector and utilise joint qualifications, it would have exposed the independent sector market to increased competition by a growing number of public sector audiologists wanting to sell hearing aids. Conversely, it might have opened the NHS hearing aid market to competition from private sector RHADs, as was looking likely, as MHAS was being implemented (The use of the word market, in this case, refers to a quasi-market, c.f. Harrison and McDonald, 2008;81-83). Public sector professionals attempted to protect the NHS hearing aid market through rhetoric that questioned the knowledge and competence of RHADs to work in NHS audiology services;

"It was accepted that if a HAC [Hearing Aid Council] qualified dispenser wanted to join they would need to gain both

additional knowledge and clinical competencies, which would need to be assessed by BAAT. It was also accepted that for a HAC qualified Hearing Aid Dispenser to be successful in these assessments they would need significant clinical experience within the NHS. In light of this BAAT has agreed to investigate possible mechanisms by which HAC qualified hearing aid dispensers might achieve membership of BAAT.” (Wyke, 2001; 5).

However, evidence suggests that there was a degree of apathy amongst rank and file technicians regarding the professional project discussed so far. On more than one occasion, the BAAT Chairman had to call upon technicians to take more interest in the activities of the professional association, BAAT;

“BAAT’s membership is increasing all the time, but members do not seem willing to involve themselves in helping to run the Association. It is important that everybody should show an interest in what is going on and get involved regionally as well as nationally. It is your future that is at stake - the future of your profession and therefore your career and therefore your job. If you care about your future then make sure you have a say in it by getting involved in BAAT in any capacity, however small. The more committed people we have, the more effective an organisation we will be.” (Johnson, 2001; 4).

At the time of publication, BAAT had failed for a second year to elect a new chairperson or vice chairman forcing the then Chair Jackie Johnson to serve for another year. This excerpt reveals how the professional association, BAAT, attempted to link and promote its

work to employment and practice. The implied apathy amongst the rank and file supports the view that the professional project described so far, represented the self-interests of a small group professional elites rather than the entire membership of BAAT. Furthermore, the RNID report *Waiting to Hear* (RNID, 1999) supports a more plausible view, that public funding (or the lack of) had more of an effect on employment and practice than the professional associations.

4.1.2 Taking advantage of the states' modernising agenda: the RNID campaign for access and equality for hearing services

During the same period, the RNID were involved in an extensive campaign to improve services for people with hearing loss. Murdock and Lamb (2009) describe their campaign as an insider-outsider approach which involved working with mass communications such as news stations and directly with politicians to raise issues of inequalities in NHS hearing aid provision as a matter for public and political concern. Like the audiologists, the RNID took advantage of the favourable political conditions, namely the government's pledge to reduce NHS waiting times and expand public involvement in shaping the NHS.

The RNID believed that as the largest purchaser of hearing aids in the world, the NHS had significant leverage to significantly reduce the price of digital hearing aids through bulk buying and direct negotiation with manufacturers. Furthermore, it argued that there was no better time "*to change so many lives, so radically, at so low a capital cost*" (Murdock and Lamb, 2009; 144). So much did their campaign appeal to the state, that they were eventually co-opted by the Department of Health to implement a modernisation programme. Working in

partnership with the Institute of Hearing Research the MHAS programme was initiated and involved the phased introduction of digital hearing aids, IT structure and new service procedures and patient protocols (RNID, 2002).

Through the publication of *Waiting to Hear* (RNID, 1999) the RNID were successful in raising hearing aid services as a matter of state and public concern. As Deans (1989) states, lobbying is an essential aspect of large charities, particularly those involved in medical research like the RNID. Despite legal limitations, medical research charities, like the RNID, have increasingly been drawn into the political processes. The amount of money and attention these charities gain is dependent on how well they can market their respective diseases. However, some diseases are more popular than others in different contexts (for a discussion on how diseases are marketed, see Deans, 1989;151-155). Nevertheless, Deans (1989) concludes that governments fund popular diseases in response to public pressure and as a way of gaining public support for themselves.

In any other context, hearing loss is generally not a popular condition like cancer or heart disease and attracts less than 1% of medical research spending (AoHL, 2011). However, the case of RNID involvement fitted well in a context where the government was keen to explore greater patient and public involvement and reduce waiting times (Murdock and Lamb, 2009). Furthermore, by the time news had reached the public that digital hearing aids were being offered at a few modernised sites, it became hard for the government to resist public pressure to invest in rolling out a modernised service across the UK (Murdock and Lamb, 2009).

There is a long history of public involvement in healthcare in the UK, although, at its inception, the NHS was a “*paternalistic and producer-dominated institution*”, meaning that service users lacked the independence and legitimacy to act (Baggott, 2005; 535). This situation began to change in the 1970s and the decades that followed. The New Labour Government who were committed to rebuilding public confidence in the NHS placed a greater emphasis on making the NHS more accountable to patients (Baggott, 2005), and this directly appeals to changing notions of governance in public services.

Politically, patient involvement can also be viewed as opportunistic for politicians who may use it as a rhetorical device to legitimise their political systems (Newman et al., 2004). There is a growing consensus for its use as a political device in advanced democratic societies worldwide (Forster and Gabe, 2008). Forster and Gabe (2008) state that public involvement can be used to reinvigorate political culture at a time when the public is increasingly disillusioned and disengaged with mainstream politics, as was the case when New Labour was elected. Furthermore, they suggest that there are economic motives for the state in espousing public involvement as it supposedly encourages the more responsible use of services (Forster and Gabe, 2008).

Whatever the motives behind greater public involvement, there is no doubt that the public in the form of the RNID and others took advantage of this situation to increase access to hearing healthcare and reduce waiting times for hearing aids. In this sense, public management reform empowered patient groups to take action against inadequate services. The involvement of the RNID in the MHAS project is an example of the concept of co-production described

by Boviard (2007). Like the concepts of patient choice, co-production arises from contemporary public management reforms which encourage public engagement and participation which are aimed at making public services more cost effective and responsive to the needs to users and communities. However, co-production is relevant to the service delivery phase of service management, but also extends *"across the full value chain of service planning, design, commissioning, managing, delivering, monitoring and evaluation"* and therefore it challenges professionals to find new ways of interacting with the public (Boviard, 2007; 847).

While Boviard (2007) generally favours co-production, he raises several concerns based on empirical analysis of co-production in action. Firstly, while there exist numerous cases of co-production globally, it does not prove the existence of a trend. Secondly, it would be premature to conclude that co-production produces greater cost effectiveness. The implementation of MHAS was costly for the state and, had the effect of increasing waiting times. Thirdly, examples of co-production are relevant to specific contexts and may not be widely generalisable. RNID involvement in MHAS is highly contexted but may add to other examples. Fourthly, Boviard (2007), observes that governance issues can be problematic and are not always resolved. A final and pertinent concern is the political feasibility of co-production especially when it involves placing doubt on the role of professionals by favouring decisions made by users and communities and rebutting media criticism when things go wrong. Boviard (2007) explains that *"politicians would need to support users in constructing their own identity rather than accepting the one constructed by experts"* (2007; 858).

This suggests that in the future, should the trend for greater public involvement continue, successful professions will be the ones that continuously engage with the public (and the state) in constructing identities for practice. As will be discussed, in audiology the private sector recognised the public desire to be seen on the high street as a part of widening access and reducing the social stigma of hearing loss. Furthermore, the independent sector supported the state's ideological principles for market reform.

4.2 Independent sector involvement in NHS hearing aid provision

MHAS represented a turning point for audiology services and patients with hearing loss, due to significant investment in upgrading the NHS audiology infrastructure and implementation of new clinical procedures that involved spending more time with individual patients. As a result, there was a surge in public interest and expectation around hearing healthcare (King, 2002). Consequently, NHS waiting times for digital hearing aids increased rapidly and it became clear that NHS audiology services could not manage this demand.

A central issue was that NHS audiology services lacked enough qualified staff and it would be some time before there was an appreciable increase in the size of the workforce. The profession had, in 2002, realised its ambition for a graduate entry profession and had recently adopted a bachelor's degree. However, it would take the first cohort of students until 2006 to graduate. NHS professionals represented by BAAT, BAAS and BSHT, held meetings with the NHS Executive (NHSE), between 2000 and 2001 to resolve the workforce shortage (Johnson, 2001). It was concluded that NHS audiology services required both long and short term solutions to remedy the

problem. It was agreed that more training places would be centrally funded to boost the future workforce. In the short term, services were advised to implement skill mix reviews and increase administration staff to support professional practice. Finally, it was agreed with the Overseas Labour Service, that Audiology is listed as a shortage occupation, thus making it easier to recruit trained staff from overseas (Johnson, 2001).

It appears that involving the independent sector in NHS hearing aid provision was one solution that NHS professionals had avoided when negotiating with the NHSE. As already suggested, public and independent sector interests, namely protecting market shelters, had resulted in the exclusion of the independent sector in negotiations concerning amalgamation. It is therefore likely that those same interests prevented NHS professionals from suggesting independent sector involvement for increasing capacity. Nevertheless, with the publication of *The NHS Plan* in 2000 (Department of Health, 2000), it was not long before the state and public would consider independent sector involvement as a possible solution for increasing NHS capacity for adult hearing aid provision.

The NHS Plan (Department of Health, 2000) set out several government pledges which included, amongst others, the development of a partnership and cooperation between the NHS, patient agencies and independent providers, with the aim of increasing capacity. The government planned to harness extra capacity through these partnerships to treat more patients on the NHS by changing the relationship between the NHS and the independent sector.

"For decades there has been a standoff between the NHS and the independent sector providers of healthcare. This has to end. Ideological boundaries or institutional barriers should not stand in the way of better care for NHS patients" (Department of Health, 2000; 96)

Private sector interest in hearing aid provision was a consequent impact of the MHAS roll-out which saw the average retail price of digital hearing fall from £2500 to around £900-1000 (Murdock and Lamb, 2009). Once news about NHS provision of digital hearing aids spread, consumers were unwilling to pay for something they could potentially obtain free of charge. The only opportunity left for the independent sector was to promote their supply of digital hearing aids, based on delays in the NHS (Murdock and Lamb, 2009).

Subsequently, in 2002, the then Health Secretary, Jacqui Smith, announced a limited pilot project to evaluate how the independent sector could be involved in increasing capacity for the delivery of MHAS (King, 2002). Furthermore, the project typified the state's desire for partnership and cooperation between the NHS, patient agencies and independent providers by including the Department of Health, public and independent hearing professionals, RNID, NHS Purchasing and Supply Agency, MRC Institute of Hearing Research and Action on ENT (King, 2002; 11). However, the announcement was met with resistance from public sector professionals.

"At this point, the uncertainty from the project group was compounded by the revelation that Jacqui Smith MP had just announced at the RNID 'Breaking the Sound Barrier' event that there were to be MHAS trials with the independent sector.

Hence, no evidence of growing the NHS workforce to meet the needs of roll out and the announcement of an independent sector trial.

Clearly this is unacceptable and guaranteed to cause disharmony in the current workforce. BAAT and the other audiology professions through [Audiology Professions Group] APG protested in the strongest possible terms and prepared a press statement highlighting the relevant issues. The potential impact of this statement has precipitated extended dialogue with the Department of Health.” (Parsons, 2001; 6)

This excerpt, taken from a BAAT reports on the NHSE project group’s progress on the education, training and career structure, exemplifies the reaction of the profession to the news of independent sector involvement in adult NHS hearing aid provision. The concern amongst public professionals was that independent sector involvement would obstruct investment in training and educating NHS professionals. In short, it was a self-interested concern that it would hamper their credentialing strategy. The reaction demonstrated the general “*standoff between NHS and independent sector providers of healthcare*” discussed in the NHS Plan (2000; 96). However, it is not clear what relevant issues BAAT and the APG (which represented public audiological professionals) predicated their protest. Whatever these were, they were not important enough to change the Department of Health’s decision to involve the independent sector.

Hanlon (1998) talks about the ascendance of the private sector as an indicator of the government’s attempt to limit public expenditure, curtail the privileges of professionals, reduce corporatism and

rejuvenate the free market, a view supported by Dent (2006). For Timmermans (2008), the ascendance of the private sector marks the gradual abolition of professional market shelters. Professional market shelters are unique privileged institutional positions that certain professions hold in a society that shield workers from competition and the profession from third party and government interference (Timmermans, 2008; 164, also see Freidson, 1970).

Timmermans (2008) discusses how privileged market shelters can be both beneficial and harmful to professions. On the one hand, market shelters may enable professions to determine workplace behaviours and protect professionals from outside influence. On the other, strongly institutionalised market shelters may thwart scientific and organisational innovation. Therefore, it makes sense that public policy would seek to discipline professionals, especially those with strong institutional market shelters as they may be involved in thwarting innovation. In light of this, the publication of *Waiting to Hear* (RNID, 1999) highlighted the inequality of digital hearing aid provision between the public and private sector as a direct result of a robust institutional market shelter for public hearing aid work.

It is therefore no surprise that the public and the state-supported removing the market shelter afforded to public sector audiologists by involving the independent sector. In this way, they might guarantee innovation in public hearing healthcare. Conversely, it is also natural that public sector professionals would tactically resist independent sector involvement. Such tactics have been used by medicine for the same purposes, but with more significant effect (Timmermans, 2008 and Dent, 2006).

4.2.1 Funding crisis

Despite increases in state funding and independent sector involvement in NHS hearing aid work, waiting times for patients accessing hearing services remained high (Ross, 2008). By 2006 some English regions reported waiting times of up to two years and areas of Scotland had waiting times exceeding a year (Health Committee, 2007). This case reveals how increased funding failed to demonstrate a corresponding increase in hospital activity, such that audiology waiting times continued to be an issue for the state.

Timeline	Government expenditure announcements
January 2000	Department of Health announcement of £10.7 million for 20 MHAS sites
September 2000 – March 2002	20 First wave sites are modernised
December 2001	Department of Health announced further £20 million
April 2002 – March 2003	47 Second wave sites modernised
February 2003	Department of Health announces £94 million to extend MHAS to all England
April 2003 – March 2004	67 Third wave sites are modernised
April 2004 – March 2005	Fourth wave – final sites are modernised
March 2005 onwards	All audiology departments in England continue to run their modernised sites

Table 6: Time frame and government expenditure for MHAS (Adapted from Murdock and Lamb, 2009)

By 2006, the state had developed its plans for independent sector involvement, and these were published in The NHS Plan of 2004 (Department of Health, 2004). The plan contained a pledge to increase independent sector involvement by 2008 in order to increase NHS productivity.

While state discourse had transformed from concepts of patient partnership to patient choice, the government pledged that, by the end of 2005, patients would have the right to choose from at least five different healthcare providers for their treatments. This choice was subject to the condition that providers met NHS standards and

could meet a national maximum price for care. This pledge was premised on the same idea of increasing capacity to treat more patients. It was envisaged that, by 2008, the independent sector would provide up to 15% of procedures for the NHS. Finally, the government also pledged to treat patients closer to home. These pledges were driven by financial incentives and performance management, where money, control and responsibility would be handed down to local health authorities and PCT's (Department of Health, 2004).

In 2006/7 a House of Commons Health Committee was formed to review adult audiology services in the UK (Health Committee, 2007). The health committee sought to answer several questions including; whether accurate data on waiting times was available, why audiology services appeared to lag behind other specialities in respect of waiting times and access, whether enough new audiologists were being trained and how significant a role the independent sector should play in providing audiology services (Health Committee, 2007). The Committee offered the opportunity for the public and independent sector professionals and the public to debate the future of NHS hearing aid provision in the UK. The most pertinent question concerned the role of the independent sector for NHS hearing aid provision.

The public sector professionals expressed several concerns about independent sector involvement.

"...The BAA has major concerns regarding these contracts and their consequences for people with hearing impairments: in particular:

- *The cost-effectiveness of ISTC provision.*
- *Quality assurance/clinical governance arrangements of these contracts.*
- *Destabilising effects on NHS Audiology services and workforce development.*
- *Determination of the numbers contracted.*
- *Treatment of patients with complex needs or pathologies requiring referral.*
- *Access to a full service including counselling, repairs and maintenance, hearing therapy and assistive listening devices.*
- *Data transfer of hearing aid specifications to the NHS Audiology Services.*
- *Quality of the hearing aids provided...*" (Health Committee, 2007; ev55)

The recently formed BAA, which at the time was represented mainly by public sector professionals, felt that NHS services were better value for money and that continuing to fund independent sector provision threatened to undermine the gains that had been made through substantial investment in the training and education, career pathway and infrastructure of NHS services.

Whilst the BAA was under the impression that independent sector partnerships had been successful in some areas, they expressed concerns that some independent sector partners had not fulfilled their obligations, had been paid for work not done and that up to fifty per cent of patients required remedial access to NHS audiology services for further rehabilitation (Health Committee, 2007; ev55). In their view, independent sector provision exceeded the cost of treating patients in the NHS by "*at least a factor of two*", and therefore they

suggested independent sector involvement should be considered a “*temporary stopgap*” (Health Committee, 2007; ev55). However, when pressed by committee members the BAA representative, Ruth Thomsen, was unable to substantiate these claims.

Naturally, independent sector opinion concerning their involvement was different from that of the public sector professionals.

"In our view, the government needs to get serious about giving patients choice and the means of access to hearing care - free at the point of delivery - which the NHS accepts that they need. The skills and capacity of the NHS - for specialist audiology - and the independent sector - for adult hearing aid dispensing - need to be fully engaged and the systems freed up to allow this to happen efficiently and effectively. Opening up the NHS to the hearing aid market would benefit patients and consumers. Competition would improve choice, quality and cost." (Health Committee, 2007; ev61)

Unlike the defensive position adopted by the public sector, the independent sector adopted confident rhetoric informed by the policy context and demands of the public. The NHS Plans of 2000 and 2004 (Department of Health, 2000 & 2004) supported more significant involvement of independent sector provision of NHS services, with the aim of improving choice, quality and low costs. By calling on the government to ‘*get serious*’, they were challenging the state to put their policies into action. The independent sector could define a clear division of labour; the public sector for ‘*specialist audiology*’ and the independent sector for ‘*adult hearing aid dispensing*’. It contrasted with public sector professionals who suggested that patients with

hearing aids were patients for life. As a rhetorical tactic, it challenged the idea put forward by the public sector that all patients were complex; a claim the public sector professionals continued to use for a number years to come.

The backing by the Association of British Dispensing Opticians, the Association of Optometrists and the Federation of Ophthalmic and Dispensing Opticians of the independent sector was vital as it also highlighted the economic incentives in securing NHS hearing aid work. It heralded the likes of Specsavers, a multinational brand, that would later become synonymous with competition for adult NHS hearing aid work. There was little doubt by the RNID as to their 'appetite' for providing NHS services:

"Specsavers are not involved in providing the NHS services at all. They have never been involved in any of the contracts, as I understand it. They have a huge appetite and a huge growth programme in terms of hearing aid services and I know that they would welcome the opportunity to fit NHS patients."
(Health Committee, 2007; ev11)

The evidence suggested that Specsavers, and the independent sector in general, were engaged in a long-term strategy to secure adult hearing aid work from the NHS. Until this point, independent sector provision was as a temporary measure used to reduce waiting times for NHS hearing aids. This had been achieved by some considerable investment by independent sector companies in the technological infrastructure and training of hearing aid dispensers to carry out NHS work. As far as the independent sector was concerned, it was this

investment that contributed to better outcomes than the NHS and better services to clients on the high street, in convenient locations.

Theirs was also a claim of efficiency. Specsavers was highly critical of the capacity of NHS audiology services. Evidence submitted by the independent sector repeatedly claimed that they could significantly increase capacity given the number of high street dispensers waiting to fit hearing aids, this was another useful rhetorical strategy because it provided an alternative to waiting for several years before enough BSc graduates were trained to fill the shortfall in staffing capacity.

The RNID were uninterested in the standoff between public and independent sector professionals and chose to highlight the *"long animosity between audiologists in the NHS and people who fit hearing aids independently"* as trivial (Health Committee, 2007; ev7). As an organisation representing the public interests of people with hearing loss, it was mainly concerned with widening access and reducing inequalities in hearing aid provision, an ambition that had changed little since their campaigns of the late 1990's. They thought that the public and independent sectors should come together;

"Frankly, I think the two should come together. But we must protect the vulnerable people in our society. People ought to be able to hear well, regardless of whether they are wealthy or not. Everybody should be able to get a good quality hearing aid, well fitted, regardless of whether they have money in the bank or not." (Health Committee, 2007; ev12)

The RNID welcomed independent sector involvement in adult hearing aid provision if there was appropriate clinical governance. It was

content to accept that independent hearing aid dispensers were capable of fitting hearing aids in routine cases and that patients had reported high patient satisfaction with independent sector provision.

"...we have experienced independent companies fitting NHS patients with NHS digital hearing aids and the feedback from the patients was very positive. They liked the experience of being able to go into a shop on the high street and get their hearing aids rather than having to go out to an acute care hospital where they have to wait as part of a kind of "sick patient syndrome" in the NHS. They like that. They like the access." (Health Committee, 2007; ev11)

The RNID provided a rhetorical counter-argument to the medicalisation approach used by the public sector professionals based upon the idea that people with hearing loss are not acutely ill and therefore do not need to be treated in acute hospitals. The RNID felt that high street provision destigmatised hearing loss by making hearing aids as accessible and visible as spectacles. The evidence presented here marked a point at which terms such as routine and complex became enmeshed in professional discourse aimed at securing work and the appropriate funding for it (discussed later).

4.3 Modernising Scientific Careers and professional status

The professions' credentialing strategy was an equally important aspect of professional development, which until 2008 had been unfolding in the background. Because of the states' interest in hearing healthcare in the late 1990s, the subsequent amalgamation of the three occupations and the implementation of MHAS, audiology

became a graduate entry profession through the adoption of a bachelor's degree in 2002.

As the audiologists, backed by the state, favoured a graduate healthcare profession, the main effort of elites was to convince rank and file members of the need to adopt a bachelor's degree. Elites used the state's agenda to legitimise their rhetorical position.

"...we have been invited to a series of meetings with our other professional colleagues and chaired by the Department of Health. These meetings will examine the way our professions may work towards the goals which I have outlined above (professional registration and a degree level qualification). This is a fundamental opportunity for change, and improvement, which I believe we should not ignore. If we do then change will be thrust upon us, at least this way we will have the presence to be able to influence that change." (Brown, 1998; 4)

Their argument maintained the idea that change was inevitable and that the profession had no choice but to adopt a degree level qualification. Moreover, by engaging in the process earlier, there was a chance for the profession to have a more significant influence than if it did not. Furthermore, the rhetorical strategy used, particularly by audiological technicians, was also aimed at denigrating the existing non-graduate work-based qualifications.

"We work in an environment where virtually every other practitioner in audiology has a higher recognised qualification than our own. Within the multitude of different service structures that proliferate, it becomes difficult to back up one's

own position of responsibility. Often within a team, credit is given for academic qualifications and not experiential learning.

Can we really blame the NDCS for suggesting that minimum qualifications for practice in paediatrics is at MSc level? What other choice do they have given all we can demonstrate nationally is BAAT I & II." (Parsons, 1998;6)

Whether this rhetorical strategy appealed to the rank and file professionals is unclear. In any case, by adopting a bachelor's degree, audiology might be viewed as an early adopter of the states' MSC programme. MSC was one of several state-sponsored programmes aimed at transforming the training, education and career pathways of the UK public healthcare professions. Other programmes include Modernising Nursing Careers (Department of Health, 2006), Modernising Allied Health Careers (Department of Health, 2008), and Modernising Medical Careers (UK Health Departments, 2004). Between 2005 and 2008, the policy background of MSC had sufficiently developed to the point where it commanded the increasing attention of the profession because it represented a way of increasing professional status and power through the adoption of a new career framework based on a system of credentials.

MSC was an extensive program of investment and reform of the career structure of healthcare scientists in the NHS. *The New NHS: Modern, Dependable* (Department of Health, 1997) set out several pledges aimed at modernising the healthcare workforce. They included developing a national pay spine and developing new models of training and education. However, it was not until the publication of the NHS Plan of 2000 (Department of Health, 2000) that these

pledges were formed into a set of specific objectives, outlined in the section '*Changes for Nurses, Midwives, Therapists and other NHS staff*' (Department of Health, 2000; 82-87).

There was a vision that protocol-based care should take hold in the NHS at all levels of the career ladder and that this model of care should be used to develop key staff roles and empower clinicians to take on new skills. In audiology, the assessment and fitting of hearing aids using MHAS protocols was an example of such protocol-based care. Other examples including assistant practitioners in radiography taking on the role of performing mammograms, releasing Radiographers to take on tasks traditionally performed by a Radiologist thereby increasing capacity and productivity for the breast screening program (Department of Health, 2000; 85). The Chief Nursing Officer's ten key roles for nurses (Department of Health, 2000; 83-84) were used as examples of the kind of complex tasks that other clinicians could take on and included:

- Ordering diagnostic investigations such as pathology tests and X-rays.
- Making and receiving referrals directly, say, to a therapist or a pain consultant.
- Running clinics, say, for ophthalmology or dermatology.
- Prescribing medicines and treatments.
- Triaging patients using the latest IT to the most appropriate health professional.
- Taking the lead in the way local health services are organised and in the way that they are run.

The NHS Plan of 2004 (Department of Health, 2004) strengthened the state's position. It mandated that NHS staff should work differently and cited even more examples of areas where staff had improved and become more flexible. Examples included the creation of Advanced Radiography Practitioners, who could interpret the results of diagnostic tests, Emergency Care Practitioners who had been trained to take on minor injuries, with practitioner trials in surgery, anaesthesia, critical care, renal services and MAUs that showed promise for staff taking on roles previously performed by doctors (Department of Health 2004; 59).

The policy set out a direction that called for abandoning "*old hierarchical ways*" (Department of Health 2000; 82) and shattering "*the old demarcations*" (Department of Health 2000; 83) for "*flexible team working between clinical professions*" (Department of Health 2000; 82). Governance structures were introduced in the form of the new NHS Modernisation Agency which brought together NICE, patients, clinicians and managers to develop protocols and the Commission for Healthcare Improvement that monitored performance at local levels.

Notwithstanding the internal conflicts discussed earlier, MHAS in the context of this policy exemplified the state's vision for modernisation as a partnership between NICE, patients, clinicians and managers. As discussed, by 2005 MHAS saw the state invest in digital hearing aids and the technologies to fit them in the NHS, national protocols and standards and a new training package for audiologists in the form of the BSc in Audiology.

The NHS Plan of 2000 was general in its approach to setting out the State's modernising agenda. The publication on *Making the Change - A Strategy for the Professions in Healthcare Science* (Department of Health, 2001) developed a specific vision for modernising the healthcare science workforce. It was the first time that the generic title 'Healthcare Science' was used in the policy to refer to over fifty science, engineering and technology professions working in the NHS.

"Adoption of a generic title such as this will help to create a common identity, purpose and status for these staff that is similar to other professional groups in the NHS such as doctors, midwives and the allied health professions" (Department of Health, 2001; 2)

The plan set out a framework for developing the healthcare science workforce. It acknowledged the impact of science and technology and recognised that future developments would continue to be a significant driver for change. It was a long-term plan for healthcare science. However, the state required that the healthcare science professions demonstrate a corresponding commitment by being flexible, breaking down barriers and developing future skills (Department of Health, 2001, 5). As discussed, anticipating an opportunity to professionalise, it is evident that audiologists took up the cause early on through the process of amalgamating technicians, therapists and scientists in audiology as well as developing the bachelor's degree based on a vision of the future of hearing healthcare providers in the NHS. The policy set out the States plan to:

- improve the supply of scientific and technical staff

- strengthen and modernise education and training
- introduce a robust regulatory framework
- value staff and create a good working environment
- develop an infrastructure for building an attractive career pathway
- ensure that the contribution of healthcare science was fully recognised within the NHS (particularly Trust boards)

(Adapted from Department of Health, 2001; 5-6)

Some organisations were created to form an infrastructure to support healthcare science, most notably the Academy for Healthcare Science (AHCS) and the National School of Healthcare Science (NSHCS). AHCS was established in 2012 by the UK Health Departments and the healthcare science professional bodies and served as the overarching professional body. Its main functions included raising the profile of healthcare science, engaging and supporting strategic initiatives and acted as the overarching body for issues relating to education and training. NSHCS was established in 2011 to act on behalf of the Chief Scientific Officer to support and deliver healthcare science education programs.

In 2005, a career framework for Healthcare Scientists in the NHS was published which proposed a nine-band career framework (Department of Health, 2005). Following this, there was a national consultation aimed at setting out the rationale for the MSC framework (UK Health Departments, 2008). Finally, in 2010, *Modernising Scientific Careers: The UK Way Forward* was published, and this set out the final proposed career pathways, regulation and standards of education, training and means to support delivery (UK Health Departments, 2010)

Bolton et al. (2011) examine Modernising Medical Careers and summarise that it represents a tactic that can be understood as part of the State's NPM campaign. They argue that MMC is intended to shift the balance of power away from doctors and their professional bodies to management and government through the introduction of more streamlined, competency –based training and rigid controls by external agencies. The same summary can be applied to MSC.

For medicine, MMC represents a challenge to its traditional socialisation process based on occupational values of specialist knowledge and prolonged and intensive period of training resulting in a special type of 'expert' because MMC demystifies and shortens this process (Bolton et al., 2011). As such, medics are critical of MMC and continue to defend occupational professionalism and criticise the state for over interfering. Audiologists were less critical of MSC as they viewed it as a means of increasing professional status.

In developing the MSC career pathway, the Department of Health sought to allay concerns that non-medically trained staff could be taking on roles in direct diagnostic and patient care for which their training could be insufficient (Department of Health, 2010). It is unclear from the policy whether these concerns were professional or public, nevertheless, the result was that the Academy for Royal Medical Colleges was co-opted to define professional examinations further and to seek endorsement over which areas of medical work could be passed down scientists (UK Health Departments, 2010).

Between 2009 and 2010, the Department of Health, led by the CSO Professor Sue Hill, commissioned NHS Improvement to work with 18 pilot sites as part of a *Department of Health National Audiology*

Programme (NHS Improvement, 2010). Increasing productivity was one of four aims which also included identifying and sharing innovation, improving quality and long-term sustainability. The programme covered a wide range of projects in adult and paediatric audiology. As examples of increasing productivity through skill substitution, projects covering the development of a direct access tinnitus pathway, multidisciplinary balance pathway and audiology-led otology triage, are the most pertinent examples.

All three projects involved collaboration between audiologists and ENT consultants to redesign pathways for non-acutely ill otology patients, and this involved the development of agreed clinical guidelines and protocols where patients with red-flags required intervention by ENT. There was a specific focus on the knowledge, skills and competence of audiologists where the published evidence aimed at reassuring providers who had “*concerns regarding the expansion of direct access audiology services*” (NHS Improvement, 2010; 22). Increasing capacity in ENT was the primary productivity gain reported for all three projects. Secondary gains included reduced follow-ups, reduced duplication and unnecessary investigations, reduced did not attend (DNA) rates and reduced complications from mismanaged conditions such as tinnitus.

MSC and the Higher Specialist Scientific Training (HSST) that set to introduce consultant posts within the MSC career pathway, supported by the introduction of professional doctorates, was welcomed by the profession. In 2006, the BAA Professional Development Committee published an article in the BAA Magazine in favour of introducing consultant positions as it thought they would bring the profession in line with others that had established similar grades of practitioner

(BAA Professional Development Committee, 2006). It was the BAA's opinion that professional doctorates were how support could be provided in training consultants and these would help the profession to advance academically and clinically (BAA Professional Development Committee, 2006). Other informants to this study were also enthusiastic about the prospect of professional doctorates, but for different reasons:

"The other thing – and you will think this sounds very shallow – but I think it is in respect of being called doctor, of being an academic doctor, particularly sometimes when you are in a healthcare environment and there are lots of medical doctors. I think it can but help sometimes with the respect they give you." (Informant 5)

MSC and doctorates were viewed as a way of increasing professional status and power within a medically dominant division of labour. This informant had attached special status to the title 'doctor' and the respect it potentially conferred within the clinical setting. Credentialism creates a social closure by which those without are excluded from practice (Freidson, 1994). Credentials are necessary for professional associations, recruiting professionals and the public to identify experts without having to rely on word of mouth testimonials because they presuppose that the credential holder has attained an organised system of conventional training.

Drawing inspiration from Weber, we understand that social groups, in the pursuit of social closure, seek three dimensions of reward; *"economic, social and power"* (Macdonald, 1995; 27). For the professions, credentialism is one of the most critical resources for

achieving these rewards and therefore, for achieving collective social mobility. However, it should be noted that there are other subtler ways of achieving social closure that might involve the deployment of different ways of self-presentation and behaviours (Macdonald, 1995; 51-52). Furthermore, as credentials form a cultural rather than a property-based capital/asset, their potential reward can be misleading or illusory. Macdonald's (1995) view is that possessors of credentials have a degree of cultural capital and therefore have an advantage over those who do not possess them. However, the degree of independence and jurisdiction is dependent on the wielders of economic power, in this case, the state, or those with superordinate credentials such as those possessed by traditional professions like medicine (Abbott, 1988).

The challenge then for elites, is to successfully argue that their cultural capital can be translated into earning a successful reward and that such capital might offer individual workers the choice of how their skills are transferred in specific contexts ultimately giving them independence from any one organisation (see Hanlon, 1998). It was also evident that elites sought to do just this:

"But, meanwhile in healthcare science there is a big push for the healthcare science to have more prominence and to have more of a voice and I think there is an opportunity there for Audiologists to get in there; for example, all hospital trusts are supposed to have a lead scientist who may or may not have an actual position on the trust board, so if that can be an audiologist – great, then we have got an audiological voice up there, so I think we need, everybody needs to be aware because it is part of the healthcare science and you know, there

are forty-odd other specialities, but we have got a chance to get in there and have a presence with power and more of a voice for audiology, potentially.” (Informant 6)

This quote represented a wider self-serving professional interest for status and power within hospital trusts. In a sense, it spoke of a need to compete with other disciplines for the attention and resources of hospital trusts and backed the idea that audiologists still felt like a marginalised profession. As a rhetorical device, it encouraged audiologists to take up the opportunity to fill lead scientist positions for the good of the profession. There was evidence that the profession sought even broader ambitions for status and power:

“We are very pleased to see audiologists taking roles at a national level and leading the field. Ruth Thomsen has been appointed as Professional Chair (Neurosensory) at the Academy for Healthcare Science, Jagjit Sethi is the Theme Chair (Neurosensory) at the National School of Healthcare Science and Francine D’Souza has been appointed as the UKAS Audiology manager. Rachel McCarthy has taken on the role of BAA representative to the Federation for Healthcare Science, taking over from Mark Lutman who retires in September. I wish them all well in their appointments and look forward to working with them in their roles.” (Smith, 2012; 5)

Not only did the profession want to increase status, power and influence of resources in departments and hospitals trusts, but also had ambitions to compete within the arena of the state. This excerpt printed in the *BAA Magazine* exemplified the professions’ drive to increase its status on a national level. Like the previous quote, it took

an encouraging tone. At all stages, whether in the departments, hospital trusts or the state arena, there is compelling evidence that the profession readily engaged in the MSC programme, believing that it would increase its power and status.

However, not all professionals were convinced that MSC would deliver power and status. Lutman (2009) summarised several criticisms against the MSC programme. Firstly, it was felt that the primary beneficiary of MSC was the Department of Health because it took workforce planning away from individual professions and put the complex and non-uniform careers across some 50 disciplines under their central control. Secondly, Lutman (2009) felt that no consideration was given to the global or international perspectives of professional development. He felt that over the forthcoming decades, the scientific workforce would become more internationally mobile as *"healthcare scientific research, knowledge and expertise do not respect national frontiers"* (Lutman, 2009; 27). Thirdly, he felt that the scientific groupings linking audiology to the neurosensory sciences were completely arbitrary, particularly, as audiology's closest cognitive discipline was speech and language therapy which was outside the Department of Health category of healthcare science. Fourth and lastly, because the focus of the MSC was entirely on the NHS career structure, it failed to recognise the increasing plurality of provision between the NHS and independent sector. If, as it was suggested, that the independent sector would play an increasing role in public sector provision, then Lutman suggested that MSC would have to be adapted. Others were also critical of MSC. As one informant stated:

"I think it offers the illusion of a career escalated that takes you from Band 2 to Band 9, whereas in fact, modernising careers puts some roadblocks and people won't get 8 leadership post without a doctorate degree, whether or not a doctorate degree is a good thing in that context, but you really won't – you will probably get a 7 unless you have got a master's degree in the HTS. That's kind of how it is going, and there will be far fewer 7 & 8's anyway because that's what modernising careers want is lots and lots of 5's, and even an element of 4's. And that is the problem, so it offers some opportunity and some illusions of where it's going to take people, I think." (Informant 3)

By suggesting that MSC offered the illusion of career, this informant implied that the way in which the state and profession marketed MSC was misleading. This informant questioned the credentialing strategy for its effectiveness in calling into doubt the requirement for a doctoral degree for leadership posts. The informant also suggested that from a workforce planning perspective the Department of Health requires lower grade staff. In the case of audiology, only lower grade staff are required for routine hearing aid work which constitutes the most significant demand for audiology services in the UK. Consequently, this informant also felt there would be fewer opportunities for people wanting senior positions in the NHS.

Nancarrow and Borthwick (2005) offer some useful insight into changing professional boundaries and the implications for skill substitution as described here. A number of factors including unmet demand for some healthcare services, contemporary public management reform and increasing public involvement have placed new pressures on healthcare workforce boundaries. As a result, the

importance of workforce flexibility is receiving increasing international attention and, in the UK, has resulted in state-sponsored healthcare workforce modernisation that supports boundary renegotiation. Terms such as diversification, specialisation and substitution are widely used in the policy. However, until now, there is still no clear theory to describe and evaluate these specific models for changing boundaries (Nancarrow and Borthwhick, 2005).

Vertical substitution, which usually involves passing down dirty or unwanted tasks to subordinate professions (Hughes, 1958), as described here, may increase the professions scope of practice, but may have varying effects on the professions' formal status or reward (Nancarrow and Borthwhick, 2005). An example of another form of vertical substitution includes nurses who prescribe medication. They may have increased status within a profession, but do not earn the same or have the same status as doctors (Nancarrow and Borthwhick, 2005). Furthermore, vertically substituted tasks still tend to be owned by the medical profession. The inclusion of the Royal College of Physicians in the examination process of healthcare scientists typifies medicine's control over tasks now carried out by audiologists. As Nancarrow and Borthwhick (2005) state, the long-term impact of state-sponsored skill substitution remains to be seen, although professions are guaranteed some safety if they can retain a high level of demand for their services. It is therefore expected that the profession should remain sceptical of the benefits of MSC.

Nevertheless, at the time of writing, the MSC programme described here has been implemented across all the healthcare scientist disciplines and the first HSST trainees are due to graduate in 2019. Meanwhile, in 2010 with the election of a Conservative /Liberal

coalition government, the profession was facing yet more market reforms in the shape of Any Qualified Provider (AQP).

4.4 Extending patient choice and cost containment in NHS hearing aid provision

At the time of writing, the MSC programme described, had been applied across the various healthcare scientist disciplines including audiology and has escaped much alteration or reorganisation despite a change in two UK governments. This is explained by the fact that Health Education England, which provides oversight and leadership for professional education and training, was excluded from the *Health and Social Care Act* of 2012 (Health and Social Care Act, 2012). This remaining narrative concerns this Act and its stimulation of further market reforms in the form of AQP and cost containment within hearing healthcare. AQP and cost containment had consequences for professional development, some of which were expressed through the professionalising rhetoric discussed here.

4.4.1 Policy background to extending choice and competition in the NHS

The formation of a Conservative/ Liberal Democrat coalition in 2010 marked a programme of reorganisation in the NHS in England. The reorganisation initially proposed in the White Paper '*Equity and Excellence: Liberating the NHS*' (Department of Health, 2010), set out to give patients greater choice and control and this proposal was later elaborated in the Health and Social Care Act of 2012.

The case for change was based on three reasons; rising demand and treatment costs, a need for improvement in treatment outcomes and the state of the public finances. Therefore, choice and competition

were how the government wanted to improve service quality and value for money. The White Paper sought to create a framework for choice and competition based on quality not price, and this made it different to the Any Willing Provider scheme which was introduced to audiology in 2008, where competition in the market between public and independent sector providers was based on price alone (see Department of Health, 2008).

Patient choice can be viewed as a crucial element of health care governance, sitting alongside the theme of patient and public involvement (Dent, 2006). On summarising choice, Dent (2006) notes an increasing articulation of notions of efficiency and technical competence in policy. Therefore, patient choice is linked to NPM and market principles in the public sector health system (Dent and Pahor, 2015). As the cost of healthcare rises due to greater longevity and the escalating price of drugs and technology, public involvement, especially in the form of patient choice, has turned into key policy aimed at cost containment (Dent and Pahor, 2015).

In return for choice and control, it was proposed that patients should accept “*greater responsibility for the choices they make, concordance with treatment programs and the implications of their lifestyle*” (Department of Health, 2010; 24). In 2011 the Department of Health published a document entitled *Operational Guidance to the NHS: Extending Patient Choice of Provider*, which set out a phased implementation of the AQP scheme for the following services in England;

- Musculoskeletal services for back and neck pain
- Adult hearing services in the community

- Continence services (adults and children)
- Diagnostic tests closer to home such as some types of imaging, cardiac and respiratory investigations to support the primary assessment of presenting symptoms
- Wheelchair services (children)
- Podiatry services
- Venous leg ulcer and wound healing
- Primary Care Psychological Therapies (adults) (Department of Health, 2011; 5)

Economically, patient involvement is considered cost-effective because it encourages the public to become more responsible for their use of public services, and this is especially true in the case of 'self-care' and the 'expert patient' who are encouraged to be less reliant on the NHS (Forster and Gabe, 2008; 352). The emphasis on choice has enabled the development of a mixed economy of healthcare, where multinational companies are encouraged to compete to provide NHS funded services (Forster and Gabe, 2008).

Critics have observed the increasing emphasis on individual responsibility (or responsabilisation) for healthcare as part of the Public Patient Involvement agenda, and this is being enacted through policy that drives patient choice (See Baggott, 2005; Dent, 2006; Kuhlmann, 2006). This is indeed evident in this case. Kuhlmann (2006) argues that patient involvement is a deceptive promise of consumerism because as a form of patient participation, it does not translate easily into changing power relations between professions and the public because the public is often not prepared for their new governing responsibilities. The situation is not helped by the fact that the medical profession is hesitant and even hostile towards greater

patient involvement (Dent and Pahor, 2015; Kuhlmann, 2006 & 2008).

Advantages and disadvantages of patient choice are linked to the flexibility of healthcare professionals, and some extent managers, in engaging constructively with the public and the level of that flexibility determines whether patient involvement is empowering or disempowering for the public (Dent and Pahor, 2015), and this applies to hearing aid provision in audiology. Ross (2008) notes, the critical restriction in both public and private sector hearing aid provision is the consumers lack technical knowledge. Concerning the hearing aids, it means they are unaware of the choices that are available to them (Ross, 2008; 125). Consumer choice is limited therefore to style, for example, whether the aid sits behind or in the ear, rather than knowledge of a more technical nature.

Newman et al. (2004) explore the process of public participation in deliberative forums, such as user panels, youth forums, area-based committee. They note constraints to public participation by demonstrating how evolving policy is influencing how strategic actors and local organisations constitute the participating public. These actors and organisations represent the public as "*passive consumers; as a naive, childlike and clamorous public; and/or as lacking in skills, capacities or trust*" (Newman et al., 2004; 210). They also suggest that consumerist images of the public are becoming more entrenched, where only a minority of actors and organisations recognise the skills that the public can bring to the deliberative process.

4.4.2 The perceived threat of AQP: privatisation of hearing healthcare

Initially, the AQP scheme was received with a degree of suspicion by public sector professionals. For many years, public sector audiologists in the UK had anticipated that one day hearing aids would no longer be free on the NHS. As one informant stated:

"There has always been a kind of threat of 'well, we are going to voucher systems', you know, 'hearing aids are not going to be sustainable', etc. There has always been that threat as long as I have been in the profession and as yet, nothing major has happened." (Informant 13)

Some felt that the introduction of AQP increased the possibility that the cost of hearing aids could be passed onto them.

"From a cynical perspective, it is also important that professionals and patients continue to question and speculate if this [AQP] is a clever way for the government to introduce cost-cutting in healthcare services, even though, the Department of Health has made it clear that it is not the intent. We hope that these are not the initial steps in transferring the cost of treatment to users, as has taken place in eye and dental care. More importantly, measures should be taken so that independent organisations do not grow too big and achieve a monopoly, which may create potential risk in hearing healthcare in future. For this reason, independent regulatory bodies and charities should function independently rather than making partnerships with the private organisations who would

contest in AQP to avoid any issues related to conflict of interest.” (Manchaiah and Casey (2011; 21)

It was perceived that the threat was greatest when independent sector companies gained monopolies. When the above extract was written, Specsavers, a multinational optical and hearing aid dispensing company, had partnered with AoHL in an attempt to raise awareness of hearing loss. Naturally, the public sector was wary of this union, perceiving it to be a conflict of interest that had the potential to destabilise hearing aid services provided by NHS hospitals.

“I think AQP is a very temporary thing – I think it’s designed to be temporary and I think that in the not-too-distant future the provision of chiropody services, wheelchair services and hearing aids will essentially become like glasses... so you will go along to Specsavers or Vision Express or Boots, and you’ll be able to get an NHS range of hearing aids for nothing but if you want something a bit better, you will end up paying for that. So, I think AQP is a step towards that.” (Informant 7)

The threat of privatisation applied to all the services that fell under AQP policy and included these and others such as chiropody and wheelchair services. The inclusion of this quote underlines the prevailing opinion at the time; that independent retail companies such as Specsavers and Boots were instigating privatisation by using their market dominance to influence government. Some felt that this would create inequality through a two-tier system of service delivery in the UK.

Speed and Gabe (2013) take issue with the argument, but the Health and Social Care Act (and AQP) represents a radical break with the past that signals the end of the NHS. Instead, they suggested that it is an extension of the previous Labour governments neoliberal reform of the public sector that invokes new professionalism. By undermining professional dominance - pitting desired outcomes against evidence, inefficiency/ ineffectiveness against the need for efficiency savings - the state has created the 'perfect storm' for which competition between providers and new outcome measures present the best solution (Speed and Gabe, 2013; 566). Thus, the principles of the Health and Social Care Act and AQP shift public sector provision towards a form of consumerism or buyer dominance and the State towards the most powerful actor in the field of provision. Therefore, it is reasonable to assume that the threat of this new professionalism underscored the negative discourse about AQP; for as much as there was concern about passing costs to patients, there was also concern about how public sector professionalism is being challenged by a dominant state, through competition with the independent sector for public hearing aid provision.

AQP is intended to instil market competition into public sector provision. Speed and Gabe (2013) have demonstrated that in some cases private companies have become the principal providers of NHS services. The result is that NHS employees must move from public to private sector employment and out of the direct purview of the Secretary of State for Health. As market competition becomes the dominant motif over public provision, Speed and Gabe (2013) concede that it is hard to identify where the public interest lies. For them the devolution of responsibility down to Clinical Commissioning Groups (CCGs) maintains a façade of public provision and the rhetoric

used by the State to promote the Act, that is, “*driving up quality and keeping down costs*” is an extension of neo-liberal rhetoric. Therefore, as an extension of neo-liberal reforms, it does not spell an immediate end of the NHS but a rather a gradual one.

“In this context, with the buyer dominant, there is a real danger that the NHS becomes little more than a branded franchise operation.” (Speed and Gabe, 2013; 572)

Therefore, it is reasonable for the profession and its elite to speculate and suggest ways to avoid the end of free hearing aid provision.

4.4.3 Perceived opportunities of AQP: Business mindedness and marketing skills of public sector professionals

A transformation in the way that public sector departments started to manage competition by turning the threat or challenge into an opportunity countered the perceived threat that AQP was a step closer to privatisation

“...hospital-based departments, in a way, have been strengthened by the threat of AQP, because it has made them sit up and think, ‘Actually, we need to be more business-minded. We need to look at what we can do to improve the way our service looks to patients.’...

...from a personal point of view, from our department, it certainly did that. We thought, ‘If we are going to be in competition with other providers, we need to make sure that what we are offering is the best that we can offer’.” (Informant 11)

Some felt that hospital trusts had protected departments to the point that they disincentivised innovations in practice such as offering care closer to people's home. No longer satisfied with accepting the organisational control and market shelters of hospital trusts, audiology departments increasingly started to treat their services as if they were independent business concerns. If anything, AQP began to have the effect of increasing choice and quality in the areas where it was implemented. Because of growing competition, public sector audiology departments needed to find ways to market their services. One strategy focused on the skills and training of public sector audiologists compared to those of hearing aid dispensers.

"Well it goes down to the training of hearing aid dispensers through Hearing Aid Counsel exams or Foundation degree levels, so that basically equips you to assess and fit hearing aids with relatively straightforward patients, whereas the training that Audiologists and Audiological Scientists have, means, whether they have BSc's or MSc's, trains you to think outside the box and to be able to deal with complexity ... So that means that for a patient, if they are different from just the routine symmetrical hearing aid fitting, that they can still be helped and the NHS qualified Audiologists have the ability to cope with that and are not fazed by it, and I think that gives much better value to the patient." (Informant 6)

As described earlier, this quote echoes that of the hearing aid dispensers, who years earlier, had set out a clear division of labour; the public sector for '*specialist audiology*' and the independent sector

for 'adult hearing aid dispensing' (The Health Committee, 2009: ev 61).

4.4.4 Creating a division of labour based on patient complexity

In the context of a potential market comprising of differing skill mixes between the public and private sector, there was a belief, by public sector professionals, that their skills offered better value for money. Furthermore, it was the general opinion of public sector professionals that all hearing care patients should be assumed complex and therefore could only be treated by public sector professionals. As the following excerpt from BAA Magazine illustrates;

"Attempting to pre-empt these complex blockages and operate under prescriptive procedures is a commonly used solution. However, this is fundamentally flawed, for example in considering degree of hearing loss, the degree of disability experienced by individuals with the same hearing loss will vary significantly based on a multitude of different influencing factors." (Brassington, 2013; 31)

This strategy could be viewed as an attempt by the public sector professionals to retain as much hearing aid work as possible. However, not everyone agreed that routine from complex audiology patients could not be separated:

"My dad is 85, he has noise-induced hearing loss, he is hail, hearty, well, compos. He's pretty routine; he hasn't got a medical problem, he hasn't got cognitive problems, he hasn't got eyesight problems. You know you have somehow got to cut the cake, haven't you? You can't put high value, high

investment resources into everybody otherwise we will be broke. You've got to cut the cake in various ways, and the key thing is, how do we cut the cake as fairly as possible and with the highest bang for your bucks in terms of access?" (Informant 2)

This quote demonstrated a differing view of value in audiology. It presupposed the possibility that routine hearing care cases could be screened from the complex cases and that in doing so greater value for money could be achieved by directing cases to appropriately skilled professionals. It was evident that the profession itself did take the state of public finances with genuine concern. More importantly, discussions around defining routine and complex patients led the profession to publish guidance on identifying complex and routine cases, with the aim of enabling clinicians to direct hearing care patients to the most appropriate treatment pathway and enable useful discussions with commissioners about funding (BAA, 2015).

Managerial notions of performativity, such as these perceived opportunities of AQP and the recreation of a division of labour based on patient's complexity represent an increasing feature of professionalising discourse in audiology. Fournier (1999; 288) argues that the rules by which professions can establish their legitimacy have changed considerably over the last fifty years with the advance of liberal forms of governing (such as NPM), which increasingly focus on marketability, budget control and audit.

Thus, transformations in professionalising discourse are aimed at keeping pace with advancing liberalism and highlight the constructed and political nature of the professions. This discourse has come to

represent new forms of occupational professionalism which Fournier (1999) recognises as conditional rather than pre-determined. The main issue is how far new forms of occupational professionalism, represented through the discourse of performativity, is internalised by professions (For example see Bolton, 2005; Moffatt et al., 2014). Nevertheless, this case demonstrates how professional elites continually adapt their discursive strategy in response to the changing policy landscape in how changing discourses produce effects on practice, such as recreating divisions of labour. However, the profession faces more significant challenges in the form of increasing inequality and cost containment.

4.4.5 Inequality and cost containment in publicly funded hearing healthcare

In ending the presentation of evidence for professional development in audiology, the issue of accelerated cost containment as a result of state policy since 2010 and the detrimental effect of cost-cutting in hearing healthcare in the UK is discussed. Based on sociological interpretations of public management reform, it is possible to summarise that all the policy described inevitably results in some form of cost containment and therefore poses challenges for the future direction of professional development (Bezes et al., 2012).

The 2008 global economic crisis plunged many countries including the UK into an era of public spending cutbacks and austerity (Pollitt and Bouckaert, 2017). For some, this era can be contrasted with that of the 'boom years' of 1995 to 2007, although even these years were marked by pressures to reform and improve (Pollitt and Bouckaert, 2017; 23, see also Harrison and McDonald, 2008). Nevertheless, Pollitt and Bouckaert (2017) assert that austerity has become a

significant influence on the utilisation of the various models of public management reform and there does not appear to be one single appropriate model to manage the financial crisis.

"The implications of financial austerity for management reform are ambiguous. On the one hand, austerity for makes reform more difficult, because reforms cannot be lubricated with new money, and objections cannot be 'bought off'. But on the other hand, a sense of crisis can make it easier to consider radical options and more fundamental changes than would otherwise get onto the agenda of feasibility." (Pollitt and Bouckaert, 2017; 23)

While it is not within the remit of this thesis to discuss the specific tools for austerity, historically, when considering cost containment, the state has implemented policies to that focus on the supply of NHS resources or on various means of reducing demand (Harrison and McDonald, 2008). One way of reducing the supply of NHS resources is to cut funding for specific treatments, as has been attempted by various CCGs for hearing aid provision for mild to moderate hearing loss. Unsurprisingly, the consequences of cost containment and rationing, have seen the resurgence in the activities of a disapproving public as represented by charities such as AoHL.

In 2012, Action on Hearing Loss surveyd the impact of budget cuts on audiology services in England and Wales (AoHL, 2012). Information was gathered through Freedom of Information requests to 135 NHS trusts. 95% of English trusts and 100% of Welsh Health boards responded. The survey found that 43% of trusts in England have been affected by the cuts where two of these had changed their

policy on the provision of bilateral hearing aids, and one had decommissioned Hearing Therapy. The 43% of trusts reported broader effects of cost-cutting including a reduction in full appointments, increasing waiting times, a reduction in the number of specialist staff for complex work and the reduction of available information resources (AoHL, 2012, 8).

Open-ended questions revealed other impacts of budget cuts on equipment and staff. Some trusts reported that test equipment was not being updated and some also reported reductions to budget for non-staff items. There were also several implications for audiology staff which included; redundancy, less job diversity, increased workload, lower morale, reduced clerical cover, lower staff grades and difficulty in recruiting new staff (AoHL, 2012)

In 2015, the sector regulator for Health Services in England, Monitor, published a report that evaluated AQP and patient choice for NHS hearing services in England (Monitor, 2015). It was reported that there was a significant inconsistency with the way choice, primarily through AQP had been rolled out across the UK, resulting in inequalities in access to NHS hearing services (Ross, 2008, Monitor, 2015). The report highlighted amongst, other factors, the budgetary pressures of introducing AQP.

A survey of CCG's revealed that the number of patients using adult hearing services increased after the introduction of AQP. Some groups reported increases by over 30%. Overall this had resulted in increased spending on adult hearing aid services. The CCGs felt that the rise in demand for services was provider driven. Specsavers was a particular target for criticism for unscrupulously marketing its NHS-

funded hearing care services in mail shots, newspapers and billboards, and therefore driving the provider-led demand (Lacobucci, 2013). However, it was the view of Monitor that the increase in demand reflected the presence of an unmet need for hearing aids, a view that had been supported by AoHL for some years (c.f. AoHL, 2015). Nevertheless, this rising demand put increasing financial pressures on CCGs.

In June 2014, the North Staffordshire CCG announced proposals to decommission hearing aid provision for patients with mild to moderate hearing losses to save around £1.2 million. The CCG questioned the clinical effectiveness of hearing aids for mild to moderate hearing loss relating this to a paucity of robust evidence. It was becoming evident that other CCGs might follow suit and reduce funding for hearing aid services which prompted AoHL to publish *Under Pressure: NHS Audiology Across the UK* (AoHL, 2015b).

Under Pressure (AoHL, 2015b) aimed to identify and understand the threats to hearing service provision and expose the effects of the governments “*cruel and senseless*” cuts and influence “*proper investment in services*” and “*enforce national standards*” in audiology service provision (AoHL, 2015b, 3). Several questions were submitted through a freedom of information request to all NHS service providers in England Scotland Wales and Northern Ireland between September and December 2014. The report found that 30% of NHS providers had their budgets reduced resulting in increased waiting times and reduced follow-ups. An increase in demand, put down to a net ageing population (but not provider lead demand), had forced 33% of providers to reduce their services through measures such as reducing

staff, reducing average qualification of staff and changing hearing aid candidacy.

CCG	Year cut was proposed	Proposed cut	Outcome (after professional and public campaign)
Cornwall	November 2014	To stop providing NHS hearing aids to people with a hearing loss of less than 35dB	Proposed cuts abandoned
Devon	December 2014	Adults with hearing loss would only be provided with one hearing aid	Proposed cuts abandoned
South Norfolk	Autumn 2015	To withdraw the provision of NHS-funded hearing aids for adults with mild hearing loss	Proposed cuts abandoned
Mid Essex	Autumn 2015	To withdraw the provision of NHS-funded hearing aids for adults with mild hearing loss	CCG paused process
North Staffordshire	Summer 2014	To end the provision of NHS hearing aids for people with mild or moderate hearing loss	Proceed with a slightly adjusted proposal to cut provision for just those with mild hearing loss
South Staffordshire	2015	Following North Staffordshire: To end the provision of NHS hearing aids for people with mild or moderate hearing loss	Proposed cuts abandoned
Worcestershire	March 2016	To end the provision of NHS hearing aids to people with mild hearing loss	Proposed cuts abandoned

Table 7: Proposed cuts to hearing aid services and outcomes after public campaign, arranged by CCG. Information adapted from www.actiononhearingloss.org.uk 'Hands of our hearing aids campaign' page. Accessed 10/09/2017

The report made several recommendations to the government, commissioners and NHS audiology services. A particular recommendation was made to the National Institute for Health and Care Excellence (NICE) and NHS England to prioritise the development of quality standards to enable providers to make the case to commissioners for high quality, comprehensive services and for the English government to follow governments in Scotland and Northern Ireland and publish the delayed national action plan for hearing loss. The report highlighted that despite the NHS budgets being ring-fenced by state austerity plans, services had been cut in real terms.

The effects of austerity, as an extreme form of public management reform, may produce significant consequences for audiology and other healthcare professionals in the future. The evidence presented suggests that the adverse effects of cost-cutting are beginning to take hold in hearing healthcare. However, this is also a timely opportunity for the profession to take stock and reevaluate its professionalising strategy. Having broadly described and discussed professional development in audiology I will now evaluate the potential challenges and opportunities for the profession.

4.5 Challenges and opportunities for professional development

Having discussed professional development between 1997 and 2016 and the dynamic relationship between the profession, state and public, the possible challenges and opportunities for professionalisation in audiology are discussed. While the focus of this research has been on professional elites, the whole professional organisation, not least the rank-and-file professionals have been

affected through modernisation. The state, through the use of various doctrines of contemporary public management reform, has been most influential in this modernisation process.

The focus of public management reform in audiology has been to contain cost and by increasing public involvement, make the state more effective and legitimate. Uniquely, through the process of the profession, state and public co-producing MHAS, this study also demonstrates how the public can be instrumental in the professionalisation process too, although ultimately progressive policy around choice has disempowered the public through forced responsabilisation around hearing aid provision.

In the literature review, the fact that several sociologists have noted a general trend towards different types of professionalism (see Evetts, 2009 & 2011, Noordegraaf, 2007 and Kuhlmann, 2006 & 2008), were discussed. All have observed that notions of professionalism are changing in light of NPM principles and new forms of governance. In short; Hanlon (1998) has noted increasing cleavages in professions especially between public and private sector professionals, and Freidson (2001) has noted the loss of discretionary tactics, especially in medical practice. On the more optimistic side, Evetts (2009, 2011) describes continuities and changes of professionalism, while Kuhlmann (2006, 2008) suggests a role for professions as mediators between the state and the public.

However, occupational change is dependent on contexts such as place, time and the contingent knowledge of the profession (Freidson, 2001). While new professionalism has been linked with the states' NPM agenda and new forms of governance, the link remains

speculative for the time being. As Evetts (2011) explains several complicating factors make a causal link difficult, including (but not limited to), the demystification of professional knowledge and expertise, cases of malpractice, media exaggeration and oversimplification, political interference and divisions between public and private services.

With the contemporary focus on professionalism as a discursive practice (For examples see Fournier, 1999 and Evetts, 2003), there are uncertainties as to how new forms of professionalism are being adopted. As discussed, the realist approach used by Bolton (2005) to examine the 'making up' of nurse managers indicates that professionals may indeed implement managerial policies through discourse, but only through the mediating gaze of their professional symbolic frameworks. Moreover, this unlocks the possibility of multiple types of contextualised professionalisation and professionalism as has been observed by Kuhlmann (2006 & 2008; also see Noordegraaf, 2007 and Evetts, 2011). However, one significant limitation thus far has been a lack of a collective strategy to include new forms of professionalism into the legal framework. Instead, professions have relied on credentialist strategies which are less successful than the legal kind (Kuhlmann, 2009). The implication for audiology is that until new forms of professionalism, including ongoing boundary work with medical otology, are legally enforced, the profession will remain in a precarious position where it holds incomplete jurisdictions over much of its work.

Nevertheless, Evetts (2011) interprets several consequences, challenges and opportunities for professions and the researchers that study them. For Evetts (2011), there is an opportunity (for

researchers) to evaluate and assess new patterns of organisational professionalism. As Kuhlmann (2008) states, new forms of professionalism carry the potential for innovation in healthcare, however, in considering these opportunities we must also reflect on the dual role of the professions as officers of the state and servants of the public. However, before turning to these possible opportunities, we must first consider the challenges to professionalism.

4.5.1 Consequences and challenges for professional development

Freidson (2001) predicts that jurisdictional boundaries will continue to be altered by constant reassignment of professional tasks to less qualified workers. He further states that professionals will be transformed into “*especially privileged technical workers*” because the discretionary aspects of professionalism will be lost to professions having to serve immediate political, economic and popular interests (2001; 209). Although, some professionals in teaching, health care, legal counselling and advocacy and accounting, will retain some of their core tasks and much of their privilege in society. As Evetts (2011) denotes, some powerful professions have often succeeded in resisting managerial and organisational control because the tacit nature of their work processes or the definitions of what counts as success cannot easily be standardised.

As discussed, a leading political and economic interest is cost containment in public services. The popular or public interests relevant to this include reducing waiting times for hearing aids, reducing inequality between public and private sector provision of digital hearing aids and reducing the stigma of hearing loss. This case demonstrates how state sponsored clinical skill substitution is

resulting in non-medical otology work being passed down to audiologists to drive efficiency in ENT. Consequently, audiologists increasingly take on leading roles in tinnitus and balance work. As described, much of the clinical work is standardised through protocols and standard operating procedures, removing much of the discretionary aspects of such work. The emphasis on protocols and standard operating procedures also mean that hearing aid work has come under increasing managerial control and therefore easier to reassign to professionals working in the independent sector. Based on the empirical evidence, it is difficult to determine which aspects of clinical audiological work will resist standardisation in the future. Nevertheless, this lends weight to the argument that professionals are being transformed into especially privileged skilled workers.

Freidson (2001) also predicts a trend towards a two-tier professional system with a clear division of labour, consisting of a tier of a permanent cadre of elite professionals dedicated to research and setting standards of performance for the broader tier of transient rank-and-file qualified practitioners who may be employed on a temporary or part-time basis. The elites will be specialists performing complex tasks while the rank-and-file will be generalists performing routine but fully professional tasks which may require a degree of discretion and theorisation.

As efforts to standardise the work of rank-and-file generalists will be intensified, to reduce costs and place them under greater control and supervision, Freidson (2001) predicts that credentialism is likely to remain the primary mechanism for entering and navigating the labour market. However, training and education curricular will have to respond more to the demand for practical training to perform tasks

required by employers. Standardisation will be applied to university syllabi where courses and examinations in healthcare will be based on protocols for examination, treatment and referral of patients. For Freidson (2011), the requirement for standardisation will be led by organisations, however, in the UK public health system, these changes are being led by the state.

Indeed, MSC is a good example of the standardisation of university syllabi. The evidence discussed indicates that although the profession was consulted at various levels of policy development and implementation, the overall education and career framework has been determined by the state, where courses and assessments in audiology are based on protocols for examination, treatment and referral of patients. Similar policy initiatives have been applied to the education and career frameworks of doctors, nurses and allied health professionals. It appears that doctors have been most resistant to this level of state-sponsored modernisation as it challenges traditional aspect of training and socialisation. Conversely, audiology has welcomed MSC and credentialism as a way to increase its status. As discussed, this strategy still leaves the profession without legally protected jurisdictions of work.

Along with standardisation, there will be increasing use of targets to evaluate outcomes of professional work. The focus on achieving targets can distort work processes and may have a detrimental effect on other less measurable but important client orientated tasks and responsibilities (Evetts, 2011). While standardisation and the setting of targets are essential for checking underachieving practitioners, it can be a disincentive to creative, innovative and inspirational professionals (Evetts, 2011; 415). The minimisation of the

discretionary aspects of professionalism, caused by standardisation, for rank and file practitioners will reduce their satisfaction with their work. According to Freidson (2001), this will be exacerbated by an increasing income gap between rank-and-file and elite professionals which may result in tension and conflicts between them. The evidence indicates that recent state-led cost containment and rationing is having an effect on frontline professionals in the form of redundancy, less job diversity, increased workload, lower morale, reduced clerical cover, lower staff grades and difficulty in recruiting new staff (AOHL, 2012).

Historically, tensions and conflicts within audiology have resulted in the formation of new professional organisations aimed at addressing discontent amongst professionals. For example, BAAT was formed in 1984 when it became apparent that audiological technicians could not achieve their professionalising ambitions under the BSA (Wyke, 2004). More recently Audiology has seen the rise of a few small professional organisations aimed at furthering the interests of particular sectors within the profession. They include;

- *The National Community Hearing Association (NCHA)* formed in 2014 to be the voice of community hearing care in the UK, transforming the needs of service users in local communities and support members and decision-makers with policy analysis and evidence (NCHA, 2017)
- *The Association of Independent Hearing Healthcare Professionals (AIHHP)* formed in 2011 to promote and maintain professional and ethical standards of hearing healthcare within the private sector. It has a slant towards independent practitioners and small businesses

rather than hearing aid audiologists working for national companies, which are supported by BSHAA.

- *The Hearing Loss and Deafness Alliance* (HLDA) consists of 28-member organisations working to represent the needs of people with hearing loss and other issues related to otology, hearing services and public health in the UK (HLDA, 2017). The organisations include professional associations representing various sectors in audiology and charities representing the various interests of the alliance.

Of course, this phenomenon is not unique to audiology. In a recent example of professional discontent Timmons, (2010) describes how after 60 years the Association of Operating Department Practitioners (AODP) went into administration in 2006. This was due to the unwillingness of members to pay their fees combined with competition from the Association for Perioperative Practice (AfPP) which better represented the needs of ODPs.

Hanlon (1998) expands this point further by suggesting that cleavages will form within professions based on the type of patient, location and ideological differences between public and private sectors. Furthermore, as these cleavages form, certain sectors within professions be left with increasingly incomplete jurisdictions of work. As hearing aid work increasingly moves to the high street, public sector audiologists are left doing work of which they have incomplete or legal jurisdiction over; however, this is not to claim that professionalisation of audiology is incomplete (Denzin and Metlin, 1968). Boundary work will be a challenge for audiologists in the future as they continue to strive for full and final jurisdictions over specific tasks. State-sponsored skill substitution through MSC may drive and

even accelerate this process, however, as Abbott (1988) indicates, jurisdictional disputes are still likely to take many years to resolve.

Nevertheless, the consumer patient will sense a change in the quality of services. Freidson (2001; 212) notes that they will perceive changes as tokenistic and bureaucratic as *"their problems or needs will be forced into standardised administrative and epidemiological moulds to be dealt with by predetermined methods"*. This is part of a changing professional/ patient relationship where patients are increasingly being converted into 'customers' through the establishment of quasi-markets (Evetts, 2011). Ultimately this may lead patients to seek alternative practitioners (Freidson, 2001).

Regarding Complementary and Alternative Medicine (CAM) and neo-Weberian concepts of marginality, Saks (2015) argues inequalities within and between professions may have considerable implications in generating inequalities for patients and the public. For example, he suggests that the engendered inequalities are most significant for inter-professional collaboration and joined up care between dominant and marginal or subordinate professions. As routine tasks get passed down, a division is created between generalists and specialists (Freidson, 2001). By dint, high street generalists in routine hearing aid care become increasingly subordinate to public sector specialists and ENT consultants. The insistence of AQP policy that the GP act as intermediary blurs the lines of communication between high street dispensers, NHS audiologists and ENT consultants delivering NHS hearing care. The lines of communication and collaboration between private and public sector audiologists are further tainted by the fact that these services compete with each other. Therefore, policies that shape the relations between private and public NHS providers carry

the risk of creating considerable confusion for people with hearing loss (Ross, 2008)

Patients can be stigmatised and isolated from the mainstream if they choose to access marginal professions, although, this is less applicable to the average hearing aid user. Patient access may be limited by the geographic dispersal, sustainability and affordability of certain types of practitioner. Firstly, there is a significant inconsistency with the way choice, primarily through AQP has been rolled out across the UK, resulting in inequalities in access to NHS hearing services (Ross, 2008, Monitor, 2015). As routine services move out of acute NHS Trusts, specialist services for complex work remain. By nature, complex cases are less in volume and require more costly interventions and are therefore less sustainable. Patients may be forced to travel greater distances for treatment. Many participants discussed the possible 'hub and spoke' model being utilised in the future.

Finally, Saks (2015) suggests that other internal professional inequalities such as gender, ethnicity and class, while not necessarily discussed in this thesis, may also exacerbate inequalities for patients. Saks (2015) stresses that political leaders should become more aware of the implications for professional development within and between professions when deciding policy. Furthermore, he recommends that professionally engendered inequalities should form a priority agenda for sociological research (2015; 14).

4.5.2 Opportunities for professional development

Like Freidson (2001), Evetts (2011) argues that it is essential that professions retain some forms of occupational control of work;

"...identity, work culture, specialist team working, discussions amongst specialists, knowledge and expertise formation and its maintenance all improve the conduct of professional work and its practice while being of benefit to both practitioners and their clients." (2011; 416)

There is no evidence to suggest that these forms of occupational control of work have been necessarily eroded in audiology. As the profession expands in terms of size and skill, it appears that in some ways these forms are being strengthened not least because of a rise in demand for its specialised services. Furthermore, through different skill substitutions that keep costs low and quality high, audiology has secured its position within hearing healthcare (see Nancarrow and Borthwick, 2005).

In essence, a balance needs to be struck between state and occupational control of work. As discussed earlier, with respect to market shelters, strongly institutionalised occupational control can stand in the way of scientific and organisational innovation (Timmermans, 2008). Thus, there is an opportunity for the profession to demonstrate its scientific and organisational innovation for the benefit of patients and clients in return for occupational control over its work, and this is likely to take the form of continuous dialogue or jurisdictional claims with the various audiences and stakeholders including the state and the public (see Abbott, 1988). Evetts (2011) also recognises several opportunities for organisational forms of occupational control, for example, human resources and business management practices.

The incorporation of human resource management into professional employment practices have improved diversity and equal opportunities. Evetts (2011) summarises that many human resources management methods have benefited professionals by improving diversity and equal opportunities in the workplace. These methods include job contracts, job descriptions, formal interview and selection procedures, employment rights and benefits, appeals procedures, sickness benefits and cover for maternity, caring and other absences (Evetts, 2011; 417). The result of adopting human resource management practices would be the abandonment of less formal procedures including social networking and informal recommendation for employing professionals. Such procedures only benefit a select few privileged practitioners and are perceived as unfair and inadequate by the majority. Modernisation of public healthcare careers has brought many of these benefits to employees. As a plurality of provision takes hold in hearing aid provision and healthcare in general, more evidence is required to assess their use in the independent sector. It is in the interest of the state, local commissioners and the profession to ensure equity across the various sectors providing public healthcare.

At a micro and meso level, management practices are being used by individual practitioners and professions as a strategy for career development and professionalisation respectively, and this is particularly evident in nursing (see Bolton, 2005). Where jurisdictional disputes and negotiations were played out in the broader arena of job markets and educational systems (Abbott, 1988), they are now being played out within organisations. While the medical profession continues to use its cultural authority and legitimacy to maintain dominance, other occupations are taking the

opportunity to colonise key decision-making positions within large organisations (Evetts, 2011), and this is true of other professions such as nursing, and this practice is extending to audiology.

In recent times, the state has taken an increasing interest in creating nurse managers because nursing consumes and controls a large proportion of hospital resources (Bolton, 2005). At a professional association level, the Royal College of Nursing (RCN) has adopted the States agenda as part of their professionalisation project, albeit with the NPM ideals masked rhetorically. Professionals may be attracted to the discourse of empowerment, energy, motivation and autonomy and this newspeak may act as a powerful form of control. However, as Bolton (2005; 8) states;

"Literature concerning the modern matron carefully avoids the mention of management, using the terms such as leadership and 'care coordinators, which appeals to both consumers and health service professionals' concern with the delivery of a quality of service."

In the hospital setting, Bolton (2005) demonstrates that nurse managers implement management policies within their own symbolic or framework. They take the opportunities that management policies offer to innovate practice while at the same time mediating the excesses of such policies, such as discarding unnecessary paperwork. The rules which are attached to their primary roles as nurses, caring professionals and public sector workers, seamlessly influence their actions in implementing the rules of managerialism. Nevertheless, Bolton concludes that the incorporation of managerialism with professionalism is not in appearance only.

Chapter 5: Conclusion

In the previous chapter, the professionalisation of audiology was discussed from the viewpoint of each of its key stakeholders, the state, public and profession. For the profession, a range of challenges and opportunities were discussed. This chapter will begin by summarising the professionalisation of audiology, and this will be followed by some recommendations for practice, where notions of trust, ethics and the possibilities for a new role for professions as mediators, is linked to practical examples in audiology. Following this, there will be a discussion of the limitations of the study and how they have been addressed. An essential feature of a doctoral thesis is that it provides an original contribution to knowledge and this will be discussed before making some recommendations for future research.

5.1 Implications of the focus on elite professionals for the findings and recommendations

As expected, professionalisation is the project of a small elite group rather than that of rank and file professionals, and this, of course, has implications for the findings and recommendations identified (Larson, 1977; Timmons, 2010). In short, social closure and status are still primary drivers for professionalisation among professional elites in Audiology. While this objective seemingly opposes new public management reform and its focus on cost containment and accountability, this opposition is never more apparent than when the front-line practice (access and equality in hearing care) is challenged.

As demonstrated early on in Chapter 4, rank and file professionals may become apathetic to lofty notions of occupational professionalism when having to deal with the effects of budget restrictions on the practice such as the time before modernisation or after the global financial crisis and austerity. Furthermore, the state and public may be demonstrably disinterested in protecting market shelters that reduce access to hearing care services. Nevertheless, apathy and disinterest in this elite project should be cautioned against, not least because it produces tangible outcomes as evidenced by profession being an early adopter of MSC, amalgamation or the formation of networks to counter the extremes of austerity. The implications for the findings and recommendations are that they apply to the range of stakeholders of professionalism since they are enacted through elite discourse, which in itself may have real consequences for front-line hearing healthcare. This claim is supported by the fact that a naive view that an independent social reality exists was adopted as part of constructionist epistemology (see Chapter 3: Methodology).

5.2 Summarising professionalisation of audiology in the UK

In this thesis, the professionalisation of audiology has been explored in the context of public management reforms since 1997. There are three key stakeholders in the professionalisation process; the state, the public and the profession. Considering contemporary knowledge about the professions, the feature of these stakeholders in professionalisation is to be expected (Kuhlman, 2006). Moreover, we can expect a deal of tension between three because each has their exclusive interest in the professionalisation process (Kuhlmann, 2006).

In this case, the state is shown to be the most powerful influence on the development of hearing healthcare in the UK. That is not to say that the state is merely acting as a mediator in professional affairs (Johnson, 1972). Indeed, this case demonstrates that the state makes it possible for the public and profession to participate in the governing process, and this was most evident in the MHAS programme and the Health Committee of 2006/7, when both the public and professions deliberated with the state on the future of hearing healthcare in the UK (RNID, 2002; Health Committee, 2007). This evidence supports Johnson's (1995) notion of governmentality; that professions form part of the state's ensemble to govern. The evidence supports the operation of new forms of governance, and elements of independent sector involvement and AQP verifies the operation of NPM as another public management reform in use. Overall, this case study confirms the view that various public management reforms are being used simultaneously (Pollitt and Bouckaert, 2017).

Growing demand and limited resources around hearing healthcare, mean that the objectives of the state are to keep costs down through driving efficiency. It is understandable why public management reforms, particularly NPM, are viewed by some as a punishment handed down to professions by the state (Dent, 2006; Bezes et al., 2012; Bolton et al., 2011). However, after considering all the evidence, the view that the state is as coherent and calculating as this looks unlikely. As Pollitt and Bouckaert (2017) assert, the various public management reforms including NPM and governance, provide the state with a set of tools with which to achieve its overall objectives. However, the state cannot calculate the variety of consequences, and the case of professionalisation in audiology

supports the notion that there are various consequences, challenges and opportunities for the profession (Evetts, 2011).

Demonstrating the interests of the public in such a way that constructs them as a major stakeholder in a case study examining the professionalisation of audiology is somewhat ambitious. Except for Kuhlmann's (2006) thesis that deals with the German healthcare system, few empirical studies take such a broad approach. However, public involvement in professionalisation in audiology is difficult to ignore given the far-reaching impact that large charities such as the RNID and the NDCS have on practice improvement (for example see RNID, 2002). These improvements arise out of the public interest to develop equality and access to hearing services and reduce the personal and social costs of hearing loss. Where large archetypal professions such as medicine have been shown to defeat extensive public involvement in their respective professionalisation projects, audiology has not (see Evetts, 2011). That is not intended to be a negative appraisal of the situation; instead, it emphasises significant structural differences in audiology compared to medicine and affirms the need for more comparative studies of the smaller healthcare professions (Larkin, 1983; Timmons, 2010).

As the state has the most influence on professionalisation, so too does it influence the nature and extent of public involvement. In other words, public involvement should be examined in the context of public management reforms. The more extensive literature confirms that liberal democratic states increasingly incorporate the public as part of their reform. However, increasing focus on forms of governance might be regarded as a remedy for the NPM paradigm and its focus on business-like efficiency (Osborne, 2010; Pestoff et al., 2012). The

narratives of public involvement in audiology confirm that a range of public management reforms are being used concurrently. For example, MHAS emulates governance in its most accurate form, whereas choice and AQP appeals to NPM in its loosest form. The public's voice is represented at the highest level of deliberative forums (For example see The Health Committee, 2009). However, like the profession, there are consequences, challenges and opportunities of public management reforms for the public.

One way to examine public involvement is to explore how it has been either empowering or disempowering for patients (Dent and Pahor, 2015). The evidence shows that MHAS as a form of co-production empowered the public, whereas elements of choice under AQP were less empowering because limitations were set on the choices patients could make (Ross, 2008). This research raises the possibility of forced responsabilisation within hearing healthcare (see Hanlon, 1998). In recent times, austerity has refocused public attention on growing inequality and access to hearing healthcare (AoHL, 2012 and 2015; see also Monitor, 2015). It is conceivable that in the future, patients will be forced to bear the cost of hearing aid provision and this is strongly supported by the evidence of several CCGs that have already attempted to cut available hearing aid provision for people with mild to moderate hearing loss (see Table 7). Through austerity, we may be witnessing the return of an '*audiology in crisis*' marked by underfunded and understaffed NHS audiology services and significant variations in service delivery (RNID, 1999).

Finally, we arrive at the far-reaching effect of public management reforms on the professionalisation of audiology. As expected, professionalisation is the project of a small elite group (Larson, 1977;

Timmons, 2010). As such, it is demonstrated an exclusionary tactic aimed at social closure and raising professional status (Larson, 1977). There is evidence of the profession taking up business and bureaucratic ideals, and this supports evidence for the possible adoption of 'new professionalism' within audiology (Evetts, 2009). If anything, the inclusion of new professionalism should be viewed as a way for the profession to reconcile the interests of the state with its exclusionary objectives. However, as Kuhlmann (2006) suggests the possibility for the profession to include inclusionary tactics should not be discounted. Nevertheless, this thesis concludes that there are both challenges and opportunities for audiology.

The most significant challenge for the profession is that it becomes fragmented because of competing interests and a plurality of provision between the public and independent sector (see Hanlon, 1998). With an intensified focus on standardisation, targets and cost containment, the profession will also face the challenge of maintaining the quality of hearing services for the public. While audiology consists of a predominately female workforce, there will be opportunities for improved diversity and equal opportunities because of the incorporation of human resource management in the profession (Evetts, 2011).

5.3 Recommendations for practice

A strength of the Doctor of Health Science degree is its aim to produce high-quality research which contributes to the theoretical and knowledge base of healthcare with an ultimate focus on promoting practice improvement. While the nature of new types of professionalism is contested, there is growing support amongst sociologists of its necessity in modern public domains; as a way of

reconciling the interests of the state, public and professions (Freidson, 2001; Evetts, 2009; Kuhlmann, 2006, 2008; Noordegraaf, 2007). Furthermore, the need for new professionalism is linked with increasing public mistrust of the types of professionalisation that give way to occupational, conservative or exclusionary forms of professionalism (Hanlon, 1998, Freidson, 2001, Kuhlmann, 2006). However, the recommendations for improving trust in professions that arise from the literature remain esoteric at best.

Furthermore, professionalism, which is central to this thesis, has been demonstrated principally as a rhetorical process on the part of a small group of professional elites; the challenge here is to transform this abstruse advice into practical solutions for them. However, the power of rhetoric to produce action should not be underestimated (Miller and Rose, 1993). In that vein, the following recommendations are themselves partly rhetorical and, if they are to be implemented, would require extensive development. These solutions may also be adopted by other healthcare professions of a similar size and mandate.

5.3.1 Trust, ethics and a new role for professions as mediators

As discussed, Freidson's (2001) view is that occupational professionalism, as a means of controlling work, is in danger of being reduced to mere technical authority as professions are forced to serve immediate political, economic and popular interests. Therefore, he says that most professions are in danger of losing their 'soul' (Freidson, 2001; 213). Freidson goes on to examine the role of trust, and how it is linked to codes of ethics. The special nature of professional knowledge and skills mean that the professions are obliged to invoke trust from the state and public, and this is linked to

a type of 'noblesse oblige' where professions claim to place the good of the clients and the development of the discipline above their economic self-interest (Larson, 1977; Freidson, 2001). The way trust is invoked through writing formal codes of ethics. Such codes are designed to persuade the public that the formulation of ethical standards justifies trust.

Freidson distinguishes between two types of ethics; practice and institutional (Freidson, 2001). Practice codes help professionals determine how to apply their specialist knowledge and skills in a variety of circumstances. Ultimately, they are designed to ensure that monopoly over practice is not used for selfish advantages (Freidson, 2001). More importantly, ethical codes will be interpreted as mere rhetoric if the profession does not have a system for disciplining those that violate them. For Freidson (2001), professionalism needs to regain trust by enforcing a professional code of ethics.

When it comes to ethical codes in audiology, the picture is ill-defined. Registration with The Health and Care Professions Council (HCPC) is mandatory for RHADs and Scientists and therefore both follow the HCPC code of standards of conduct, performance and ethics (HCPC, 2016). Furthermore, both follow HCPC standards of proficiency (see HCPC, 2014a and 2014b). In the case of practitioners, the largest professional group, registration is voluntary, and therefore practitioners are not bound by any code of ethics. The BAA has chosen to adopt the HCPC code of ethics (BAA, 2012; HCPC 2016); however, registration with the BAA is also voluntary. A tentative suggestion would be that the profession continues to campaign for mandatory state registration for all audiology professionals. However, this will

not necessarily offer any more privileges than the profession currently enjoys (Timmons, 2010).

Nevertheless, according to Freidson (2001), practice codes are not an essential part of professional ethics. However, this is reserved for institutional ethics; Freidson best describes this as a type of code that equates to the professions' 'soul' and:

"They deal with the economic, political, social, and ideological circumstances which create many of the moral problems at work. The issues with which they are concerned includes the way practice itself is financed, administered, and controlled in the concrete places where professionals work, and the social policies which establish and enforce the broader legal and economic environment within which practice takes place. Institutional ethics are concerned with the moral legitimacy of the policies and institutions that constrain the possibility to practice in a way that benefits others and serves the transcendent value of discipline." (Freidson, 2001; 216)

For Freidson, the ideology of professionalism embodies a devotion to practising for the greater public good. It can be an existing public good or one anticipated in the future. It should be expressed not by individuals, but collegial bodies which can provide the authority in expressing the collective opinions of the discipline (Freidson, 2001). These collegial bodies probably resemble professional associations such as the BAA and BSA. Furthermore, Freidson asserts that the role of these bodies is to declare unethical social policies that deny equal access to services and worsen working conditions. In such cases, he believes that it is right and ethical for the professions to seek support

from the public to bring collective action against the vices of unconstrained bureaucracy and market ideologies.

As discussed in the literature review, Freidson's approach ignores the possibility that bureaucratic and market ideals can also provide opportunities for professions (see Evetts, 2009). It ignores the possibility that such logics can be incorporated into new forms of professionalism (Hanlon, 1998, Noordegraaf, 2007, Evetts, 2011). Critically, Freidson's approach also ignores new forms of governance and the new role for the public as integral stakeholders in professionalisation (Kuhlmann, 2006). In the case of audiology, this thesis demonstrates that the public, in the form of major charities, takes on the role of holding state policies to account (AoHL, 2012 and 2015). Kuhlmann (2006) proposed a new role for professions as mediators and comes close to mitigating the criticism levied against Freidson by incorporating new forms of governance. She states:

"Within the scope of governance of changing welfare states, the professionals are needed - perhaps more than ever - to legitimise political decisions and to maintain public trust in social services, especially in view of leaner budgets and more demanding service users." (Kuhlmann, 2008; 47)

Therefore, it is reasonable to suggest that the profession of audiology appropriate a new role for itself as a mediator between state and the public, and this should involve the adoption of an institutional ethic, but one that is attentive to new forms of governance and recognises the value of new forms of professionalism. This thesis has demonstrated that audiological elites have attempted to adopt an exclusionary form of professionalisation. While not necessarily

suggesting abandoning exclusionary tactics, it is recommended that the profession adopt a more inclusive professionalisation project (for the diversity of exclusionary and inclusionary professionalism see Table 3). In practice this may involve, amongst other strategies; more cooperation and teamwork, the inclusion of managerialism and standardisation of care, changing gender relations with the profession and inclusion of users in regulatory bodies (Kuhlmann, 2006). There are optimistic signs that the profession of audiology is already adopting a mediating role and as such, it stands as an example to other professions.

5.3.2 Professions as mediators: examples from audiological practice

The *Hearing Loss and Deafness Alliance* (The Alliance for short) is an exemplar of a partnership between 28 organisations representing public and independent sector professionals and the voluntary sector. The Alliance is notable for developing, with NHS England and NHS Improvement, a commissioning framework for hearing loss services which were intended to help CCG's deliver high quality, cost-effective hearing care while avoiding cost cuts and rationing (NHSE, 2016). More importantly, The Alliance continues to work with NHS England to implement the Department of Health's *Action Plan on Hearing Loss* which sets out to tackle the personal, social and economic costs of uncorrected hearing loss in the UK (Department of Health, 2015)

The *Action Plan on Hearing Loss* acknowledges that a rapidly growing and ageing population will increase the number of people with hearing loss (Department of Health, 2015). The plan also accepts that the growing population will stretch hearing healthcare, where there is already a variation in the access and quality of services. The plan

proposes an integrated approach involving a range of stakeholders including the state, public and professions to find solutions to the growing challenges. The plan proposes an emphasis on measures to prevent hearing loss, improve commissioning frameworks and innovate models of care (Department of Health, 2015). While it is not intended to act as a detailed implementation plan, it is proposed that NHS England will facilitate the actions by working with a range of organisations.

In many ways, the action plan appeals to new models of governance with its slant on incorporating a range of stakeholders, including the public, for reforming public health. Importantly, the plan defines Freidson's (2001) notion of 'the greater good' for hearing healthcare in the UK. Therefore, it is reasonable support its use as a type of 'institutional code of ethics' for the profession of audiology (see Freidson, 2001). However, in this case, it is The Alliance, rather than the individual professional associations that represent the type of collegial authority required to implement and set standards against this code. Ultimately, the Alliance epitomises the type of inclusionary professionalism that is advocated by Kuhlmann (2006).

In recent years, there has also been a focus on 'priority setting partnerships' for setting national research agendas in hearing and balance in the UK. Priority setting partnerships bring clinicians, patients and carers together to identify and prioritise uncertainties about the effects of treatments. In audiology, these partnerships have focused on setting priorities for tinnitus and mild to moderate hearing loss (Hall et al., 2013; Henshaw et al., 2015). Wider research priorities, involving a range of professional associations and third sector organisations have also been set for ENT, hearing and balance

care (Bohm, 2015). There is no doubt that the threat of cuts to hearing aids for mild to moderate hearing losses have influenced in setting research priorities in this area. As such, the net result (evidence for the efficacy of hearing aids) may be used in the future to hold state policy to account.

While these examples demonstrate a practical role for professions as mediators; there is a possibility that these projects will not be realised unless there is a coordinated approach. As previously discussed, audiology is becoming increasingly fragmented because of the many competing interests within, and this may exacerbate inequalities in access and quality of hearing healthcare services (see Saks, 2015). Doubts are raised about the usefulness of the BAA. The surge of new professional associations in audiology over the last decade indicates that the BAA is failing to represent the collective interests of the whole profession. Indeed, as described earlier, the competing ideologies between public and independent sector, meant that the BAA was initially created to amalgamate and represent the public sector professionals only. Therefore, it is reasonable to suggest the formation of a new collegial body which can provide the authority in expressing the collective opinions of the profession.

5.4 Limitations of this study

There are several limitations to this study. Firstly, the relatively low number of interviews conducted is both a strength and a weakness. It is a strength, because as stated it covered a significant proportion of the professional elites, as audiology is a small profession. As described in the methodology chapter, I was able to capitalise on my role as an insider and thus captured a representative cohort. Undoubtedly it would have been more challenging to gain access to

as many participants had I been an outsider. However, the number of interviews was still small for a project of this nature and scope, and this has been mitigated by the inclusion of a wide variety of secondary materials for understanding the professionalisation project. Of course, there are limitations about using secondary materials. However, their use is unavoidable in chronological cases of this kind (for other examples see Larkin, 1983; Witz, 1992; Timmons, 2010)

A further limitation of this study is that it has been considerably focused on English policy and reform. While MHAS and MSC were UK wide programmes, policies which focused on choice such as AQP were predominantly English. The devolved nations, Scotland, Wales and Northern Ireland have not adopted AQP. Nevertheless, we must view contracts-based commissioning as part of a more comprehensive strategy under public sector management reform, particularly New Public Management. Therefore, this applies to anyone interested in how public management reform is implemented, especially in a smaller profession. Through lack of inclusion of professional elites from the home countries of Scotland, Wales and Northern Ireland, this study misses an opportunity to explore the nuanced differences in the professionalisation process across the whole of the UK.

On a similar note, another limitation is the focus on issues mainly affecting adult audiology. Overall, paediatric audiology, much like the home countries, has avoided competitive contracting for services. Nevertheless, children's hearing services have faced issues with recruitment, lack of training and funding (NDCS, 2017). In some places, AQP is having a detrimental effect on paediatric audiology because adult services are being prioritised and some paediatric staff are being moved to adult departments to stave off demand and

capacity pressures (NDCS, 2017). Overall, the inclusion of paediatric audiology elites would have strengthened the considerations of public involvement in the professionalisation process especially as the NDCS are instrumental in setting professional standards in this field.

Another shortcoming regards the deficit of independent sector elites, and this was based mainly on a lack of opportunity to access to such people. Professions are often regarded as homogenous entities and therefore internal conflicts (in this case between public and private interests in adult hearing aid work), goes mostly unnoticed (Abbott, 1988). Audiology in the UK covers a range of diverse specialisms, working sites and practices. As stated, the opportunity to explore how professionalism is used as a discourse of control between public and private sectors has been missed, and this would be a recommended study in the future.

Despite these shortcomings, the range of data collected for this study still allows for up-close and in-depth coverage of the case. The inclusion of extra data sources may have strengthened the arguments made, but it is unlikely that doing so would have led to any new or ground-breaking insights into how public management reform has shaped the professionalisation process.

5.5 Original contribution to knowledge

It is still the case that archetypal professions such as medicine and law, dominate the professions literature (Larkin, 1983; Timmons, 2010). As Timmons (2010) states, contemporary literature has tended to focus on complementary and alternative occupations and has neglected emerging professions whose knowledge is less contentious. Thus, the inclusion of a study of the professionalisation

of audiology is valuable because it furthers our understanding of how another small and relatively unknown profession, whose knowledge and skills are not contentious professionalises.

Furthermore, while there is a consensus for new types of professionalism, the literature also suggests that public management reform has had little influence on medical dominance (Evetts, 2011, Freidson, 2001). Therefore, medicine is still able to resist state intervention. Freidson (1970) alerts us to the dominance of medicine which has gained a status which protects it more than other professions from outside scrutiny and criticism and which is granted an extraordinary autonomy in controlling both the definitions of personal and societal problems and the way in which these problems fixed. Medicine has expanded to areas once dominated by religion and law appoint supported by Abbott (1988). Furthermore, Freidson (1970) argues that medicine has come to dominate an elaborate division of labour and has jurisdiction from broad and far-ranging areas of work.

As the other healthcare professions have developed, they have done so in a way that enhances medical dominance by securing their marketing share and professional mandate (Larkin, 1983; Freidson 1970, Nancarrow and Borthwick, 2005). Medicine has continued to build its reputation as an archetypal form of expertise. Unlike minutely specialised forms of expertise, the relationship between medical experts and the public is less obscure and more open to public scrutiny and criticism. Although medicine, like other professions, has lost some of its prestige in public, it has not lost its pre-eminent position in the labour force (Freidson, 2001). Therefore, the dominant

position of medicine in modern Western society means that it is still able to resist state intervention.

According to Kuhlmann (2006), medicine may have the greatest flexibility in combining new and classic patterns of professionalism, unlike subordinate professions like audiology. Nevertheless, this should not deter smaller professions as the way professions adapt to new forms of professionalism varies considerably and irrespectively of their size and power (Kuhlmann, 2006). The case of audiology presents one possible way that a profession may incorporate new patterns of professionalism and one way of developing strategies to promote its interests.

The originality of this study is that it demonstrates the extent of state dominance for small professions such as audiology and, this should not necessarily be viewed negatively as this case demonstrates some benefits of public management reform, new professionalism and the emergence of a new role for professions as mediators in practice. This thesis should be of interests to a range of audiences including the key stakeholder in professionalisation, the state, the public, the profession including its elite and rank-and-file practitioners.

5.6 Impact of this thesis

Before discussing the impact of this thesis, it is worth reaffirming that professionalisation and professionalism have been studied from a social constructionist perspective. Social constructionism conceives our knowledge of the world, including human beings, as the product of human thought, language and interaction (Burr, 2018). Human beings create and sustain social phenomenon such as professions, to the point whereby they assume that these phenomena are pre-given and fixed. This thesis presents a version of professionalisation and

professionalism in audiology that is socially constructed through a discursive process. While the focus is on professional elites, we can imagine that their rhetoric represents a dualistic conversation between themselves and the other stakeholders in professionalisation, including rank-and-file practitioners, state and the public. Social obstructionism offers an emancipatory approach by challenging our taken-for-granted knowledge by helping us realise that social phenomena are historically and culturally specific (Burr, 2018; Gergen, 1985), and this is demonstrated by the evidence of changing notions of professionalism in audiology and beyond (for example, see Evetts, 2009, Noordegraaf, 2007, and Kuhlmann, 2006).

For individuals, the impact of this thesis may highlight that each one of us is involved in a personal professional project. This project is impacted upon by a professional socialisation process, where we are compelled to accept and reproduce professional norms such as the deference we pay to elites (Larson, 1977). It is hoped that the impact of this thesis will be to promote rank-and-file individuals to interrogate top-down rhetoric, in particular, exclusionary patterns of professionalism, such as upheld career pathways and credentialism. Indeed, a basic feature of this study is its focus on understanding the functions, responsibilities and exposing the reach of power of professional elites, by questioning their rhetorical process. As long as the interrogation of professional norms is conducted with sensitivity and integrity, there is an opportunity for positive personal and professional development that steers away from exclusionary patterns of occupational control (Kuhlmann, 2006).

On a service level, it is acknowledged that many audiology departments in the UK are part of larger organisations such as hospitals trusts or multinational businesses. The evidence indicates that the incorporation of managerial and bureaucratic logic in service strategy has challenges and opportunities (Evetts, 2011). There is growing evidence that audiology leaders are beginning to incorporate NPM ideals in service development as a way of maintaining market share for hearing aid work. It is hoped that the impact of this thesis will remind the services of their obligation to become more accountable to the public. The consequences of not doing so mean the ultimate disempowerment of service users (See 4.4.4 Extending patient choice and competition in the NHS).

For the profession of Audiology, that is, the elite cadre of Audiologist, the impact of this thesis should result in a reflection on the influence of their professionalising rhetoric. The motivations for this study were reflected in Chapter 1 of this study. Concerning professional elites and the state, it was felt that this relationship was unequal in terms of power and at times antagonistic and faced with ever-changing policy, elites have felt powerless in the past. Professionalising rhetoric such as that concerning amalgamation, credentialing and protecting hearing aid work for the NHS is the antithesis of neoliberal state rhetoric which favours cost-containment and public accountability. In short, the profession is unlikely to succeed in raising its status without filtering its rhetoric through NPM or governance principals.

5.7 Recommendations for further research

This research opens numerous possibilities for further research for those wishing to study the professions. State-sponsored skill substitution is an explicit part of state policy that has significant

implications for professional practice. Whereas Abbott (1988) considered that jurisdictions change at a glacial pace, state-sponsored skill substitution has the potential to accelerate the timescales involved in resolving jurisdictional disputes. Abbott's thesis deserves more attention and revision in the coming years yet. Future research would focus on micro level practices such as how the division of labour changes within clinical practice and the tensions that arise between audiologists and ENT.

Audiology is taking on a new mediating role, however, the context of austerity has probably expedited this. Professional self-interest in the form of social closure and status are being put to one side to help limit the excesses of the state-sponsored cuts. This collaborative working has the potential to accelerate professional development and benefit the public, as evidenced through MHAS. However, questions remain about the longevity of this form of mediation. If it is just a circumstance formed within the context of austerity, there is a possibility that the profession will step up its exclusionary professionalisation project if/when austerity ends.

5.8 Summary

In summarising this case study, professional development in audiology has been used to explain a version of professionalisation. As such, it is demonstrated as a multilevel diffusion process involving the state, public and profession. The professions literature has been used to explain this version of professionalisation and elements of audiology concur with the central sociological insights. However, instances of audiological practice exemplify a potential role for professions as mediators. These practices are to be encouraged and promoted as examples for other professions to follow.

Appendices

Appendix 1: Participant Invitation Letter

Tendai Ngwerume
Senior Audiologist
XXXX XXXX XXXX
XXXX XXXX
XXXX
XXXX XXXX
E. XXXX
T. XXXX

Date

Dear

My name is Tendai, and I am a Senior Audiologist from XXXX. I would like to invite you to participate in my study being undertaken at the University of Nottingham entitled '**The professionalisation of Audiology in the UK: Exploring the relationship between the professional organisation and practice**'. This research study is being undertaken as part of my professional doctorate which culminates in a doctoral thesis written for academic review. It is supervised by Dr Stephen Timmons and Professor Ruth McDonald.

My study aims to explore the relationship between the professional organisation and audiological practice in view of the external forces that shape clinical work. I have chosen you as a suitable informant on the wider issues of our profession, based on your public credentials as either a subject expert or your involvement in major projects or transformations in Audiology nationally or locally. I will require about an hour of your time to conduct an interview. I have attached/ included an information sheet which I would ask you carefully read. If you have any questions or require further clarification of my study, please do not hesitate to contact me.

Your participation is voluntary and confidential. Should you agree to take part, you may still withdraw at any time. If you are willing to be interviewed, please can you confirm your agreement by phone, email or post?

Regards,

Tendai

Appendix 2: Interview Schedule

Title: The professionalisation of Audiology in the UK: Exploring the relationship between the professional organisation and practice.

Semi- structured interview; questions to be used in the study:

- Please can you outline your career background in Audiology?
- What external forces have shaped audiological practice in the last 20 years?
- In what way have these forces shaped practice?
- In what ways can these forces be viewed as beneficial or limiting to practice?
- As the nature of audiological practice has changed, how do you think the definition of "audiologist" has changed?
- How will we define ourselves in the future?
- Audiologists are formally represented by the British Academy of Audiology and the British Society of Audiology, are there any other organisations that represent us?
- Can you make a comment on their reach of power in shaping audiological practice?
- In light of the aforementioned external forces affecting practice, what has been the role of the professional organisations?
- Looking ahead through the next decade, how do you think audiological practice will change?
- What role will the professional organisation have to play?
- How adaptable are audiologists and the professional organisation to external forces?
- What contingencies are required to maintain our position within the system of professions we work in?

Appendix 3: Ethics Approval Granted Letter

Direct line/e-mail [REDACTED] 23 May 2012 Tendai M Ngwerume Senior Audiologist [REDACTED]	 The University of Nottingham Faculty of Medicine and Health Sciences Medical School Research Ethics Committee Division of Therapeutics & Molecular Medicine D Floor, South Block Queen's Medical Centre Nottingham NG7 2UH Tel: +44 (0) 115 8231063 Fax: +44 (0) 115 8231059
Dear Mr Ngwerume Ethics Reference No: [REDACTED] Study Title: The professionalization of Audiology in the UK: Exploring the relationship between the professional organisation and practice. Lead Investigator: Mr Tendai M Ngwerume, DHSci Student, School of Nursing, Midwifery and Physiotherapy Supervisors: Dr Stephen Timmons, Associate Professor/Senior Lecturer, [REDACTED] [REDACTED], Professor Ruth McDonald, [REDACTED] [REDACTED] Duration of Study: 08/2012-10/2015 38mths No of Participants: 25 Thank you for your letter dated 22nd May 2012 responding to the issues raised by the committee and enclosing the following revised documents: • Ecfomjan2010.doc 22/05/2012 • Project Proposal.doc 22/05/2012 • Invitation Letter.docx 22/05/2012 • Informationsheet2010.doc 22/05/2012 • Econsentform2010.doc 22/05/2012 • Interview Schedule.docx 22/0/2012 These have been reviewed and are satisfactory and the study is approved. Approval is given on the understanding that the Conditions of Approval set out below are followed. Conditions of Approval You must follow the protocol agreed and any changes to the protocol will require prior Ethics' Committee approval. This study is approved for the period of active recruitment requested. The Committee also provides a further 5 year approval for any necessary work to be performed on the study which may arise in the process of publication and peer review. You promptly inform the Chairman of the Research Ethics Committee of	

- (i) Deviations from or changes to the protocol which are made to eliminate immediate hazards to the research subjects.
- (ii) Any changes that increase the risk to subjects and/or affect significantly the conduct of the research.
- (iii) All adverse drug reactions that are both serious and unexpected.
- (iv) New information that may affect adversely the safety of the subjects or the conduct of the study.
- (v) The attached End of Project Progress Report is completed and returned when the study has finished.

Yours sincerely



Dr Clodagh Dugdale
Chair, Nottingham University Medical School Research Ethics Committee

Appendix 4: Participant Information Sheet

University of Nottingham,
School of Health Sciences

**Faculty of Medicine & Health Sciences
Queen's Medical Centre
Nottingham
NG7 2HA**



**The University of
Nottingham**

The professionalisation of Audiology in the UK: Exploring the relationship between the professional organisation and practice.

Name of Investigator: Mr Tendai Ngwerume

Volunteer's Information Sheet

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part or not. If you decide to take part, you may keep this leaflet. Thank you for reading this.

Research study background

Established professions are bound by a set of tasks or work. The work of professions is continually reshaped by external forces such as the political or financial climate in a given time. Professions must, therefore, adapt to continue to control their specialised work or risk losing their status as professions.

Audiology in the UK is an example of a profession whose work is continually being reshaped by external forces.

The professional organisation is responsible for making claims for the professions work. The professional organisation refers to the overall structure of a profession, that is, the different specialisms, segments and various forms of work practices. Each specialism or segment is represented by an elite professional, normally elected to their positions by the professional members.

It is proposed to examine the relationship between the professional organisation and the work of audiologists in the UK.

What does the study involve?

If you choose to participate, the study will require approximately an hour of your time. In this time you will be interviewed about your views on the professionalisation of audiology. The interview will be audio-taped for later transcription and analysis.

The interviews will take place in a convenient location for you. This can be your place of work, at conferences or courses you attend. Similarly, interviews will be scheduled at a time most convenient for you.

If you are happy to participate, please reply by email confirming your decision. You will then be contacted to arrange the interview place, date and time. You will be contacted one business day before the interview to confirm arrangements.

Why have you been chosen?

You have been chosen on the basis of your credentials as either having public involvement with major projects/transformations in audiology such as MHAS/MCHAS, MSC and AQP) or as a national and international subject expert in key audiology subjects such as hearing aid technology, cochlear implants, tinnitus and balance.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part, you are still free to withdraw at any time and without giving a reason.

What if something goes wrong?/Who can you complain to?

In case you have a complaint about anything to do with the study, you can initially approach the lead investigator or his supervisor (contact details below). If this achieves no satisfactory outcome, you should then contact the Ethics Committee Secretary, XXXX, Division of Therapeutics and Molecular Medicine, D Floor, South Block, Queen's Medical Centre, Nottingham, NG7 2UH. Telephone XXXX. E-mail XXXX.

Will your taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password-protected database and is strictly confidential. Any information about you which leaves the research unit will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

This research study is being undertaken as part of a professional doctorate which culminates in a doctoral thesis written for academic review. When the data is analysed, the research may be written for journal publications, trade press publications, conference presentations and regional professional meetings. It will not be possible to identify you from the academic thesis or any published works. The timetabled deadline for completion of the academic thesis is October 2015. You will be notified in writing of any published works arising from this research. Furthermore, you will receive a summary of the findings upon thesis completion.

Who is organising and funding the research?

The professional doctorate (Doctor of Health Science) is funded by the East Midlands Strategic Health Authority from the Learning Beyond Registration fund.

Contact for Further Information

For further information, in the first instance, please contact the lead investigator:

Tendai Ngwerume
Senior Audiologist
XXXX XXXX XXXX
XXXX XXXX
XXXX
XXXX XXXX

Tel: XXXX
[E. XXXX](#)

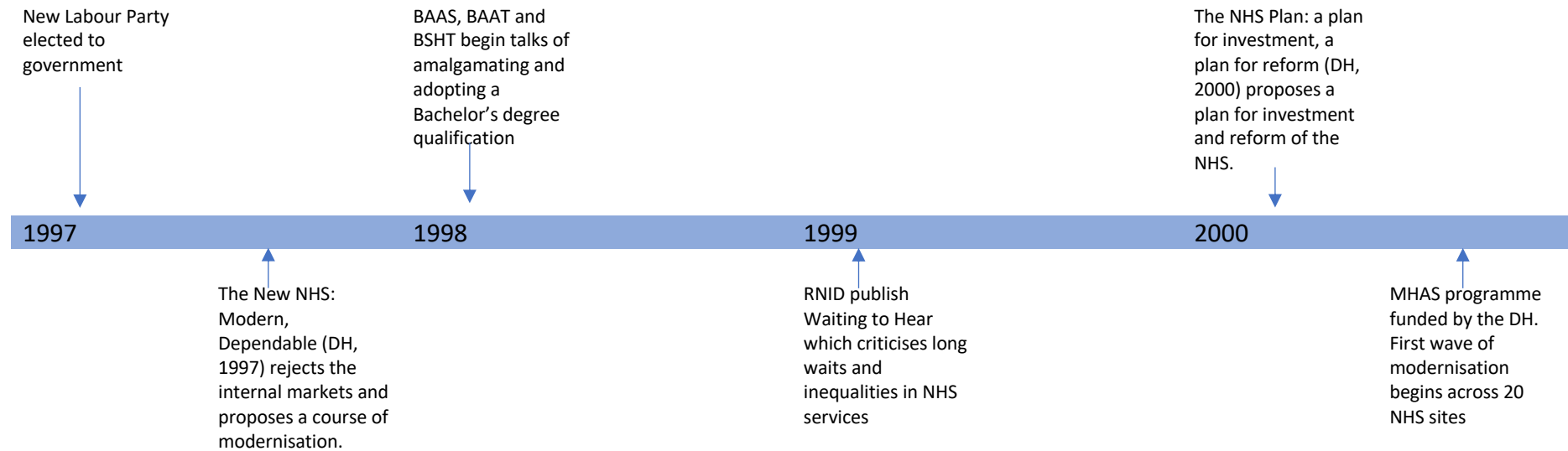
Alternatively please contact his research supervisor:

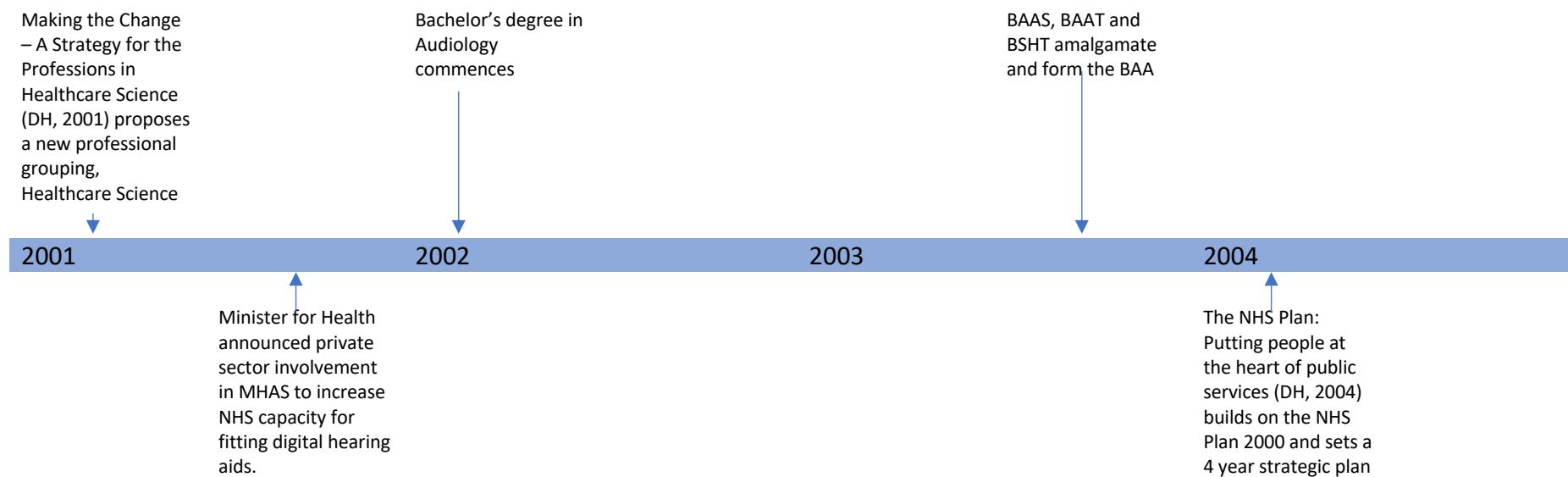
Dr Stephen Timmons
Associate Professor (Senior Lecturer)
XXXX XXXX XXXX
XXXX XXXX XXXX
XXXX
XXXX XXXX

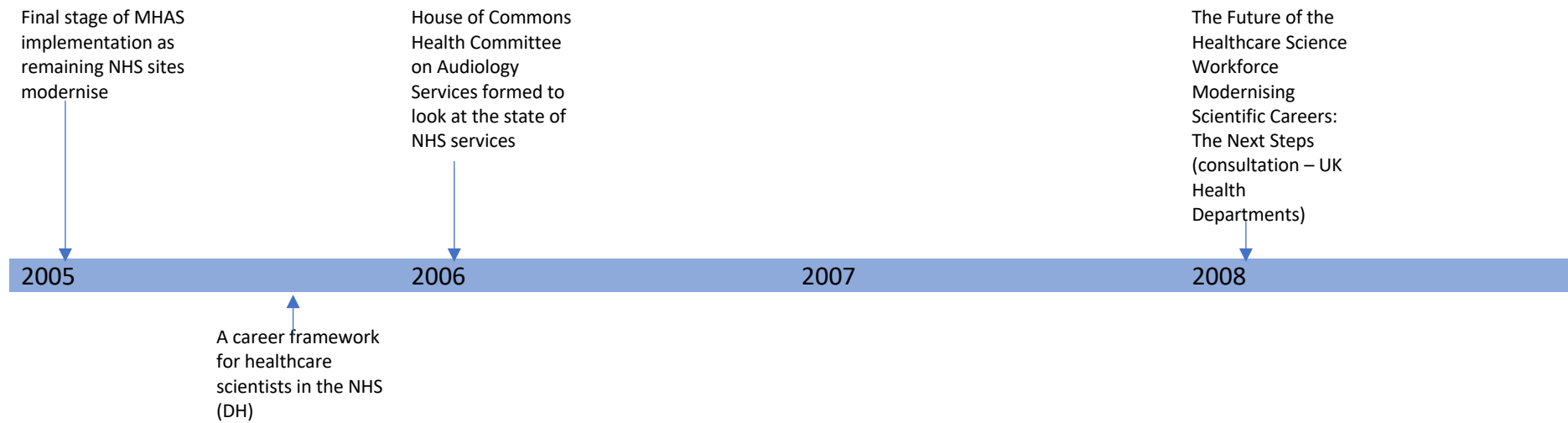
Tel: XXXX
[E. XXXX](#)

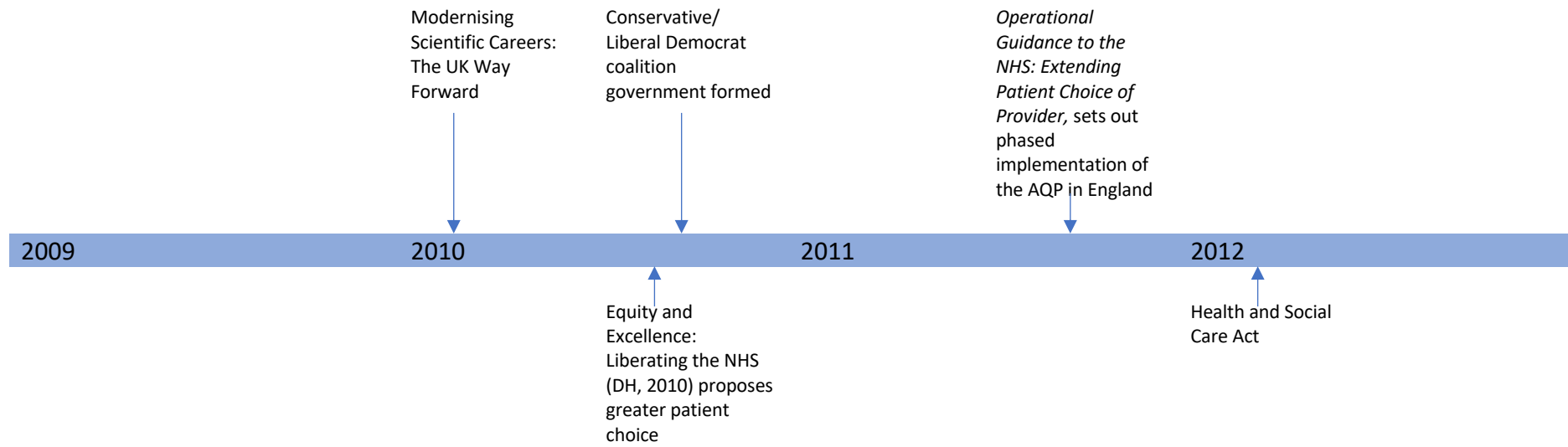
Thank you for taking part in this study.

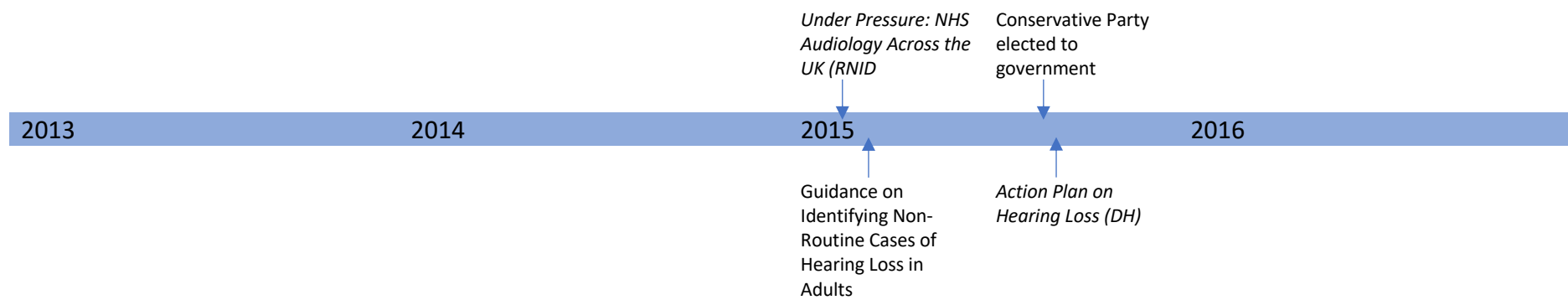
Appendix 5: Professional Development in Audiology Timeline: 1997 – 2016











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