Professional work and austere healthcare in the UK- the case of physiotherapy.

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Abstract

Following the 2008 global financial crisis, the UK government implemented austerity measures across the public sector to address the financial deficit. This had a significant impact on those working at the frontline of public sector services, including the National Health Service (NHS). Despite government assurances that the NHS would be protected, it has been hugely affected by austerity. Austerity and its associated logics, such as neoliberalism, have the potential to impact on how professions working in the NHS organise and exercise their professional work due to requirements to deliver cost efficiency savings and improve productivity.

This thesis examines how one healthcare profession, physiotherapy, experiences and reconciles austerity in their daily professional work, using the neo-Weberian approaches to the sociology of professions as a theoretical framework. Analysis of the professions and how they reconcile logics that challenge traditional notions of professionalism thus far have focused on the archetypical and powerful profession of medicine. Whilst medicine has not been unaffected, the profession has arguably been able to maintain their position at the apex of the healthcare professional hierarchy when faced with challenges to professional work.

Using semi-structured interviews and document analysis, this thesis examines how the physiotherapy profession, historically-considered 'subordinate', negotiates challenges to their professional work. The findings suggest that whilst austerity is unspoken in NHS discourse and on the frontline, it has profoundly

affected the organisation of the NHS and the professional work of physiotherapists. Physiotherapists worked (often at the detriment of their own health and wellbeing) to deliver patient care in resource-restricted settings. Bedside rationing became normalised and a focus on discharge out of hospital in some acute settings became organisational culture. Clinical reasoning and decision making in these settings was reconceptualised as resource-lead clinical reasoning. Patients' rehabilitation potential was (often unknowingly) cognised with resources at the forefront, which demonstrated a changing notion of rehabilitation potential, driven by resource-lead clinical reasoning, to a concept of resource-contextualised rehabilitation potential.

Professional elites undertook professionalising activities such as restratification and jurisdictional encroachment to extend physiotherapy's professional project, whilst rank and file members took on increasing levels of complexity, risk, and workload. Physiotherapists always had to negotiate power and hierarchy to practise their professional work and attempts to create change, resist measures, or improve services were often unsuccessful, leaving some feeling powerless. Some professional elites were able to use established networks with other (more powerful) professions or individuals to their advantage, whereas others experienced detrimental power imbalances, to the point of bullying and harassment.

The role of physiotherapy had changed, becoming more focused on assessment and triage with subsequent delegation throughout the intraprofessional hierarchy. Physiotherapists interpreted a loss of meaningful work as a deconstruction of their professional identity, and thus, identity was reconstructed in contemporary

healthcare settings. This led to some questioning the foundations of the profession entirely. Precarious work and dysfunctional employment practices were identified, something scarcely identified in other examinations of professional work. This thesis demonstrates how subordinated professions, such as physiotherapy, are more exposed to the harsh winds of austerity, and may be more vulnerable to precarious work practices. This thesis demonstrates how the legacy of subordinated professionalism lives on, impacting on how physiotherapists function and deliver care in contemporary healthcare. This has implications for not only physiotherapy's future, but for that of other professions historically-considered subordinate, such as the allied health professions. These findings have implications for the sociology of professions literature and future research.

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List of abbreviations

ACP	Advanced Clinical Practice
AHP	Allied Health Professions/Professional
AI	Artificial Intelligence
AQP	Any Qualified Provider
AWP	Any Willing Provider
BBC	British Broadcasting Corporation
BMA	British Medical Association
CAG	Confidentiality Advisory Group
CCG	Clinical Commissioning Group
CDO	Collateralised Debt Obligations
CIP	Cost Improvement Programme
COVID	Coronavirus Disease
CPD	Continued Professional Development
CQC	Care Quality Commission
CSP	Chartered Society of Physiotherapy
DoH	Department of Health
EBM	Evidence Based Medicine
FCP	First Contact Practitioner
GDP	Gross Domestic Product
GP	General Practitioner
HEE	Health Education England
HRA	Health Research Authority
I/T	Indeterminacy-technicality ratio
IFS	Institute for Fiscal Studies
IRAS	Integrated Research Application System
IRB	Institutional Review Board
ISTC	Independent Sector Treatment Centre

ITU	Intensive Therapy Unit
LD	Learning Disability
MSK	Musculoskeletal
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
NPM	New Public Management
OT	Occupational Therapist
PA	Public Administration
PCD	Primary Ciliary Dyskinesia
PCG	Primary Care Group
PCT	Primary Care Trust
PDR	Personal Development Review
PMLD	Profound and Multiple Learning Disability
PPE	Personal Protective Equipment
QIPP	Quality, Innovation, Productivity and Prevention
RCN	Royal College of Nursing
REC	Research Ethics Committee
RTT	Referral to Treatment
SDR	Selective Dorsal Rhizotomy
SHA	Strategic Health Authority
SHO	Senior House Officer
SMA	Spinal Muscular Atrophy
TUPE	Transfer of Undertakings (Protection of Employment)
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

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Chapter One: Introduction

1.0 Introduction

The 2008 global financial crisis initiated a cascade of austerity measures across the public sector in the UK in an attempt to recover lost funds. Austerity has had an enormous impact on social life, health, wellbeing, and has widened inequality (Stuckler *et al.,* 2017; University College London, 2017; Oxfam International, 2013). For those working on the frontline of the UK's publicly-funded National Health Service (NHS), austerity has made it increasingly difficult for healthcare professionals to fulfil their professional responsibilities (Kerasidou and Kingori, 2019; Tucker, Moffatt, and Timmons, 2020). This thesis will examine how one healthcare profession in the UK NHS, physiotherapy, reconciles austerity and their professional work. This chapter will introduce the motivations for undertaking this study, situate the study in both context and theoretical contribution, and then present the structure of the thesis.

1.1 Motivations for undertaking the study

As a qualitative researcher, it is imperative to consider the motivations (and the researcher) behind the research question. Whilst this is also justified through identifying gaps in the literature, this study was also conceived through personal experience, or 'intellectual curiosity' (Lofland *et al.,* 2006), stemming from my own clinical experience working as a physiotherapist in the NHS. Early on in my PhD, I was encouraged by my supervisors to keep reflexive journals. In doing so, I reflected upon my motivations for examining austerity and physiotherapy practice:

'I have questioned my own motivations an interest to research this particular area. Undoubtably, I have experienced austerity and fiscal restrictions as a professional working in the NHS since I qualified in 2013. At times, this has been something which has caused frustration, discomfort, anger, and despair; both experienced personally and observed in my colleagues. It feels a very real concept, something which when I have discussed my research with family, friends, or acquaintances, is met with "oh, that is very topical/current/controversial. And I must agree with them,' Reflexive journal extract: 4th June 2019.

An earlier piece of research I had completed first brought the concept of austerity and limited resources to the foreground. I explored how a NICE[1] recommended treatment modality was used in the treatment of Cerebral Palsy by physiotherapists in the NHS. This study identified how physiotherapists commonly amended their treatment plans based upon what resources were available to them (Tucker, Drummond, and Moffatt, 2017). This prompted a deeper reflection upon on my own practice, something which continued through this study, culminating in a somewhat epiphanic realisation of how I had personally conceptualised limitations on my own practice:

'A great deal of self-realisation of my own experiences came to light during my data collection and analysis, where I found participants articulated situations that I had been in myself, in a way that I could not articulate myself. I found myself internally saying "Yes! That's exactly how I felt; that is exactly how it feels," to the point where I reflected upon how I had perceived

[1] The National Institute for Health and Care Excellence.

my entire career. Where I had internalised limitations on my practice and professional confidence as my own failure, I came to recognise as lacking resources, time, and supervision… As a clinician who is a perfectionist and consistently aiming to deliver above and beyond, the personal stress of feeling like I could not do so took its toll physically and mentally… I wish to work with those participants who remain clinical to uncover real experiences and do my best to tell their stories, in the hope of improving conditions for them and their patients…' Research Journal Extract, 20th October 2021.

1.2 Situating the study

There is much rhetoric surrounding the pressures the NHS in the UK continues to be under. For example, newspaper articles describing the NHS as *'on its knees,'* (Campbell, 2019) and *'dying,'* (Gregory, 2015) appear regularly. The NHS has not been immune to the impact of austerity, despite government rhetoric being that the NHS would be protected from austerity measures (HM Government, 2011). The effect of austerity on health, wellbeing and socio-economic life has been well documented (Stuckler et al., 2017; University College London, 2017). The effect of austerity on healthcare professionals working on the frontline has been scarcely researched in the UK. An earlier piece of my research highlighted how austerity had the ability to affect the nature of professional work for clinicians (Tucker, Moffatt, and Timmons, 2020); this study sought to examine this in greater depth.

Changes in social, political, economic, and organisational backdrops have the potential to challenge traditional notions of

professionalism (Freidson, 2001); requiring the professions to engage with changing social rhetoric (Fournier, 2000). Examinations into how the professions reconcile challenges to their professionalism tend to focus on archetypical professionalism in healthcare, this materialises through a focus on medicine and to a less extent nursing (Currie *et al.,* 2012; Waring and Bishop, 2013; Waring, 2014; Moffatt, Timmons, and Coffey, 2016). Professions who do not occupy the apex of professional hierarchies and those traditionally considered subordinate may not possess the same ability to reconcile challenges to professional practice, unlike their archetypical counterparts. This study seeks to address this gap in knowledge. In the context of healthcare, the subordinated professions include nursing and the allied health professions. This study uses physiotherapy as a case example of an allied health profession.

This empirical research undertook semi-structured interviews and document analysis to obtain insight into how austerity is conceptualised in practice and the impact it has on physiotherapy professional work. The study shows how physiotherapy's legacy of subordination remains in contemporary healthcare and how this impacts their ability to reconcile austerity and other countervailing powers to their work. The study demonstrates how subordinated professions, such as physiotherapy, are subject to additional systems of power, dominance, and hierarchy in order to carry out their work, and negotiate challenges to their professionalism. The study will show how the physiotherapy profession are undertaking reprofessionalisation and restratification strategies to maintain their presence in the healthcare market and sustain professionalism in a growing

competitive health system. Furthermore, the study will demonstrate how the profession is at risk of precariatisation, something little explored in the professions.

This study makes a theoretical contribution to the sociology of professions literature. This study provides insight into how subordinated and non-archetypical professions negotiate challenges to their professional work and how these challenges reconceptualise the nature of physiotherapy's professional work. The study demonstrates the ongoing utility of contemporary notions of the sociology of professions in examining professional behaviour and interprofessional relations within the healthcare professional ecology. This study identifies how meaningful work is central to physiotherapists' construction of professional identity, and how contemporary healthcare challenges their ability to engage in meaningful work. The concept of precarious work in the professions is identified; a concept which appears to be understated (or not yet observed) in the sociology of professions literature.

1.3 Structure of the thesis

1.3.1 Chapter Two: Literature Review

This chapter contextualises the study, introducing and defining the concept of austerity, the 2008 global financial crisis, and their relation to overarching neoliberalism. The impact of changing social, political, and organisational culture on the NHS and its marketisation is discussed. The implications for those working within the NHS are outlined and the theoretical framework (the sociology of professions) for examining this is presented. This chapter argues that whilst the sociology of professions literature

offers a useful framework with which to examine professional work in contemporary society, it occupies a narrow focus on the archetypical professions (e.g., medicine), who occupy a position at the apex of hierarchy and power. This chapter presents the case for the primacy of examining professions outside of medicine and their ability to practice their professional work within an austere, neoliberalist economy; culminating in a statement of the research question, aims and objectives.

1.3.2 Chapter Three: Methodology

This chapter discusses in depth the methodology used to explore the research question. The study's design, and methods of data collection and analysis are presented. The interpretivist epistemology underpinning this study is discussed and justified, and the ethical considerations of the study follow. This chapter is presented in two sections to reflect the study's journey over four years. The planned study was an ethnography; following a complex ethical review process, the study was further delayed due to the COVID-19 pandemic. Ultimately, the observational component of the study was abandoned due to the challenges posed by the pandemic. Therefore, this chapter will first outline the study's actual methodology and will then in a separate section, discuss the planned ethnography and its logistical and ethical challenges.

1.3.3 Chapter Four: Document Analysis

This chapter aims to conceptualise austerity in the context of the physiotherapy profession as presented in public-facing documents. This critically-informed interpretive document analysis explores the concept of austerity in discourse and in

relation to the physiotherapy workforce, including strategies of response to austerity, both across healthcare and specific to the physiotherapy profession.

The analysis will demonstrate how neoliberalist ideology is reproduced at micro, meso and macro levels of the healthcare ecology. Furthermore, state use of the discourse and ideology of professionalism to extend neoliberal values into the public health sector is demonstrated. The effect on the physiotherapy profession in relation to their professional behaviours (and to maintain their position within the healthcare professional ecology) is discussed.

1.3.4 Chapter Five: Qualitative Data Analysis

This chapter presents the analysis of the qualitative interview data of the 21 participants who took part. Through the themes that were constructed from the data, this chapter presents an account of the impact of austerity on physiotherapists' professional work. This chapter articulates how austerity was an unspoken concept but was visible through both implicit and explicit means. The impact of austerity on physiotherapists' clinical reasoning and decision-making is reconceptualised and it is shown how the dynamics of the professional ecology in contemporary healthcare materialise through strategic and reactive professional action, influences of power and hierarchy, and how physiotherapists perceive their professional future. Outside of, but entangled with austerity, other countervailing powers to professional work are identified and the impact on physiotherapy professionalism explored. The impact of COVID-19

on professional practice, including the opportunity for innovation, is highlighted.

1.3.5 Chapter Six: Discussion and Conclusion

This chapter synthesises the findings and draws together the document and qualitative data analysis to demonstrate how the legacy of physiotherapy's subordination and its historical consideration of a profession supplementary to medicine remains. This chapter discusses how physiotherapy, as an example of a subordinated profession, is more exposed to the harshness of austerity and how, to negotiate these challenges, they are required to navigate complex systems of power, dominance, and hierarchy. Furthermore, the concept of precarity in professional work is explored. This chapter closes with a discussion of the study's contribution to the literature, limitations, and implications for both the physiotherapy profession and the wider allied health professions.

Chapter Two: Literature Review

2.0 Introduction

This chapter contextualises the study, introducing and defining the concept of austerity, the 2008 global financial crisis, and their relation to overarching neoliberalism. The impact of changing social, political, and organisational culture on the NHS and its marketisation will be discussed. The implications for those working within the NHS will be outlined and theoretical frameworks for examining this from a sociological lens will be presented.

The discourse of the sociology of professions is introduced. Seminal texts within the sociology of the professions literature and its development over the past century are identified and the response and reconciliation to changing societal and political backdrops hitherto, will be highlighted. The sociology of professions literature will be examined as a medically-dominated discourse, which neglects non-medical occupations. It will be argued that to some extent, the sociology of professions literature uses a narrow lens, which in an austere, neoliberalist political ideology, requires investigation. The chapter will introduce the physiotherapy profession and explore the profession's professionalisation. The case will be made for the importance of examining occupations outside of medicine and their ability to practice their professional work within an austere, neoliberalist economy; culminating in the outline of the research question, aims and objectives.

2.1 The 2008 global financial crisis and imposition of austerity measures in the UK

The 2008 global financial crisis created financial unrest across the world, with its pivotal point being the collapse of the US investment bank Lehman Brothers (The Economist, 2013; Seetharaman, 2018). A prolonged period of unsustainable lending and 'subprime' homebuyers resulted in the pooling of debts into collateralised debt obligations (CDOs) (Seetharaman, 2018). These CDOs reached $634 billion in 2007; with this, due to the high number of homeowners defaulting on their loans, insurance companies could not fulfil all deficits, prompting a government response (Seetharaman, 2018).

Across the Atlantic, the UK was first hit by the crisis with the collapse of Northern Rock bank in 2007 (British Broadcasting Corporation [BBC], 2013). Further banks, including Royal Bank of Scotland, Lloyds and the Bank of Scotland required 'bailouts' with taxpayers' money (BBC, 2013). As part of the budget in April 2009, Chancellor Alastair Darling forecast a deficit of £175 billion and the Institute for Fiscal Studies (IFS) foresaw *'two parliaments of pain,'* (BBC, 2013; IFS, 2017). With the UK deficit standing at approximately 10% of 2010-11 GDP after the financial crisis, the Conservative-Liberal Democrat Coalition government set out on the *'most drastic budget cuts in living memory,'* (Pimlott, Giles, and Harding, 2010). The financial crisis prompted the prime minister at the time, David Cameron, to state: *'the age of irresponsibility is giving way to the age of austerity,'* (Cameron, 2009). Consequently, austerity measures were imposed. The term austerity has varying definitions and connotations and thus, it is essential to outline how austerity is

understood. In this study, austerity is considered to mean the implementation of spending cuts and creation of unfavourable economic conditions to reduce the financial deficit (Pimlott, Giles, and Harding, 2010).

Austerity materialised through the then Chancellor of the Exchequer, George Osborne, outlining a set of ambitious austerity measures aiming to cut £81billion over four years (Pimlott, Giles, and Harding, 2010). Some of the most significant measures proposed by Osborne included £7billion of cuts to welfare support, almost 500,000 cuts to public sector jobs, a reduction of local government spending by 30%, a reduction of policing budget by 16% and a reduction of the defence budget by 8% (Pimlott, Giles, and Harding, 2010). Specific to health, the so-called 'Nicholson Challenge,' set by NHS Chief Executive (at the time) David Nicholson, aimed to deliver £15-20billion of cost efficiency savings in the NHS between 2011 and 2014 (NHS, 2008). Whilst initially planned to fill the period between 2010 and 2015 (HM Treasury, 2015), austerity has extended beyond this planned period. Despite senior UK government officials declaring that austerity was over (May, 2018; BBC, 2018), austerity continues to affect healthcare professionals' work (Owens, Singh and Cribb, 2019; Kerasidou and Kingori, 2019; Morley, Ives and Bradbury Jones, 2019; Tucker, Moffatt and Timmons, 2020).

Both the 2008 global financial crisis and austerity have been linked to the dominating organising logic in the West, neoliberalism. The following section will contextualise neoliberalism and its associated logics and demonstrate the marketisation of the NHS.

2.2 Neoliberalism and its associated logics

Neoliberalism was consolidated in the West in the late 1970s/early 1980s. Neoliberalism is based on ideals of a free market, decentralisation, and individualism (McGregor, 2001). The rationale underwriting the free market principle, lies in the freedom of trade, underpinned by Adam Smith's critique of mercantilist trade which governed 18th and 19th century economics (Smith, 1979; Clarke, 2004; The Economist, 2013). A free market, Smith argued, would allow for individuals to pursue opportunities to better themselves, increase specialisation and thus division of labour (Clarke, 2004). Inevitably, this would have adverse effects on deepening inequalities (Duménil and Lévy, 2004).

The free market articulates well with the reduction of state intervention and responsibility for public services, allowing for the commodification of such services to be provided by businesses and non-government organisations (Connell, 2010). Capitalising on this devolvement of government intervention, the emphasis is placed upon the individual, advocating an individualist approach that requires humans to take care of oneself, and oneself only (McGregor, 2001). Consequently, even those most disadvantaged are expected to source means of health, education, and housing; and when this is not achieved, or one experiences hardship, this is perceived as a personal failure and not necessarily as a result of social circumstances (McGregor, 2001; Sewpaul, 2015).

In the UK, Thatcher's election into office in 1979 and the so called 'Winter of Discontent' (1979-1980), is considered a key moment in neoliberalism's history and integration into the UK

(Munck, 2004). Ronald Reagan's election as President of the USA in 1981, consolidated further neoliberalist movement across the Atlantic; together, state 'interference' was withdrawn, and the free market amalgamated as part of the 'first neoliberal revolution' (Munck, 2004). Policy soon began to reflect neoliberalism's ideals (Munck, 2004). Thatcher's ideology and political ideals, termed 'Thatcherism', accentuated privately dominated markets, reformation of the welfare state, and restriction of the power and legal jurisdiction of institutions (such as trade unions), that could hamper the operationalisation of markets (Green, 1999). These ideals were made reality through reducing state intervention, restricting trade union and public sector power, privatisation (for example British Airways, British Telecommunications and British Gas), control over public spending, and promotion of wealth creation through entrepreneurial freedom (Hym, 2013).

2.2.1 Neoliberalism, the 2008 global financial crisis and austerity

Neoliberalism played a key role in the financial crisis (Crotty, 2009; Kotz, 2009; Bresser-Pereira, 2010). To some extent, such a crisis was predictable following historical accounts of different capitalist forms reaching crisis due to each form's intrinsic contradictions; of which neoliberalist capitalism is not immune (Kotz, 2009). Neoliberalism made way for three developments: growing inequality, increased risky behaviour and activity by the financial sector and large asset bubbles (Kotz, 2009). Consequently, this resulted in rapid deregulation of the financial sector and unrestricted competition (Kotz, 2009). This, alongside financialisation and a reluctance to regulate new financial

innovations, rapidly contributed to the 2008 crisis (Bresser-Pereira, 2010); prompting governments to pursue austerity measures to attempt to reduce their deficits.

Austerity has been used as a tool to reassert and accelerate the goals of neoliberalism, even further than what was achieved prior to 2008 (Whiteside, 2016; Farnsworth and Irving, 2018). This has occurred to such a scale to which Jessop (2016) posits an enduring or permanent state of austerity as an organising logic. Despite its catalytic role in the 2008 financial crisis (Farnsworth and Irving, 2018), neoliberalism has emerged *'more politically powerful than ever,'* (Crouch, 2011, p.viii).

2.2.2 New Public Management and managerialism

Coinciding with the emerging dominance of neoliberalism was the growth of New Public Management (NPM). NPM is a term used to describe the movement of private sector management and administration techniques into the public sector (Calogero, 2010). NPM was initiated in the UK in the 1970s and '80s, spreading to the USA, Australia, New Zealand and then onto Scandinavia and Continental Europe (Lane, 2000). The UK's pivotal role in NPM's development was reflected in Hood's (1991) seminal paper (Osborne and McLaughlin, 2002). Though traditionally viewed with its roots in public choice theory and managerialism, Gruening (2001) identifies several theoretical influences and bases to NPM development, including, though not limited to, classical Public Administration (PA), neoclassical PA, public choice theory, the Austrian School of Economics, and principal-agent theory.

NPM has several undisputed characteristics and some which have been additionally identified by other authors, which Gruening (2001) termed 'disputed' characteristics (see Table One).

Undisputed Characteristics (identified by most observers)	**Disputed Characteristics (identified by some observers)**
Budget cuts Vouchers Accountability for performance Performance auditing Privatisation Customers Decentralisation Strategic planning and management Separation of provision and production Competition Performance measurement Changed management style Contracting out Freedom to manage (flexibility) Improved accounting Personnel management (incentives) User charges Separation of politics and administration Improved financial management More use of information technology	Legal, budget and spending constraints Rationalisation of jurisdictions Policy analysis and evaluation Improved regulation Rationalisation or streamlining of administrate structures Democratisation and citizen participation

Table One: Characteristics of NPM (Gruening, 2001).

Reflection upon these characteristics and neoliberalist ideology, demonstrates a compatibility between the two, with aspects of NPM providing a vehicle for application of neoliberalist ideology into public service management (Broadbent and Laughlin, 2002). In the UK, the Conservative government between 1979-1997 focussed on markets as the solution to many of the issues with the public sectors, with movement from the welfare state towards the plural state (Osborne and McLaughlin, 2002; Banks, 2011). As New Labour came into power in 1997, NPM and movement towards the plural state intensified (Osborne and McLaughlin, 2002; Banks, 2011), and continues to be the dominating management approach.

2.2.3 The marketisation of the NHS

The inception of the NHS on the 5th of July 1948 was the result of a prolonged desire to amalgamate and publicly fund the previously fragmented health service (Ham, 2009). Aneurin Bevan, Health Minister, often cited as the founder of the NHS, worked alongside others to pass the National Health Service Act in 1946 with care provided free at the point of access at the core of a tax-funded, 'responsibly used' public health service (Ham, 2009; Department of Health and Social Care, 2015).

After a relatively settled period in the first two decades of the NHS in terms of reform and reorganisation, the pause of public expenditure expansion following the oil crisis in the 1970s and Thatcher's election into government in 1979, caused the structure, funding, and efficiency of the NHS to come into focus. This prompted one of the most significant reforms of the NHS to date (Klein, 2006; Ham, 2009; Paton, 2016).

Key to the osmosis of managerialism throughout all levels of NHS organisation was the Griffiths' Report (1983). Sir Roy Griffiths, managing director of the supermarket chain Sainsbury's, was enlisted by government to review NHS management. Griffiths concluded that the NHS was at *'institutional stagnation'* (Griffiths, 1983, pp. 12) due to a lack of direction, whilst being *'swamped by directives'* (Griffiths, 1983; Klein, 2006; Ham, 2009). Thus, Griffiths recommended a structure of general management throughout all levels of the service, which was swiftly implemented (Klein, 2006; Ham, 2009). This was a critical event in the marketisation of the NHS; laying a foundation for the internal market, later introduced (Ham, 2009).

The mechanism of the internal market was outlined by Alain Enthoven (1985); where district managers would be able to purchase services from both NHS and private hospitals, introducing the concept of competition into the organisation of the NHS (Butler, 1993). Running concomitantly to the internal market was contracting out of certain services, such as domestics and cleaning (Department of Health and Social Security, 1983; Sheaff, 1988); though this soon extended to other services such as portering, transport, diagnostics, and pathology (Butler, 1993). Such contracting sought to consolidate the purchaser-provider split, an integral component to the internal market (Butler, 1993).

Further to the imposition of the internal market and contracting out, Butler (1993) suggested that the growth of managerialism and schemes for income generation were to become harbingers for the NHS' future. Such schemes included the sale of NHS owned land for car parks and commercial enterprises; actualising

the growing pressure for the NHS to become entrepreneurial and 'business-like' (Butler, 1993; Klein, 2006; Ham, 2009). Whilst this gained support from neoliberalists, the rationale behind such reforms was questioned. Thatcher's emphasis appeared to be on consumerism and patient choice; though critics posited that this was a convenient rhetoric for an unorganised and covert attempt to accommodate a funding crisis, anti-statism, and privatisation (Butler, 1993; Paton, 2016).

Following a quickly announced review of the NHS by Thatcher in 1988, the *'Working for Patients'* White Paper was published in 1989. This reform was wrought with controversy and objection from political opposition and the medical profession (Beecham, 1989; Klein, 2006), and imposed the internal market in an official capacity.

The two main foci of *'Working for Patients'* were the purchaser-provider split and the option for GPs to become fund holders (Department of Health; Klein, 2006). The purchaser-provider split materialised through the purchase of health services from providers by health authorities (Department of Health, 1989); these 'providers' included hospitals and community services who were to become self-governing, autonomous entities (Department of Health, 1989; Klein, 2006). The indictment of the reform from the medical profession and other opposers, lay with the perceived betrayal of the principles of the 1948 National Health Service Act, though the government publicised the reform as maintaining these whilst increasing performance and patient choice (Department of Health, 1989; Klein, 2006); proffering similarities with the rhetoric surrounding the more recent Health and Social Care Act 2012.

As part of New Labour's plan to 'save' the NHS, the internal market was abolished, yet the purchaser-provider split was preserved (The Kings Fund, 2005; Paton, 2016). New Labour's occupation of office from 1997-2010 included further reorganisation of the health service, though the NHS received unprecedented increases in funding year on year in comparison to the Conservative government's attempts (Chote *et al.,* 2010).

Marketisation under the Labour government came in the form of Independent Sector Treatment Centres (ISTCs), providing the private sector with a point of entry into the NHS market. These were organisations owned and run by the private sector but that delivered NHS services (Department of Health (DoH), 2000, 2002). The aim of these centres was to reduce waiting lists for elective procedures, without the need to deal with emergencies and thus reduce waiting times (DoH, 2000, 2002; The Kings Fund, 2009).

Whilst Labour's initial plan was to depreciate the internal market, it eventually came back to fruition; this, alongside the expansion of GP fundholding to Primary Care Groups (PCGs) (Klein, 2006), provided foundations for the reform delivered under the Conservative and Liberal Democrat Coalition government elected in 2010.

Crucial to the health reforms undertaken during the coalition was Health Secretary Andrew Lansley. Lansley's plan for the NHS from publication of the White Paper *'Liberating the NHS'* (Department of Health, 2010), to the passing of the Health and Social Care Act 2012, was one of the most controversial and turbulent reforms in the NHS hitherto (Timmins, 2012). Lansley's

bill, implicitly or otherwise, sought to consolidate the marketisation of the NHS and competition within its supply of services (DoH, 2010; Timmins, 2012). Specifically, the introduction of Any Willing Provider (AWP), later termed Any Qualified Provider (AQP), allowed the private and voluntary sectors to bid for NHS contracts and deliver services (Timmins, 2012; Paton, 2016). Further, the NHS was restructured, which included the abolition of Strategic Health Authorities (SHAs) and Primary Care Trusts (PCTs), creation of Clinical Commissioning Groups (CCGs), a patient voice organisation (Healthwatch) and an economic regulator (Monitor), recruited to promote competition amongst other roles (DoH, 2010; Health and Social Care Act, 2012; Timmins, 2012).

The explicit reference to competition and entrance of the private sector into the delivery of NHS services, coinciding with a profession wide report of a lack of consultation by the government, led to confusion, discontent, and calls to withdraw the bill entirely (Nursing Times, 2011; The Lancet, 2011; Timmins, 2012; Royal College of General Practitioners, 2012; British Medical Association, 2013). Despite this, the bill was passed on the 19th of March 2012 and the main changes came into force on the 1st of April 2013 (The Kings Fund, 2019).

2.2.4 Implications for healthcare professionals

Inevitably, healthcare professionals work within ever-changing economic, social, political, and organisational settings. Evidence suggests that austerity impacts on healthcare professionals abilities to fulfil their professional responsibilities, deliver high-quality care, reshape the nature of their work, and has personal,

professional, and ethical implications (Owens, Singh, and Cribb, 2019; Kerasidou and Kingori, 2019; Morley, Ives, and Bradbury Jones, 2019; Tucker, Moffatt and Timmons, 2020).

Theoretical frameworks can be used as analytical tools to study the impact of contemporary contexts on the nature of professional work. The sociology of professions literature is an example of this. The next section will discuss the sociology of professions in detail and how challenges to professionalism, such as economic, social, and political culture have impacted on professional work thus far.

2.3 The sociology of the professions

The theoretical body of literature in the social sciences examining the professions is termed the sociology of the professions. This extensive literature has evolved since its development in the early-mid 20th century, with its early iterations most associated with the taxonomic approach. This literature has predominantly had an Anglo-American focus, and the neo-Weberian perspective is commonly used as an analytic framework (Saks, 2016).

This section of the literature review will outline the progression of the sociology of the professions and its key theoretical frameworks over time. The taxonomic, interactionist, Marxist, Foucauldian, Bordieuan and neo-Weberian approaches will each be discussed. This section will situate this study within a neo-Weberian analytical framework.

2.3.1 Taxonomic approaches

The taxonomic approach to the professions encompasses both trait and functionalist perspectives. For the trait approach to the

professions, defining features of those considered 'professional' were listed, seeking to demonstrate how professions were distinguished from 'non-professions' (Millerson, 1964; Saks, 2016). Authors of the trait approach suggested a sequential process of professionalisation (Wilensky, 1964), made positivistic attempts to measure professionalism (Millerson, 1964), and deemed groups as 'professions' and 'semi-professions' (and as Macdonald (1995) suggests, presumably non-professions) based on their perceived traits and degree of professionalisation (Etzioni, 1969). Others relatedly proposed an occupation-profession continuum with professions' 'level' of professionalisation based upon a polar scale of occupation and profession (Pavalko, 1971).

Linked to the trait approach, functionalists saw professions as integral, stabilising, and functional aspects of society (Carr-Saunders and Wilson, 1933; Parsons, 1954). Traits such as altruism and sense of public service were seen as beneficial to society in that the professions' interests were for public good and thus, placed public need at the forefront of their practice (Goode, 1957; Pavalko, 1971; Macdonald, 1995; Ackroyd, 2016).

Nonetheless, there were limitations to the taxonomic approach. Disparities between profession-defining characteristics were evident (Saks, 2016) and the social and political backdrops in which professions were located were neglected (Saks, 2010). Furthermore, these theories were critiqued for their abstractness and lacking consideration of professional power and self-interest as drivers of change (Saks, 1995; Saks, 2016). Additionally, claims to expertise, prestige and exclusivity were suggested to be self-fulfilling by emerging interactionist critiques (Saks, 2010); so

much so, Roth (1974, p.17) suggested taxonomic thinkers were the *'dupes of the established professions (helping them justify their dominant position and its payoff).'* Thus, departure from the taxonomic theories of professionalism followed with interactionists focus on micro-level client-professional interactions and the meaning attached to individuals' actions (Saks, 2016; Nancarrow and Borthwick, 2021).

2.3.2 Interactionism

Interactionist theorists observed the actions and interactions between actors, groups, and the construction of their social world (Macdonald, 1995). Interactionist writers such as Becker (1962) suggested the professions' 'socially negotiated label' did not necessarily dictate the way professions organised and executed their work (Becker, 1962; Saks, 2016). Hughes (1963) suggested commonalities between the archetype professions and the stigmatised occupations, casting doubt over the prestigious claims that had their roots in taxonomic approaches. Nancarrow and Borthwick (2021) suggest Hughes reframed the taxonomic question of what 'is' a profession, to one of understanding professions as a 'social value.' Therefore, they suggest the work of Everett Hughes was hugely influential for the development of the neo-Weberian approach to the sociology of the professions (see section 2.3.7).

Although interactionist analysis of the professions reframed how professions were considered in society and sociology, the approach was critiqued for its lacking empirical evidence and micro-level analysis; and it thus lacked consideration of wider socio-political backdrops, and meso (organisational) and macro

(society) level analysis (Saks, 2016; Nancarrow and Borthwick, 2021).

2.3.3 Marxism

Though both Marxist and Weberian approaches to the professions have roots in conflict theory (Ackroyd, 2016), German philosopher Karl Marx is often most associated with conflict theory (Nicholls, 2022). Marx saw conflict and competition as a basis in society (Ackroyd, 2016; Nicholls, 2022). For Marxist theory, professions were situated within capitalist modes of production and the class status of proletariat and the bourgeoise; thus, Marxist theories of professions were mostly concerned with the professions' relationship to state and the proletarianisation of the professions (Macdonald, 1995).

An example of professions theory deriving from the Marxist tradition would be the work of Johnson's *Professions and Power* (1972). Johnson sought to understand the power relations between professions and society, something which Johnson suggested had been neglected in previous sociological inquiry (Johnson, 1972, p.18). This power approach aimed to explore the relations between those who consumed professional services and those who produced them; and particularly how the producer could or could not control this relationship (Johnson, 1972; Macdonald, 1995). Johnson's later writing took upon a more Foucauldian approach (see section 2.3.5).

Whilst Marxist theories of the professions facilitated macro-level analysis, the approach has petered in recent times due to lacking empirical evidence and the growing use and utility of alternate approaches (Saks, 2016; Nancarrow and Borthwick, 2021).

2.3.4 Indeterminacy-technicality ratio

It is worth noting here Jamous and Peloille's (1970) thesis on the indeterminacy-technicality ratio (I/T) regarding how professional knowledge is considered. This concept is not entirely Marxist (Nancarrow and Borthwick, 2021), though is situated within systems of production. Nonetheless, both Foucault and Bourdieu (discussed later) are mentioned in the essay.

Jamous and Peloille (1970) posited that professional work involved claims to indeterminate and technical knowledge. Professional judgement could only be exercised by those who had 'qualities' within the profession (Jamous and Peloille, 1970; Traynor, 2009). They suggested professional work reflects a high level of indeterminacy to technicality (Jamous and Peloille, 1970; Traynor, 2009). A high level of indeterminate, abstract knowledge may undermine claims to professionalism as legitimacy is lost, and high levels of technicality alone may result in knowledge codification and thus increased accessibility by 'lay' members of the public, demystifying and eroding their claims to specialist knowledge and professional status (Jamous and Peloille, 1970; Traynor, 2009). Interestingly, Jamous and Peloille (1970) suggest those lower down the professional hierarchy may be more likely to promote technicality, whilst established and elite members of the profession may resist reforms with claims to indeterminacy (Traynor, 2009).

Whilst Macdonald (1995) identifies some critique of the application of this concept, it has been used by some to offer insightful analyses of how healthcare professions have responded to contemporary healthcare movements, such as evidence-based

practice (Traynor, 2009). Furthermore, Abbott's (1988) understanding of professional knowledge empathises to some extent with Jamous and Peloille's (1970) concept of indeterminacy (see section 2.3.7.3).

2.3.5 Foucauldian approaches

French philosopher Michel Foucault was interested in the relationship between knowledge and power (Macdonald, 1995). Foucault's concept of governmentality has been applied to the sociology of professions (Saks, 2016) and his work offers key concepts (such as panoptic surveillance and disciplinary knowledge) which can provide useful insight into the behaviour and role of professions in the governance of society (Nancarrow and Borthwick, 2021). These concepts, alongside governmentality, can be used to analyse how professions contribute to the legitimisation, normalisation and regulation of such activities (Saks, 2016).

Johnson (1995) adopted governmentality for his analysis and suggested Foucault saw governmentality as: *'a novel capacity for governing…in association with the invention, operationalisation and institutionalisation of specific knowledges, disciplines, tactics, and technologies'* (Johnson, 1995, p.8); thus, governmentality is the practices by which subjects are governed. Johnson (1995) used this concept to frame the 'institution of expertise' (Johnson, 1995, p.9), concluding that previous iterations of state and professions as disparate entities, are misconceived. Hence, professions have emerged as apparatus of the state and *'a key resource of governing in a liberal-democratic state'* (Johnson, 1995, p.23).

As demonstrated above, Foucault's work can offer useful insights into professions and their relationship with knowledge, power, the state, and the initialisation of expertise. However, this approach has also been criticised for lacking empirical evidence (Saks, 2010, p.891; Macdonald, 1995) and its level of abstractness (Saks, 2010; Macdonald, 1995).

2.3.6 Bourdieu and the professions

French sociologist Pierre Bourdieu's critique of the concept of professionalism may lead one to assume his work may not be of relevance to the sociology of professions. However, Bourdieu's understanding of capital, in all its forms, economic, social, cultural, and symbolic, can be used to analyse professions and their position in society (Noordegraaf and Schinkel, 2011a, 2011b). For Noordegraaf and Schinkel (2011a, 2011b) professionalism is a form of symbolic capital, achieved through processes of obtaining social and cultural capital. For example, through education (cultural capital) and institutionalised titles and credentialism (social capital) (Noordegraaf and Schinkel, 2011a, 2011b). When this becomes legitimised, professions secure symbolic capital (Noordegraaf and Schinkel, 2011a, 2011b). Thus, professions develop '*a professional habitus, a set of dispositions that influences how he or she perceives, thinks or acts,'* (Noordegraaf and Schinkel, 2011b, p.104). As this social space is occupied and respected, its position within society is legitimised, institutionalised, normalised, and thus, reproduced (Noordegraaf and Schinkel, 2011a, 2011b). Therefore, these concepts can be of used in examining the professions and their interactions with others, the state, and society, as demonstrated in Noordegraaf and Schinkel (2011a, 2011b).

Whilst a Bordieuan perspective of professionalism has not grown dominant in the field, Nancarrow and Borthwick (2021) suggest Bourdieu's theories of capital may be relevant for the allied health professions in the way professional titles are used and controlled.

2.3.7 Neo-Weberianism

Neo-Weberian scholars base their hypotheses on German sociologist Max Weber's theory of social stratification and exclusionary closure. While not rejecting Marx's postulation of the struggle between proletariat and bourgeoisie, Weber posited the complexity of social stratification and the conjuncture of economy, power, and status (Waters, Waters and Elber, 2015). Furthermore, Weber's concept of social closure, where groups assert and maintain a position in society through exclusionary tactics and usurpation of privileges from other groups, became the basis of neo-Weberian analysis of the professions (Macdonald, 1995; Saks, 2010).

Saks (2010, 2016) suggests that neo-Weberian approaches are the most pertinent, incisive and *'empirically fruitful'* interpretations of the professions (Saks, 2010, pp.888). Saks suggests that this approach allows for comparative sociological analyses and a sound basis for the analysis of professions in advanced societies (Saks, 2010, 2016). The main contributors to this line of thought are discussed in the following sections.

2.3.7.1 Freidson, professional dominance, and restratification

Sociologist Eliot Freidson's theories of professional dominance and restratification demonstrate neo-Weberian tactics of social

and occupational closure. Freidson examined how the medical profession achieved and occupied a position of dominance in the professional hierarchy. Freidson's theory outlined how doctors obtained autonomy and professional dominance through tactics of occupational closure, such as credentialist entry to the profession and licensing, to secure an apical hierarchical position, leaving other professions subordinated (Freidson, 1970a, 1970b). Furthermore, doctors dominance and control over self and collegial regulation meant they had *'the authority to direct and evaluate the work of others without in turn being subject to formal direction and evaluation by them,'* (Freidson, 1970b, p.136) (e.g., nursing and the allied health professions). Freedom to dictate the nature of their professional work and their professional dominance meant competition and encroachment across medical boundaries was restricted (Freidson, 2001; Nancarrow and Borthwick, 2001).

Freidson's *Third Logic* (2001), written at the end of the 'Golden Age' for medicine (Dingwall, 2008, p.132), suggested that professionalism was an alternative (third logic) to consumerism and bureaucracy in the organisation of social life (Freidson, 2001; Saks, 2016). Reflecting on his model of professional dominance, Freidson concedes that socio-economic and political changes have influenced (but not negated) professions and the dominant model he had previously outlined, recognising the state as *'the key force required for the creation, maintenance and enforcement of ideal typical professionalism'* (Freidson, 2001, p.128).

A further concept of Freidson's which is of interest and use for analysing professions in contemporary society, is restratification.

Freidson posited that the professions play strategic roles to protect professional interests when faced with bureaucratic change (Waring, 2014; Freidson, 1985). Freidson argued professions were able to reshape their roles when faced with external challenges, and in doing so, were able to retain their autonomy (Waring, 2014; Freidson, 1985). This theory continues to have utility as an analytical framework in contemporary literature (see 2.3.8). This concept is of interest to this study, as the basis of this theory (and much of the sociology of professions literature to date), is in a privileged and dominant social group.

2.3.7.2 Larson and the professional project

Larson (1977), building on the work of Freidson (1970a, 1970b), draws on Weber's views on social stratification and the integration of economic and social order, to conceptualise the 'professional project' (Larson, 1977; Macdonald, 1995). The professional project and professionalisation for Larson were the translation of esoteric, specialist knowledge and skill into economic and social reward (Larson, 1977). Thus, the outcome of a successful professional project was market control and social mobility; and these were not concepts which were merely given, but the result of a specific professional project (Larson, 1977; Macdonald, 1995). Further, for Larson, the success of a *'professional mobility project'* was dependent on the existence of a market (Larson, 1977, p.66).

With this market control, a profession could dictate and restrict access to their knowledge, effectively entering a regulative bargaining with the state and controlling the supply of practitioners (Larson, 1977; Macdonald, 1995; Freidson, 2001); in return for collective mobility and gaining monopoly in the

marketplace (Freidson, 2001). Whilst this is a collective project, individuals within the profession may not have the same aims, and the professional project is a constant process (Larson, 1977; Nancarrow and Borthwick, 2021).

Larson (1977) has been considered Marxist or 'neo-Marxist' (Nicholls, 2022) despite also widely being considered neo-Weberian (Macdonald, 1995; Ackroyd, 2016; Saks, 2016; Nancarrow and Borthwick, 2021). Macdonald (1995, p.22) suggests: *'Larson is often taken to be Marxian because of the tenor of her later writings.'* Indeed, Larson (1977) draws upon Marxist theory in her predominantly neo-Weberian account (Saks, 2016), but much of her theory is based upon concepts of Weberian social stratification and closure. Therefore, in this study, Larson's theory of the professional project is considered neo-Weberian. It is important to note that several authors' theories have influences from different perspectives of professionalism. For example, Saks (2016) describes Freidson's neo-Weberian account as drawing on interactionism. Saks (2016) goes onto suggest that although there can be tensions between differing sociological perspectives on the professions, they can complement each other and (sensible) eclecticism can be fruitful for investigation.

2.3.7.3 Abbott's system of professions and professional ecology

Abbott (1988) saw professions as part of a system or 'ecology' (p.33) whereby professions are interacting with each other; often competing within that system. For Abbott, professions sought ownership over a jurisdiction which was fluid and mutable; thus, where there would be change in the distribution and nature of

work tasks, there would be *'consequent jostling and readjustment within the system of professions'* (Abbott, 1988, p.33). This has important claims to inter-professional competition and division of labour; providing what Abbott described as an explanation for why some professions *"…fail…become dependent, subordinate and others disappear entirely"* (Abbott, 1988, p.316).

Another important aspect of Abbott's work is how professional knowledge is considered. As mentioned earlier, this has some affinities with the work of Jamous and Peloille (1970). For example, Abbott considered knowledge, both abstract and concrete, as a foundation for professionalism (Abbott, 1988; Macdonald, 1995). Therefore, a balance between the two was required as otherwise the profession risks losing credibility (Abbott, 1988; Macdonald, 1995). Therefore, regarding Jamous and Peloille's (1970) I/T ratio, Abbott's understanding of professional knowledge can be understood as the relational balance between indeterminate (abstract) and technical (concrete) knowledge in the exercising of professional work.

Abbott expanded on his work on the ecology of the professions, jurisdiction and interprofessional competition. Abbott (2005) introduced the concept of linked ecologies and its utility as an analytic framework when studying the 'ecology of professions.' The linked ecologies framework recognises the *'simultaneous existence of adjacent ecologies, all of whose actors seek alliances and support across ecological boundaries,'* (Abbott, 2005, p. 247). Through the linked ecologies framework, we can understand professions and their interactions as not external, fixed entities, but as ones which can contest and constrain each

other (Abbott, 2005, p.248); actions in one ecology will impact on their adjacent ecologies. This framework provides a lens for analysis when studying the professions and the complex (and contingent) social processes (Abbott, 2005, p.271) they are part of.

2.3.7.4 Critiques of neo-Weberian approaches

Despite its utility and consideration as the most *'empirically fruitful'* approach to the sociology of professions (Saks, 2010, p.888), the neo-Weberian theoretical framework is not immune to critique. A prominent writer and proponent of the approach, Mike Saks, outlines three main critiques of neo-Weberian interpretations. These critiques are mainly centred in the operationalisation of the theory, rather than fundamental flaws in its theoretical underpinning (Saks, 2010, 2016). For example, neo-Weberian analyses often lack empirical rigour or empirical evidence for claims, which consequently, can be considered unsubstantiated (Saks, 2010, 2016). Furthermore, analyses are overly negative of professional groups, focussed on their deconstruction and lack what Saks terms positive reconstruction (Saks, 2010, 2016). This is not to say the professions should not be analysed and critiqued, but Saks suggests neo-Weberian analyses tend to be focussed on their deconstruction.

Another critique of this approach relates to use of 'ideal types'. Ideal types are often used in the neo-Weberian approaches to understand professions and professionalisms, and are associated with Weber's sociology (Alvehus *et al.,* 2021). Alvehus *et al.* (2021, p.202) suggests an ideal type *'identifies a set of characteristics or traits associated with a social phenomenon and moulds an image of how these interrelate into a coherent whole.*

Ideal types are constructed on the basis of a set of theoretical assumptions, leading to several ideal types that are mutually exclusive.' Therefore, empirically, these ideal types are scarcely found, prompting some to question their utility as constructs (Alvehus *et al.,* 2021; Adams *et al.,* 2020a, Adams *et al.,* 2020b). However, ideal types do offer a theoretical tool with which to approach analysis of the professions (Alvehus *et al.,* 2021). Understanding of this is crucial to their mindful use in analysis. The contentious issue of ideal-type and their utility has been highlighted in contemporary notions of professionalism (see 2.4.8).

Despite these criticisms, the neo-Weberian approach is suggested to be the most fruitful, robust, and persuasive approach to understanding the professions (Saks, 2010, 2016; Nancarrow and Borthwick, 2021), with most of the critiques seemingly addressable (Saks, 2016).

2.3.8 Contemporary notions of professionalism

Contemporary notions of professionalism have built on the core theoretical concepts introduced in the preceding sections. Sociologists in this area have examined professions in contemporary social, economic, political, and organisational contexts. A recognition of the inability to delineate professions from context has initiated interesting theoretical reconceptualisations of the notion of professionalism.

For example, with a growth in bureaucracy and managerialism, professions increasingly working in large scale organisations, and organisations' influence on the nature, control, and organisation of work, Evetts conceptualised organisational and occupational

professionalism (Evetts, 2003a, 2003b, 2011). Evetts suggested professionalism can be used as both normative value and controlling ideology and outlined ideal types of occupational and organisational professionalism, presented in Table Two:

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

Table Two: Ideal types of organisational and occupational professionalism (Evetts, 2009).

Essentially, organisational professionalism is based upon the discourse of control via managers with rational-legal forms of authority, with an emphasis on accountability, controls, and performance management. Contrastingly, occupational professionalism is based upon discourse from within the profession, emphasising collegiality and trust (Evetts, 2009). These ideal types offer two ends of a professional spectrum,

emerging from the bureaucratic nature of modern organisations, offering a discourse for understanding contemporary professionalism within the organisational setting. Evetts (2009) uses these concepts to examine NPM and suggests NPM simultaneously promotes organisational professionalism whilst undermining occupational professionalism. Evetts (2009) provides a theoretical example of a 'new' professionalism, moving away from control of work by the professions themselves, towards organisational control associated with the increased managerialism and bureaucracy of organisations.

Whilst professions traditionally seek to delineate themselves from market logic and commercialisation, instead appealing to the notion of altruistic service for public good (Fournier, 2000), economic, social, political, and technological advances have required them to engage with this rhetoric (Fournier, 2000). This engagement has been reflected in both empirical and theoretical examinations of contemporary professionalism (for example, Carvalho, 2014). In these analyses, the dichotomy between managerialist and professional logics is significant (Potter and Morgan, 1994; Dent and Burtney, 1996; Kitchener, 1999; Kirkpatrick *et al.,* 2005; Kirkpatrick *et al.,* 2011). Empirically, there are examples of professional resistance to managerialism and adherence to professional norms and values (Exworthy and Halford, 1999; Hoyle and Grant, 2015; Kerasidou *et al.,* 2016). In this light, Noordegraaf (2007) suggests a movement from 'pure' professionalism to 'hybrid' professionalism, where the two logics of professionalism and managerialism are reconciled to negotiate professional work in ambiguous public service domains.

The growth of consumerism and managerialism as organising logics has degraded the trust and prestige that the medical profession possessed as part of the 'Golden Age' of medicine (Freidson, 2001). Complementary and alternative medicine, the advance of non-medical practitioners outside of medicine's control, pursuance of bureaucratic organisation and emphasis on performance management were all suggested to undermine the ideology of ideal-type professionalism (Freidson, 2001). However, this perspective neglects reports of incompetence, exploitation, and collusion of consumers for professional self-interest and benefit (Light, 2010); paradoxically contradicting the ideal type 'soul' of professionalism (Freidson, 2001).

Greater scrutiny on their work in contemporary settings may be interpreted as a direct challenge to autonomy and the fundamentals of professionalism. Indeed, such challenges to dominating professional logic could be construed as an 'attack' on the professions (Freidson, 2001; Light, 2010). However, considering failures in regulation and incidences of harm at the hands of professionals, these challenges to professionalism may also be a method to return public trust. For example, the Francis Inquiry exposed the failures of an NHS hospital where poor care became organisational culture (Francis, 2013). Such failures have called into question the self-regulatory nature of professional work (Dixon-Woods *et al.,* 2011). Thus, accountability and regulation standards were implemented, deconstructing the traditional notion of autonomous, self-regulation (Dixon-Woods *et al.,* 2011; Martin *et al.,* 2015).

Both marketisation and consumerism have also challenged traditional notions of medical professionalism, authority, and

autonomy (Fournier, 2000; White, 2004). Greater accessibility to information has equipped patients with knowledge which can reduce the knowledge gap between professional and patient (Hibbert *et al.,* 2002). This process of 'lay reskilling' questions the 'mystique' traditionally surrounding professions and the monopolistic ownership of knowledge, which was conventionally beyond the scrutiny and grasp of the lay public (Turner, 1995; Fournier, 2000; Hibbert *et al.,* 2002). Thus, the shrinking knowledge gap and movement away from trust-based decision making to those of choice and market consumerism (Mechanic, 1996; Vinson, 2016) has been perceived as deprofessionalisation, corporatisation and the Marxist notion of proletarianisation (McKinley and Marceau, 2002; Vinson, 2016). For a professional to become deprofessionalised, their core tenets are eroded, with an associated loss of prestige, power, occupational jurisdiction, trust and a narrowed knowledge gap between themselves and the public (Haug, 1972, 1975; Freidson, 1984).

Contemporary rhetoric surrounding deprofessionalisation tends to refute this concept, instead suggesting a reprofessionalisation or reconfiguration of professionalism (Evetts, 2011; Muzio and Fitzpatrick, 2011; Moffatt *et al.,* 2014; Waring, 2014). Nonetheless, recent challenges to professional work in the form of austerity has seen a resurgence of the deprofessionalisation hypothesis. Malin (2020) suggests austerity and neoliberal approaches to service provision creates forms of deprofessionalisation for the professions. Malin (2020, p. 26) suggests: *'if austerity finished tomorrow, it is likely that deprofessionalisation would continue, driven by the neoliberal approach to service provision.'* For Malin, (2020)

deprofessionalisation has manifested through cuts to services and professional training, globalisation, ineffective services, job insecurity and a demoralised workforce.

However, in the wider literature, the general rhetoric remains that professions reconfigure or reorganise themselves in the face of tensions between contemporary society and professional logic. Noordegraaf (2015) builds on his earlier iteration of hybrid professionalism (Noordegraaf, 2007), to posit a movement beyond hybridity. Noordegraaf (2015) outlines a state of 'organising professionalism' as a reconfiguration of professionalism, rather than deprofessionalisation in the face of social, political, and organisational change. Noordegraaf (2015) suggests this form of professionalism reconceptualises organising as integral and normal for professionals, rather than emphasising a hybrid state, which suggests an 'uneasy' or 'unnatural' combination of contrasting logics. The reconfiguration of professional action to normalise organising as a core professional activity is suggested to *enrich* professionalism rather than *hollow* it out (Noordegraaf, 2015, p.203).

Noordegraaf's (2020) more recent work presented the concept of 'connective professionalism,' a term first introduced as part of Noordegraaf's (2015) work on organising professionalism. Noordegraaf (2020) argues societal changes have weakened the 'protective shields' of ideal-typical professionalism, which has become outdated. Rather than a 'return to' professionalism, which Noordegraaf suggests is commonly referred to in the face of extra-professional challenges, he posits a reconfiguration of professionalism. Connective professionalism reflects how professionals organise within their work, are connected, and

related to others (other professionals, stakeholders, clients, state, media), and remain knowledgeable, authoritative, and autonomous (Noordegraaf, 2020). Noordegraaf's thesis observes authority, autonomy, and expertise as relational and not fixed entities, emphasising professionalism as professional work processes, not linked to the professional alone (Noordegraaf, 2020).

Whilst Noordegraaf's essay proposes important and insightful reflections on the state of professionalism, it was met with critique (Adams *et al.,* 2020a; Adams *et al.,* 2020b; Alvehus *et al.,* 2021). These critiques were anchored in the suggestion that professions had always been connected to others, practising within complex environments. Furthermore, the use of ideal types to conceptualise forms of professionalism have been critiqued as they cease to be observable or operationalizable in their ideal forms (Adams *et al.,* 2020a) (see 2.3.7.4). Additionally, Noordegraaf's theory was suggested to neglect power and how these impact on the connections professions make and the construction of expertise (e.g., race, gender, social position etc) (Adams *et al.,* 2020b). Others argued for a less binary view of professionalism (Alvehus *et al.,* 2021) and some brought attention back to [re]stratification theories (Waring in Adams *et al.,* 2020b; Alvehus *et al.,* 2021). Though the critiquing authors acknowledged the importance of highlighting connections between and within professions, stakeholders, clients, organisations, state, and media, they emphasised the importance of examining how power may influence the types and effectiveness of connections that are made (Waring in Adams *et al.,* 2020b; Adams *et al.,* 2020b). The dominance of neo-

Weberian theories in the sociology of professions was also brought into question, and an invitation was extended for greater use of network and ecological theory to be considered for future examinations of professionalism (Adams *et al.,* 2020b) (for example, Abbott, 2005).

2.4 The sociology of profession[al] medicine

The dominance of medicine as a profession extends to sociological examinations of the professions. Much of the sociology of professions literature is deeply embedded within the 'archetypical' professions: medicine and law. Empirically, the focus on medicine provided opportunity for extensive analysis (see Freidson, 1970, 1984, 1988, 2001); whilst other professions or occupations seeking professionalisation, have been overlooked (Saks, 2010).

The focal point of the 'traditional' professions of medicine, law and to some extent, the clergy, have provided a sound basis for the sociological explanation of how professions work, what makes a profession, the appeal to professionalism and processes of professionalisation. Subsequent literature sought to build upon the seminal theories and apply this to the realities of professional life. Locating professionalism within modern day capitalism, in response to political ideology, institutions, organisations and social life, has provided opportunity to bring these foundational theories into contemporary settings. Whilst it is not to devalue or disregard such early theories, the call for a movement towards recognition of the wider scope of professionalism, has been encouraged (Saks, 2010). Furthermore, most contemporary writers base their work upon the original sociology of professions

texts, whose work remain essential to the extension of the sociology of professions.

Considering their professional dominance, despite challenges to the foundations of their professionalism, medicine has been able to respond, adapt and transform. Whilst market logic can contrast with altruistic claims of professionalism, professionalism (in Marxian and neo-Weberian perspectives) requires some sort of market engagement to obtain monopolistic control (Larson, 1977; Kuhlmann, 2006). Therefore, it is beneficial to those occupations seeking professionalisation to be situated in a labour market. Despite challenges to their autonomy and authority, medicine has been able to mobilise their skills and *'diminish these threats and seek new ways to regain trust'* (Timmermans and Oh, 2010, pp. S98). For example, active engagement with evidence-based medicine to legitimise policy decisions (Kuhlmann, 2006; Timmermans and Oh, 2010) and campaigning publicly regarding the immorality of markets in the NHS (Fournier, 2000; British Medical Association, 2017).

Reponses by the medical profession to contrasting logics, such as managerialism, have been examined by Numerato *et al.* (2012); who conceptualised the interplay between managerialism and professionalism as existing upon a continuum, presented in Figure One:

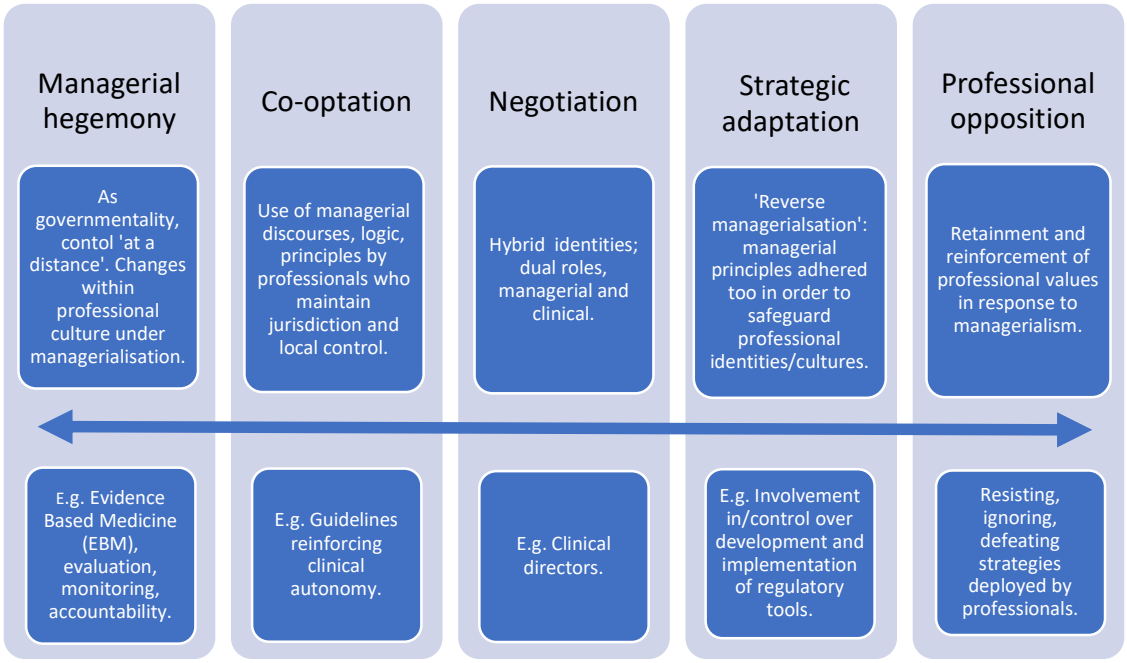


Figure One: Interplay between professionalism and managerialism in the medical profession; adapted from Numerato *et al.* (2012) and Moffatt (2014, pp.38).

These modes of response demonstrate the transformability of the professions and the ability to shift boundaries, reconstruct and reinvent themselves (Fournier, 2000; Kuhlmann, 2006). However, as a dominant profession whose power and occupation of an acquired area of the market and social life has long been established, it is unclear whether other professions would have the same ability. As Fournier suggests: *'some professions may be better equipped than others to remake themselves and to realign their field of knowledge with the logic of the market'* (Fournier, 2000, pp. 84).

Examination of other professional groups, particularly those who were traditionally considered subordinate to medicine, is less well developed. In this study, austerity is used as a case example of an organising logic which contrasts with professional logic, and

which has the potential to impact on the nature of professional work. Regarding research within an austere health setting, literature has mostly focussed on medicine and to an extent nursing (Currie *et al.,* 2012; Waring, 2014; Moffatt, Timmons, and Coffey, 2016). Though medicine has not been immune to organisational challenge and austerity, it has been suggested that they have sustained their place at the *"apex of the healthcare professional hierarchy"* (Currie *et al.,* 2012; pp.940). In the case of nursing, NPM, neoliberalism and managerialism has posed opportunities for exploitation (Selberg, 2013) ***and*** extension of their professional project (McDonald *et al.,* 2009). For non-medical, non-nursing healthcare professionals attempting to reconcile their professional work in contemporary healthcare, this is met with successes and losses, and a clear conflict to their ability to fulfil their professional responsibilities (Tucker *et al.,* 2017, Tucker, Moffatt, and Timmons, 2020).

Despite a medical dominance, literature has broadened the sociological examination beyond medicine. For example, Timmons and Tanner's (2004) work on operating department practitioners, the examination of podiatry (Borthwick, 2000; Borthwick *et al.,* 2010), and Nancarrow and Borthwick's (2005) theoretical analysis of the interprofessional dynamics amongst a range of healthcare professionals. Two notable more recent publications (Nancarrow and Borthwick, 2021; Saks, 2020) address the monopolistic focus on medicine within the sociology of professions further. Nancarrow and Borthwick (2021) address the absence of a sociological perspective on the allied health professions (AHPs), providing insights into a range of AHPs' past and the pressures that have shaped them. They provide a

comparative analysis of the UK and Australian health systems and how AHPs have (and are) negotiating these. They also highlight the integral role for support workers and their relation to AHP professional work, something explored in depth by Saks (2020).

Saks (2020) and their contributors identify the large, unqualified, and often non-regulated support workers as the 'invisible providers of healthcare.' Saks' text is thought to be the first book to examine the role of support workers from a sociological perspective, despite their exponential growth in numbers and role in carrying out professional work as governments attempt to enhance cost effectiveness across health systems. Both texts are seminal for the future of diversifying the sociology of professions literature and provide a basis for empirical examination of such concepts.

The theory of medical dominance, using Freidson's model as an example, has been described as 'over-muscular' (Larkin, 1983, p.8), as nursing and AHPs are also able to exercise exclusionary strategies in the pursuance of monopoly, albeit generally less successfully (Larkin, 1983; Nancarrow and Borthwick, 2021). Nonetheless, there is little empirical evidence on this. Furthermore, what we can observe from the literature review and what is common to critiques of several approaches to the sociology of professions is that empirical evidence is lacking. This study aims to contribute to addressing the lack of empirical evidence in the sociology of professions by empirically examining professional work in the context of austerity by a non-medical, allied healthcare profession, using physiotherapy as a case example.

2.5 The case of physiotherapy

Physiotherapists work in a range of specialisms and settings in both private and public services. They work with people who have experienced illness, injury, or disability to improve their independence and facilitate recovery (CSP, 2018a). Physiotherapists often work within teams of other healthcare professionals, such as (but not limited to) doctors, nurses, occupational therapists, speech and language therapists, psychologists, orthotists, and podiatrists.

The physiotherapy profession provides an interesting example of a non-medical, non-nursing, allied health profession in terms of its development of (and threat to) monopolistic knowledge, acquisition of autonomy, and their relationship with medicine. Physiotherapy did not seek to compete with medicine in their early professionalisation. Instead, the profession capitalised on technical tasks which were performed by early physiotherapists on the direction of doctors, perhaps 'riding on the coattails' of medicine. Physiotherapists accepted subordination to medicine in exchange for the ability to practice their work (Larkin, 1983). This was arguably successful, as they gradually increased their jurisdiction and pursued credentialist entry to the profession, whilst establishing their value in the market, and ultimately being successfully included in NHS provision.

After initially accepting subordination, the profession continued to expand their jurisdiction and attempted to distance themselves from paternalistic medical control (Nicholls, 2018). This too was arguably successful, with physiotherapists obtaining legal autonomy from doctors in 1977 (CSP, 2017). Whilst it should not

be assumed that hierarchy or paternalistic control ceased at this time, it is an example of a unique acquisition of autonomy from doctors, in which other occupational groups, such as nurses, have struggled to achieve (Hugman, 1991; Witz, 1992; Carpenter, 1993; Davies, 1995; Salhani and Coulter, 2009; Dahlke and Stahlke Wall, 2017).

The reasoning for this is unclear. The profession's historical underpinning of 'body as machine' is itself underpinned by a scientific, medically-based model of education and practice (Nicholls, 2018), perhaps concomitant with medicine's foundations. Therefore, physiotherapists have generally capitalised on the evidence-based practice movement (Nicholls, 2018), using this to justify their position and jurisdiction. Comparatively, nursing's jurisdiction is wide and varietal, with at times, confusing rhetoric surrounding its ideology and professional project (Taylor, 1997; McDonald *et al.,* 2009; Rankin, 2009; Barnett, 2012; Dahlke and Stahlke Wall, 2017), spanning a 'holistic' rather than medical model (McDonald *et al.,* 2009). Could it be that physiotherapy's narrower mandate provided opportunity to defend jurisdiction and create occupational closure? However, this could also pose threats to the profession's sustainability in contemporary healthcare. For example, physiotherapy has been subject to encroachment from other (cheaper) occupations, such as exercise technicians, sports therapists, and rehabilitation assistants, who's own professionalisation is becoming formalised and credentialled (Jones, 2006).

Nonetheless, physiotherapy has also had opportunities to broaden their scope of practice through encroaching on the

medical profession's jurisdiction. For example, increasing demand on General Practitioners (GPs) has provided an opportunity for physiotherapists to extend their scope of practice through first contact practitioner (also known as First Contact Physiotherapy) (FCP) roles. FCPs provide a first contact service in GP surgeries, assessing patients presenting with musculoskeletal problems who would have otherwise been seen by a GP, thus reducing demand on GP appointments (Goodwin and Hendrick, 2016; Moffatt *et al.,* 2018). Furthermore, physiotherapists have encroached upon other areas of medicine's jurisdiction, such as achieving prescribing rights (Millet, 2018) and legal rights to injection therapy (CSP, 2021a).

The physiotherapy profession provides an example of processes of neo-Weberian professionalisation outside of the archetypical professions. The profession exercises social closure (e.g., closing the profession to those unqualified or lacking credentials), whilst also usurping a more powerful profession (medicine) of certain tasks (termed a 'dual closure strategy' [Witz, 1992]). The profession is pursuing occupational closure and capitalising on neoliberalist and austere health policy to broaden their professional project, based upon economic principles of cheaper practice in comparison to doctors. This is arguably a process for the professional elites. How this affects rank-and-file members of the profession is unclear.

The physiotherapy profession offers an example of the 'professional jostling' described by Abbott (1988) in that they are attempting to sustain their professional interests and continued presence through encroachment. The profession's legal acquisition of autonomy and continued encroachment upon

medicine's jurisdiction, whilst also experiencing threats to their sustainability, poses important questions. How has physiotherapy managed to achieve and practice autonomy where others have failed? How are they able to encroach upon medicine's jurisdiction whilst also faced with threats to their sustainability? What are the implications of this on their intra-professional relationships? And how successful will these approaches be when faced with challenges to their professional practice in the long term?

The physiotherapy profession provides an interesting case example of an allied health profession. The profession has managed to mobilise itself from a subordinated position to one with both individual and collective autonomy. Physiotherapy was thus able to negotiate power imbalances and hierarchy to further itself as a profession and thus provides insight into how a non-archetypical profession professionalises. Nonetheless, the profession is arguably still subject to interprofessional hierarchy. Important questions arise from this: what role does longstanding and reproduced power relations have for non-archetypical professions' professional work? Are they able to sustain autonomous work in the face of contemporary healthcare, or does the traditional model of professionalism (and its hierarchy) limit these abilities?

Doctors have experienced clear threats and challenges to their professionalism, and as discussed, have been able to adopt a range of strategies to reconcile such challenges. This leaves the question of whether those professions who do not sit at the apex of interprofessional hierarchy also possess the ability to respond (or reconcile) similar challenges. The physiotherapy profession

has previously overcome power imbalances to secure autonomy over their work, and thus deliver public services based on esoteric knowledge. Having been able to previously negotiate power imbalances, are these strategies still available in contemporary healthcare? This is particularly pertinent as social, political, and organisational change mandates greater management, organisation, outcome measurement, engagement with technological advancements, and transparency in practice than the traditional modes of professionalism allow. Examining the physiotherapy profession will thus provide opportunity to explore strategies of sustained professionalism in non-archetypical professions in contemporary healthcare, uncover workforce issues, and pose an opportunity for learning for other allied health professions. Furthermore, it will provide an empirical examination of a non-archetypical profession, as is much indicated, and needed in the sociology of professions literature. This study aims to explore these questions in the context of austerity following the 2008 financial crisis.

2.6 Research question, aims, and objectives

The research question for the study was thus: How does a smaller, subordinated healthcare profession (non-medicine, non-nursing) reconcile and accommodate austerity and what impact does this have on the nature of their professional work?

The aims of the study were:

- To explore professionalism, professionalisation and the nature of professional work in a smaller, subordinated profession in contemporary healthcare
- To use physiotherapy as a case example

- To understand how physiotherapists understand, experience and react to austerity
- To explore the implications of austerity on the nature of the physiotherapy profession's professional work

The study's objectives were:

- To complete an organisational ethnography in an acute secondary or tertiary care setting over the course of 4-6 months, achieving an estimated 150 hours of observations[2]
- To complete informal and semi-structured interviews to gain greater depth of findings and triangulate the observation data
- To complete document and artefact analysis as appropriate and relevant to the study
- To analyse the data using an interpretivist epistemology and the neo-Weberian interpretations of the sociology of professions as a theoretical framework
- To contribute to the contemporary sociology of professions literature through publication and dissemination of the research findings

2.7 Summary

This chapter has introduced the sociology of professions and its utility in examining professional groups. Furthermore, this theoretical underpinning can be used to analyse how professions respond to challenges to their professional work, such as

[2] Whilst this was one of the planned objectives of the study, the ethnographic component of the study did not take place due to complications associated with the Coronavirus Disease (COVID-19) pandemic. This is discussed in detail in chapter three.

changing social, political, and economic backdrops. This chapter has proposed that whilst this literature provides basis for fruitful analysis, it is embedded in examinations of a dominant healthcare profession (medicine). How other, traditionally considered subordinate, professions negotiate similar challenges in unclear. This chapter has introduced the physiotherapy profession as a profession of interest due to its unique process of professionalisation and attempts to sustain itself within a growing neoliberal, market-based system. Therefore, the physiotherapy profession was used as a case example of the allied health professions. The research question was thus introduced and planned aims of the study outlined. The following chapter will discuss in depth the methodology used to explore the research question.

Chapter Three: Methodology

3.0 Introduction

This chapter discusses in depth the methodology used to explore the research question. The study's design, and methods of data collection and analysis are presented. The interpretivist epistemology underpinning this study is discussed and justified, and the ethical considerations of the study follow.

This chapter is presented in two sections due to the study's journey over four years. The planned study was an ethnography. Following a complex ethical review process, the study was further delayed due to the COVID-19 pandemic. Ultimately, the observational component of the study was abandoned due to the challenges posed by the pandemic. Therefore, this chapter will first outline the study's actual methodology and will then in the second section, discuss the planned ethnography and its logistical challenges.

Section One: Actual Study Methodology

3.1 Philosophical, theoretical, and conceptual underpinning

3.1.1 Epistemological and ontological underpinning

The debate surrounding the dichotomous representation of the natural and social sciences is well rehearsed; though its relevance to this study lies in attending to the epistemological and ontological underpinnings that guide and shape the design, conduct and analysis of this study. The study locates itself with an interpretivist epistemology.

Interpretivism recognises the social construction of individual 'reality' and co-construction of wider society by social actors (i.e., humans) (Hennink, Hutter and Bailey, 2011). Therefore, interpretivism seeks to access the 'inside' perspective of human experience by those who are experiencing it, located within their social, cultural, historical, and personal contexts (Hennink, Hutter and Bailey, 2011). Interpretivism questions the possibility of studying human behaviour and social phenomena outside of the context in which they are located and recognises that due to the subjectivity of humans, there can be multiple perspectives of 'reality' rather than one 'truth' as seen in positivism (Hennink, Hutter and Bailey, 2011).

Interpretivism's history is often linked to Dilthey and Weber's emphasis on the absence of objective reality and importance of Verstehen or 'interpretive understanding' (Hughes and Sharrock, 1997; Benton and Craib, 2001; Delanty and Strydom, 2003). The concept of Verstehen dictates that social phenomena are studied in their context, emphasising the importance and relevance of

studying within the 'nature of the situation' (Tucker, 1965). Verstehen has been described as a methodological tool (Tucker, 1965) that can be used to investigate social phenomena *'that does not distort the social world of those being studied,'* (Hughes and Sharrock, 1997, p. 101). Hence, the 'insider' perspective and understanding of phenomena from the viewpoint of those located within it is inherent to interpretivism (Hennink, Hutter and Bailey, 2011).

Interpretivism faces similar criticisms to those associated with qualitative research, such as proximity of the researcher to participants and the influence of the researcher (Sarantakos, 2005). Though these criticisms are essential to consider, they are also integral characteristics to the interpretive, qualitative tradition (Sarantakos, 2005; Holloway and Galvin, 2017). The social world is unordered, unpredictable, and impossible to objectify (Holloway and Galvin, 2017); therefore, methods are required to reflect this. Furthermore, the researcher is unavoidably a social being with internal subjectivity and hence, influence on the research process is inevitable. Interpretivism explicitly acknowledges both researcher and participant subjectivity and the co-construction of reality; recognising that the researcher's personal background will impact on data collection and analysis (Hennink, Hutter and Bailey, 2011).

There is no entirely unproblematic underpinning philosophy for research. However, the appropriate paradigm must be selected to address the research question adequately and appropriately. For this study, the day-to-day life of physiotherapists and the impact of the wider social and economic context, in this case austerity, was the subject of inquiry. The research question was concerned

with the experience of those located within the social context and how they experience, accommodate, and reconcile austerity in their daily work. Therefore, interpretivism was an appropriate underpinning for a study of this kind. Furthermore, semi-structured interviews, an approach commonly used in the interpretive tradition, allowed for the exploration of the physiotherapy profession and individual actors within their organisational, social, political, cultural, and personal contexts; something mandated in interpretive study.

3.1.2 The qualitative paradigm

This study aligns itself within the qualitative paradigm. Qualitative research aims to understand and attach meaning to concepts and social phenomena rather than quantify them (Green and Thorogood, 2018). The term qualitative research or inquiry is used to describe a broad range of data collection methods, such as ethnography (a methodology in itself), interviews, and focus groups. Such techniques aim to gain an understanding of the 'how and why,' rather than the often-numerical focus of the 'what and where' common to quantitative research. Furthermore, qualitative research provides opportunity to confirm, reconstruct or uncover theory, providing explanation of social behaviour not just at a local level, but on a broader scale (Green and Thorogood, 2018). With its foundations in naturalism (the observation of subjects of inquiry as they 'are' in natural settings), constructionism (the belief there is no objective reality; that reality is constructed by social actors) and interpretivism (emphasises the meaning and understanding humans attach to their actions or phenomena) (Sarantakos,

2005; Green and Thorogood, 2018), this approach is often used in social science research.

A common critique of qualitive research is its ability to provide valid, reliable, respectable and generalisable data. However, this stems from an objective emphasis and the positivist belief in a controlled research setting to prevent the introduction of bias. Furthermore, qualitative research has been critiqued for its supplementary ethical complications due to the proximity (both physically and emotionally) of the researcher to participants (Sarantakos, 2005). This underpins the criticism of the researcher acting as a 'tool' embedded in the study itself; and that they will thereby impose their own preconceptions, assumptions, and beliefs upon the data, limiting the objectivity of the findings (Sarantakos, 2005).

Whilst these criticisms are important to acknowledge, they derive from an objectivist, empiricist position. For example, the pursuit of objective and replicable methods and findings, are not compatible with the aims of qualitative inquiry (Sarantakos, 2005). Qualitative researchers acknowledge and accept that the researcher will have influence on the research as they too are a social being, interacting with social settings and constructing theory (Hennink, Hutter and Bailey, 2011; Holloway and Galvin, 2017). Therefore, strategies to promote quality in qualitative research should be woven throughout data collection; a continuous reflection of the self and impact on the research (termed reflexivity) is mandated (Hennink, Hutter and Bailey, 2011; Coffey, 1999; Lichterman, 2017). This, alongside being explicit in researcher positionality, is essential to the

reconciliation of ethical issues, the research design and analysis itself, and transparency in how they are dealt with.

3.1.3 Theoretical and conceptual lenses of analysis

Whilst a predominantly inductive approach to analysis was used (see section 3.2.4.1.1), the theoretical body of the sociology of professions literature, more specifically, the neo-Weberian approaches, were kept in mind during analysis. This body of work represents neo-Weberian concepts of behaviour and action to maintain and extend the ideology and values of professionalism (see chapter two: literature review), including exclusionary closure and pursuit of professional projects. These concepts can be observed in the context of exogenous constraints and/or limitations on practice, and/or perceived 'threats' to professionalism. Therefore, these concepts were kept in mind and used (where appropriate) in the sense-making of behaviours by participants in response to austerity and/or resource restriction in the continuation of professional work.

3.2 Study design

The study used semi-structured interviews and document analysis to explore the research question. Physiotherapists who were working in (or recently retired from) the NHS took part in the interviews. These participants were recruited via one research site and advertisements through clinical networks and social media. This section details the study design in more depth.

3.2.1 Study setting

Two potential research sites in total were approached to take part in the study. Both sites were acute NHS organisations. The first

site to be approached expressed interest in hearing more about the study. Unfortunately, attempts to make further contact with managers following this initial expression of interest were unsuccessful. Therefore, it was assumed this site was no longer interested in taking part. A second site was approached to take part and a meeting with the senior therapy management team was arranged, and the study was presented. This site agreed to participate, and two therapy managers volunteered themselves to act as clinical gatekeepers.

Due to difficulties with recruitment as a result of the COVID-19 pandemic, participant recruitment was expanded to persons outside of the research site as outlined in section 3.2.2. All interviews were carried out remotely via video call or by telephone to comply with social distancing and other measures implemented by the UK Government at the time of the interviews due to the COVID-19 pandemic.

3.2.2 Participants and recruitment strategy

Three participants were recruited via the research site, through emails forwarded via the clinical gatekeepers inviting them to take part in semi-structured interviews. Twenty-one participants were recruited via existing clinical networks, advertisements on social media and the Chartered Society of Physiotherapy (CSP) online network, and specialist interest groups' email distribution lists. The researcher contacted specialist interest groups of the CSP informing them of the study and some of these groups agreed to forward the invitation to participate in interviews out to their email distribution lists. The researcher's contact details were documented on this invitation and any interested parties were

invited to contact the researcher for more information. Once they had been provided with participant information sheets and consent forms, they were provided an opportunity to ask questions and written consent to take part was taken if they wished to proceed. Interviews were scheduled over the telephone and/or video call at a date and time convenient to the participants. More details on the 21 participants' demographics are presented in chapter five: qualitative interview analysis.

3.2.3 Data management

All data was managed in line with the Data Protection Act 2018. All audio data was transcribed verbatim by the researcher and a university approved transcriber. All study data was kept on a university server, using password protected systems. Only the researcher and members of the supervisory team had access to the data.

3.2.4 Data collection and analysis

The two forms of data collection, semi-structured interviews, and document analysis, and their forms of analysis are discussed in detail below.

3.2.4.1 Semi-structured interviews

Interviews are a common source of potentially in-depth data in qualitative research. Interviews range from formally structured (consisting of closed yes/no questions), semi-structured, to open/informal interview styles (Holloway and Galvin, 2017). Structured interviews are rarely used in qualitative research due to their restriction on participant responses; whereby semi-structured and open interviews are commonly used as their 'loose

structure' allows for informants to answer freely (Britten, 2006). Furthermore, these types of interviews facilitate proactive listening and a reactive response from the interviewer, framing further questioning based upon the informant's responses and use of their language (Britten, 2006). Consequently, interviews with different informants may differ in their sequence of questions and/or topics of discussion (Holloway and Galvin, 2017). Semi-structured interviews often use a topic guide or question prompts to ensure the interview remains focused on the subject of inquiry; though provides opportunity for informants to explore their thoughts and feelings freely (Holloway and Galvin, 2017). Hence, semi-structured interviews were selected as the most appropriate form of interviewing in this study.

A topic guide was developed, based on the aims and objectives of the research questions and were also theoretically and empirically informed. As the interviews went on, the topic guide was relied on less and less as I became familiar with the topics and became more confident in my interviewing style. It is important to note that not all questions were always asked, and additional questions were asked where appropriate, dependent on the course of the interview. This reflected a proactive listening style and ensuring the participant was listened to and questions reflected what was relevant to each participant; this was in keeping with the epistemological position adopted. The topic guide is presented in Table Three:

Theme	Example questions
Introductions	Introducing the researcher to participant/welcoming to the interview. Confirming consent and consent for audio recording of interview. Inviting any questions about the interview or consenting process.
Demographic information	What is your professional background? How long have you been a physiotherapist? How long have you worked in the NHS and in what capacity? What is your current banding/job title? What does your current job entail? What is your area of speciality?
What are physiotherapists understanding of austerity?	What does the term austerity mean to you? Has austerity been implemented in your workplace? How has it been implemented? Have you been asked to take part in cost saving initiatives? What does austerity look like? What is your perception of austerity?
What are physiotherapists experiences of austerity?	Have you ever had to change your role or decision making due to austerity? What decisions have you made recently that were influenced by austerity? Can you provide an example of where austerity changed your daily work or influenced your decision making? Are there any risks associated with austerity? Has austerity had any implications for your profession? Do you feel able to carry out your role? What impact does austerity have on you?
How are physiotherapists	Do you feel able to respond to austerity?

responding to austerity?	How do you respond? How have other healthcare professionals responded?
How do physiotherapists see the future of the profession?	What do you feel is the future of your profession in the NHS? What does your professional future look like?
Closing remarks	Thanking participant for their participation. Do you have anything further you would like to add/comment on that we have not yet covered?

Table Three: Interview Topic Guide with Example Questions

Due to the COVID-19 pandemic, all interviews were carried out remotely via telephone or video call to comply with recommended social-distancing and homeworking. Whilst the movement from face-to-face interviews to those carried out remotely was necessary, it also had the potential to impact upon the data collection.

Once a participant had agreed to participate and signed their consent form, they were offered either a telephone or video call interview, completely dependent on personal choice. Some participants had a clear preference and others suggested it was up to me. For those who reported having no preference, I would set up a video call interview to enable face to face contact. Depending on the method of interview, a telephone number or email address would be requested, and these were kept on a password protected system.

Due to personal preference, varying abilities to connect to the internet, or access to a computer with both audio and visual capabilities, a range of methods were used by participants to

complete their interviews. This included telephone, video call via Zoom or Microsoft Teams with audio only (often, the participant could see me, but I could not see them), and video call with both audio and video activated.

COVID-19 accelerated the use of alternative methods to collect research data, including the use of telephone, video calls and online applications (Saarijärvi and Bratt, 2021). The rapid digitalisation of healthcare during the COVID-19 facilitated this increased use (Saarijärvi and Bratt, 2021); arguably, this also meant access to such technologies improved and thus healthcare professionals could utilise these methods more easily.

The use of remotely accessed methods of data collection had necessary and obvious advantages in terms of ease of access and flexibility (Holloway and Galvin, 2017; Hanna and Mwale, 2017). Although telephone interviewing is an effective method of qualitative data collection, it does have the disadvantage of reduced visual cues and ability to read and respond to body language between the researcher and participant (Holloway and Galvin, 2017). Consequently, rapport and trust can be harder to build (Holloway and Galvin, 2017). Nonetheless, the option to have a telephone interview was preferable for some participants due to its flexibility and ability to book this in at a preferable time. For example, some participants reported preference for a telephone call after they had put their children to bed; one participant carried out their interview in the car during their day off running errands. One participant described a preference for a telephone interview to avoid having to make themselves 'presentable,' as the interview was carried out during their day off. The use of this method had potential to reduce the research

burden on participants, particularly during a highly stressful time working during COVID-19. Therefore, the telephone had clear convenience benefits for the participants taking part. Nonetheless, there was one interview where the ability to see each other face to face may have been beneficial. This interview was also the shortest, at around 35 minutes. My reflections on this interview and method are presented in this extract from my research journal:

'This was my shortest interview, and the most tiring. The participant sounded subdued, tired, and defeated. The interview was very low energy. I found myself trying to draw answers out of them. It was almost like they didn't want to do it, although they had consented and agreed… It may have just been they were tired and had a bad week, or perhaps was just their tone and speaking voice over the telephone- though this is entirely my perception based upon their voice only. I could not see their face or react to/observe body language. It is circumstances like this where I wonder whether the ability to do a face-to-face interview would have been beneficial,'[3] Research Journal Extract, June 2021.

Some who opted for a video call had no access to a video feed, but they could see me, so I was conscious to ensure I reacted as if I could see them. Despite the potential challenge to building rapport without visual reciprocity, the participant being able to see me did potentially assist in this. For example, one participant

[3] Had face to face interviewing been the only option, it is unlikely this participant would have taken part due to being geographically located far from the research site.

who was able to see me, but I was not able to see them described it as being *'wonderful to see your smiley face.'*

Video call interviews where both the researcher and participant can be seen are described as the most similar to face-to-face interviews and therefore have many of the same benefits of rapport building (Saarijärvi and Bratt, 2021). In these, I was able to observe and respond to body language and visual cues; furthermore, I was able to see gestures. For example, one participant used hand gestures throughout their interview, such as rubbing their fingers together to indicate money, rather than using the word. I was able to note these in my transcripts and provide context to their spoken (and missing) words.

The use of these alternative methods, although necessary and not planned, had many benefits. Hanna and Mwale (2017) suggest the use of remote methods of data collection can empower participants and enhance their sense of control over the situation. For example, being able to choose the time and location, often in their own home or workplace. This was evident in this study, where participants often chose to do the interview either after work or during their lunch break. This can improve the familiarity with the surroundings and potentially make participants feel more able to discuss freely (Hanna and Mwale, 2017). This seemed to be the case for the majority of the participants as they undertook their interviews whilst doing daily tasks or during breaks. For example, many reported getting a hot drink to enjoy whilst we chatted, or for one participant, grabbing an ice lolly as it was one of the hottest days of the year.

Conversely, some environments, such as the workplace, and sometimes the home, meant distractions were likely. Participants were advised to access somewhere private with little chance of disruption for their interview. Those who chose to do their interview at work mostly located a private space, but some informed me prior to the interview they may be disturbed by colleagues; however, this did not occur. Similarly, in the home setting, a small number of participants were interrupted by the door ringing, postpersons, and pets. Whilst this poses the potential for participants to lose their train of thought, these were dealt with situationally and where participants described losing what they were saying, I recapped on what they had just said, and this often rerouted the interview. Those who carried out the interview in the work setting may have felt unable to talk freely. This may have been the case for the participant described earlier in this section, as they took the call whilst at work and were sat in what sounded like a public area. They appeared to have instances where they lowered their voice, and this may have contributed to the difficulty I had perceived during the interview. Nonetheless, the participants were provided with the option of other modes of interview and asked for their preference for timing, location, and availability to prevent such circumstances.

A disadvantage of using remote methods is the reliance on the quality of connection and voice when communicating via technology. A small number of interviews had temporary disruptions in mobile or internet signal. When this occurred, I informed the participant of a disruption and asked to repeat their last statement. Any disruptions that did occur were short lived and no interviews had to be abandoned due to connectivity

issues. A small number of interviews were harder to transcribe due to poorer quality connections, quiet voices and/or accents. However, all interviews were able to be transcribed in an accurate manner; this small number of interviews required more time to transcribe them accurately. These methods also rely upon access to telephones/smart phones, software, internet, and computers. Whilst this was not reported as an issue for the participants in this study, it is certainly a consideration if researching persons with restricted access to such technology.

Despite some of the challenges of using remote methods of data collection, they were an essential method to facilitate the completion of the study. Whilst there were a small number of occasions where difficulties were encountered, they were overall an appropriate and effective method of data collection, particularly in light of the difficulties in continuing research during a pandemic.

3.2.4.1.1 Reflexive thematic analysis

The initial interview data analysis plan sought to analyse 'emerging' themes in an inductive analysis of pattern emergence; however, this method of analysis has the common pitfalls of thematic analysis described by Braun and Clarke (2019, 2021). This process would have implied that the themes were there to be found, lying in wait and already present in the data. Therefore, this to some extent blunts the impact and acknowledgement of the researcher's influence in the constructing of themes and the subjectivity of doing so. Upon educating myself further on the developments in thinking regarding thematic analysis, Braun and Clarke's conceptualisation

of reflexive thematic analysis was used as a basis for the analysis of this study. Whilst their seminal 2006 paper provided a recipe of thematic analysis, useful for the novice researcher, the authors suggest that this has led to undertheorised and/or attempts to introduce quantitatively and positivist-inspired methods of reliability, something at odds with the underpinning of qualitative research (Braun and Clarke, 2019, 2021). Therefore, Braun and Clarke (2019, 2021) outline their typology of three 'schools' of thematic analysis: coding reliability, codebook, and reflexive. Explanations of all three schools of thematic analysis as defined by Braun and Clarke, are described in depth elsewhere (Braun and Clarke, 2021) and therefore will only be briefly outlined here. A justification of why reflexive thematic analysis is an appropriate methodology for this study will be discussed.

Briefly, coding reliability approaches are described as those which attempt to 'bridge the divide' between quantitative and qualitative paradigms (Braun *et al.,* 2019; Braun and Clarke, 2021). These approaches, of post-positivist epistemology, seek to introduce methods of reliability-testing using a coding frame where several researchers independently categorise date and a level of agreement (using Cohen's kappa) is calculated (Braun *et al.,* 2019; Braun and Clarke, 2021). Themes are often domain or topic summaries, rather than a united meaning and/or central organising concept (Braun *et al.,* 2019; Braun and Clarke, 2021). For Braun and Clarke, coding reliability thematic analysis is problematic due to its echoes of a quantitative pursuit of reducing bias, something which conflicts with the depth, engagement, and subjectivity integral to qualitative research and how knowledge production is viewed (Braun *et al.,* 2021).

Codebook approaches are described as sitting between coding reliability and reflexive thematic analysis, where a structured approach to coding, predetermined or early theme development is used, but not for reliability-ascertaining purposes (Braun and Clarke, 2021). The use of codebooks tends to offer a *'pragmatic compromise of some qualitative research values,'* (Braun and Clarke, 2021, p5).

Reflexive thematic analysis emphasises the role of the researcher, their subjectivity, and their active role in theme generation and data analysis (Braun and Clarke, 2021). In reflexive thematic analysis, the researcher is a resource and tool; subjectivity is not viewed as a problem to be managed, or congruent with the introduction of bias (Braun and Clarke, 2021). Hence, this approach is distinct from some other approaches to thematic analysis (e.g., coding reliability thematic analysis) and therefore, explicit statement of which school of thematic analysis one is ascribing to is imperative, as this can be in conflict with the stated epistemological and ontological underpinning. Braun and Clarke (2020) suggest this is a common issue in published thematic analysis. They suggest researcher bias is simply incompatible with reflexive thematic analysis as *'knowledge generation is inherently subjective and situated,'* (Braun and Clarke, 2021, p6). Reflexive thematic analysis was a complementary and appropriate process of analysis for this study, which locates itself within an interpretive epistemology.

A common critique of many published accounts of thematic analysis is the assumption that this approach is atheoretical, or the underpinning theoretical assumptions are not attended to (Braun and Clarke, 2019; Braun *et al.,* 2019). Therefore, it is

important to explicitly identify underlying theoretical assumptions to situate the analysis upon certain theoretical continua (Bryne, 2021). For example, essentialist versus constructivist epistemologies, inductive and deductive analysis, and semantic versus latent coding (Braun and Clarke, 2019; Braun *et al.,* 2019; Byrne, 2021).

My research questions were based upon an interpretivist epistemology. I wanted to find out how physiotherapists perceived and experienced austerity, and the impact this had on their daily professional work, for example, how they structured their work and their decision making. I wished to reflect the experiences of the physiotherapists interviewed, whilst also acknowledging my own positionality and inevitable influence in my generation of themes. Therefore, reflexive thematic analysis was an appropriate approach, as it both acknowledges the subjectivity of the researcher and the accounts of the participants.

Braun *et al.* (2019) describe inductive analysis as coming from the 'bottom up,' that is, beginning the analysis from the data and not instilling ideas from pre-existing theory onto the analysis (Braun *et al.,* 2019, p.853). Deductive analysis is where the researcher approaches data analysis with theory and/or concepts, and even codes, which are then applied to or explored in the data (Braun *et al.,* 2019, p.853). Although commonly presented as dichotomous, analysis can be both inductive and deductive, and commonly both are present in reflexive thematic analysis (Braun and Clarke, 2019). Both inductive and deductive analysis were carried out in this study. Whilst the analysis was predominantly inductive, the theoretical lens of analysis of

contemporary approaches to the sociology of the professions, such as exclusionary closure and methods to protect or expand professional boundaries when faced with external constraints to professional work, were used (where appropriate). This was to ensure theme development was relevant to the research questions, and where examples of such behaviours were interpreted.

An important part of reflexive thematic analysis is to identify whether semantic or latent coding were used. Semantic coding relates to 'surface' data and explicit references to subject matter, whereas latent coding focuses on implicit and deeper meaning (Braun *et al.,* 2019). Much like the presentation of a dichotomous continuum of inductive versus deductive, both semantic and latent coding can be used congruently (Braun and Clarke, 2019; Byrne, 2021). In this study, both semantic and latent coding were used. Semantic codes were used when describing specific events, such as the COVID-19 pandemic, and more so during the familiarisation stages of initial data analysis. Latent codes were used as I became more familiar with the data and as I began to recognise patterns across the dataset.

Process of Analysis

Braun and Clarke's inaugural 2006 paper outlined six phases of thematic analysis (Braun and Clarke, 2006). Whilst this could be interpreted as a linear process, it is a recursive and iterative process, with overlaps and repeated revisiting of previous stages throughout the process of analysis (Braun and Clarke, 2019; Braun *et al.,* 2019). The six-phases outlined are not intended to be followed rigidly but are provided as a guide to enable the

researcher to develop one's own craft of qualitative analysis (Braun and Clarke, 2020). This was reflective of the process of analysis used in this study. I repeatedly revisited previous steps and although presented here as separate sub-sections, they were not treated in isolation or as part of a linear process; rather, the discussion of each stage is presented to demonstrate my understanding of this type of analysis. As part of this process, I reviewed my research journal entries at each stage, which are presented throughout the chapter where they offer context and my thought processes behind research decisions.

Familiarisation

To familiarise myself with the data, I began with transcribing. I transcribed the majority of the transcripts either manually or by using a university developed automated transcription service. A small proportion of audio recordings were transcribed by a university recommended transcriber, due to time pressures. For those interviews whose initial transcripts were transcribed by the professional transcriber and/or the automated service, I listened to the audio and manually checked and corrected any mistakes or terminology which was documented as inaudible, but which were specific to the healthcare and/or the physiotherapy profession. Due to my experience and background as a physiotherapist and time working in healthcare, I was able to correct these incidences. This provided greater insight into the contextual location of what the participants were discussing, for example, health conditions and pieces of equipment specific to the physiotherapy profession. I made note of any gestures observed during video calls within the transcript; any use of filler words such as 'um,' 'err,' and 'ah,' were also documented to

ensure the context of the participants' statements were maintained as much as possible. Additionally, any coughs, laughs, emphases on words and/or inflection used to emphasise words were also noted within the transcripts.

Once transcription was complete, I repeatedly read and re-read the transcripts. I also repeatedly listened to the audio recordings, both without reading the transcripts and simultaneously reading them. During the first few reads of the transcripts, I made little notes as I wished to focus on actively reading them. Once I had read all the transcripts at least once, I began to note initial thoughts, feelings and questions that came to mind on the transcripts. It was also at this stage that I used NVivo software to highlight sections and annotate the transcripts electronically. I did this for the majority of transcripts. However, I began to feel as if I could not get close enough to the data through a screen. I felt more able to engage with the data when being able to write directly on the transcript and have several transcripts in front of me at once. Therefore, whilst I continued to use NVivo when generating initial codes (see next section), I returned to manually annotating the transcripts with my thoughts and feelings as I read and listened.

Generating initial codes

This phase of analysis is a more focussed engagement with the data, where sections or 'chunks' of data are organised around a similar meaning (Braun *et al.,* 2019). As mentioned earlier, my preliminary codes, potentially reflective of my novice researcher status, were predominantly semantic and descriptive, highlighting particular issues and responses to questions. This

was arguably a poor example of coding, as they lacked context. For example, codes based on named resource challenges, such as 'equipment,' and 'staff,' all encompassed under a 'practical implications of austerity' code. Whilst arguably lacking context, some semantic codes were necessary to identify what the practical impact of austerity was for physiotherapists, and thus, built context for more latent, underlying, shared meaning.

As coding went on, I used more latent codes. For example, simple and short, semantic codes which reflected methods to respond to austerity, were re-coded under 'behaviours to attempt to circumvent austerity.' This was sub-coded under 'personal and professional reconciliation of austerity.' This eventually formed basis for the theme power, hierarchy, and professional work as a profession allied to medicine.

Constructing themes

Theme construction is an ongoing active process which utilises the coding stages to develop a theme- something that *'captures a meaningful pattern across the dataset'* (Braun *et al.,* 2019, p.855). At early stages, these can represent preliminary or 'candidate' themes, which may or may not be present and/or redeveloped in the final report (Braun *et al.,* 2019).

Using the example in the generating initial codes section, a cluster of codes were gathered under 'behaviours to attempt to circumvent austerity.' I then felt this could be presented under an overarching theme, that of personal and professional reconciliation of austerity, which encompassed several different actions and behaviours that I had interpreted from the participants' accounts. This theme underwent further

development when revising and defining themes as discussed in the following section.

Revising and defining themes

This section has merged the phases of reviewing themes and defining/naming themes, as this was wholly done simultaneously. To help with the process of theme construction and review, I wrote brief summaries of what the theme meant. This helped me to process whether they were representative of my earlier codes and attempt to reconcile whether there was a central organising concept to my initial themes. Alongside this, early theme mind maps were used to help me to visualise the links between the themes. This assisted in ensuring the themes tell an overall story about the data (Braun *et al.,* 2019). During this process, I began to feel that my theme of personal and professional reconciliation of austerity, lacked context and a central organising concept. I began to brainstorm ideas about what these actions represented. I felt that power had a large influence on these personal and professional behaviours to reconcile austerity. Furthermore, I used the theoretical lens of the neo-Weberian sociology of professions literature and its concepts (see section 3.1.3) to make sense of the data. In doing this, I interpreted these methods of personal and professional response to austerity as the use of power dynamics, hierarchy, and imbalances in such. Furthermore, I interpreted attempts to protect boundaries as an extension and operationalisation of some of the theoretical behaviours outlined in the sociology of professions literature. This theme thus became reflected in the more developed and conceptual themes as presented in chapter 5, section 5.3 and 5.4.

Some themes remained semantic and potentially perceivably less conceptual. For example, themes which provided background information to the lived experience of austerity in practice, as viewed by physiotherapists working in the NHS in the UK. However, this theme was essential to provide contextual information for exploration of more latent themes.

Producing the report

Whilst this is treated as the final stage, the production of the report is not simply a writing exercise of finality (Braun *et al.,* 2019). Contrastingly, Braun *et al.* (2019) suggest this is commonly a test of how well the themes 'work.' I certainly found this to be the case and much of the constructing themes, revising themes, and defining/naming themes were performed during an initial write up of the analysis. I used this as 'exposure therapy,' whereby it assisted me to not only attempt to write about the themes I had constructed but view them as part of an overall story of the data.

It was during this first version of writing up that I felt some themes were underdeveloped and thus, the writing up initiated a further exploration of central organising concepts and theme development.

3.2.4.2 Document analysis

In addition to interview data, this study analyses relevant documents using a critically informed interpretive discourse analysis. Using insight from Critical Discourse Analysis (largely developed by Fairclough [2010], van Dijk, [1993] and Wodak [see Wodak and Meyer, 2001]), this analysis sought to provide contextual backdrop to the work of the physiotherapy profession

in the contemporary NHS specifically in relation to austerity, resources, and finances.

The analysis is critical in the sense that it sought to attend to matters of power and dominance, and the role of discourse in the reproduction of dominance and hegemony (van Dijk, 1993). In this case, the analysis demonstrates how state reproduces concepts compatible with neoliberalist ideology at micro, meso, and macro levels of society, using the discourse and ideology of professionalism to extend the neoliberal agenda.

It could be argued that use of critically informed discourse analysis could conflict with the interpretivist epistemological underpinning to this study, particularly in light of the heavily interpretivist-embedded approach of reflexive thematic analysis used to analyse the interview data (see section 3.2.4.1). Indeed, one of Braun and Clarke's examples of poor thematic analysis is an under-theorisation or 'mashup' of incompatible techniques (Braun and Clarke, 2019, p.589). However, they seem to refer to the use of attempts to merge approaches to general qualitative data and not specifically to use of methods in addition to interviews for example. Nonetheless, it is imperative that any concerns regarding incompatible or potentially contrasting paradigms are attended to and made explicit.

Whilst Fairclough (2010) describes their iteration of Critical Discourse Analysis as relativist and critical realist, van Dijk (1993, p.279) suggests there are *'many ways to do 'critical' discourse analysis'* and that *'paradigms, philosophies, theories and methods may differ.'* They suggest that in order to avoid paradigm controversies, critical discourse analysis should follow

an issue-oriented and multidisciplinary approach (van Dijk, 1993, p.279).

Heracleous (2004) categorises critical discourse analysis (and the writings of Fairclough, van Dijk and Wodak) as an interpretivist approach. Heracleous' understanding of critical discourse analysis as interpretivist, lies in its ascription to a constructivist ontology, in that social reality is constructed and discourse has a role in this (Heracleous, 2004). Furthermore, critical discourse analysis recognises that this role is not 'neutral' or without influence (Heracleous, 2004). This reflects the process of analysis itself; van Dijk (1993) suggests a position is to be taken in critical discourse analysis, which is compatible with interpretivism. Thus, this too is compatible with the reflexive thematic analysis approach used in the analysis of the interview data in this study.

As an interpretivist with an awareness of power and agency, the critical approach offered me an opportunity to attend to issues of power and dominance in the context of austerity and professional work by a traditionally 'subordinate'[4] or allied profession, using an interpretivist analytical framework.

3.2.4.2.1 Method of document analysis

The critically informed interpretive discourse analysis was completed remotely, accessing publicly available documentation from a range of institutions. This included government, national

[4] In using the term subordinate, the intention is not to imply my own perception of the profession as subordinate to medicine, but to reflect the historical use of the term to describe those professions who worked in conjunction with medicine and were implicitly implicated within a hierarchy and situated below the medical profession. The term allied is now used more widely to describe such professions; of which, physiotherapy is part of.

bodies (such as NHS England), independent bodies and think tanks (such as the King's Fund, The Nuffield Trust, Centre for Workforce Intelligence, The Health Foundation), and the UK physiotherapy professional association, the Chartered Society of Physiotherapy (CSP).

Documents published following the 2008 financial crisis were collected and included for analysis if they referred to austerity, financial hardship, methods to recover financial deficit (such as cost efficiency savings, productivity, or references to value), the allied health professions or the physiotherapy profession and/or workforce. Documents were retrieved from both academic and online search engines, government archives, the websites of relevant national bodies and the CSP website. Any reference to relevant documentation within already gathered literature was used to signpost to other data. The documents were read repeatedly, noting both implicit and explicit references to the subject of inquiry, to construct key themes from the texts.

3.3 Ethics

The ethical review of research studies by institutional boards to judge their quality and integrity has become a preordained part of the research process (Birch et al., 2012). The stipulation that such scrutiny occur followed the abominable experiments during World War Two, prompting the development of the Nuremberg code 1947 and onto the Declaration of Helsinki (World Medical Association, 2018) and the Belmont Report 1979 (Hammersley and Traianou, 2012). These codes of ethical practice and the institutional codes subsequently published by associations, universities, and organisations alike, focus on the protection of

research subjects and responsibility of the researcher to their participants (Green and Thorogood, 2018). Ethical codes of practice are generally based upon the concepts of autonomy (respecting rights and wishes of the individual), nonmaleficence (doing no harm), beneficence (doing good) and justice (fair representation of findings and research design) (Hennink, Hutter and Bailey, 2011; Green and Thorogood, 2018). To support these concepts anonymity, privacy, confidentiality, self-determination, respect, and trust towards participants is mandated (Ryen, 2004; Hennink, Hutter and Bailey, 2011; Birch *et al.,* 2012; Hammersley and Traianou, 2012; Green and Thorogood, 2018).

Whilst all these concepts should be thoroughly considered in all research studies for the protection of participants, the applicability of the ethical criteria often used to judge quality and rigour to qualitative research is increasingly questioned (Birch *et al.,* 2012). It is in no way argued that qualitative research cannot be ethical, but that due to the nature and design of qualitative research, ethical dilemmas are often not dichotomous with clear definitions between 'right' and 'wrong' (Birch *et al.,* 2012; Green and Thorogood, 2018). This is due to the often unstructured, emergent, and fluid character of qualitative research which cannot always be reconciled with standard ethical guidelines (Birch et al., 2012; Hammersley and Traianou, 2012).

Consequently, authors have called for a contextual and situational approach to resolving ethical issues in qualitative research (Goodwin *et al.,* 2003; Hennink, Hutter and Bailey, 2011; Birch *et al.,* 2012; Hammersley and Traianou, 2012; Green and Thorogood, 2018); as not all ethical dilemmas can be

predicted and are often resolved 'in the field' (Goodwin *et al.,* 2003).

This section will outline the ethical considerations for the actual study methodology. The ethical issues arising as part of the study's planned ethnography are discussed in section two of this chapter.

3.3.1 Ethical approval

The study was granted approval by NHS REC and HRA (reference 19/EM/0321). A substantial amendment to expand the recruitment strategy beyond the research site during the COVID-19 pandemic was approved by the NHS REC and HRA in October 2020 (reference Substantial Amendment 01).

3.3.2 Autonomy

Autonomy (respecting rights and wishes of the individual) was ensured throughout the study. Written consent was obtained prior to any interviews with participants took place. Participants were provided with information about the study, including its aims, and were invited to ask any questions prior to obtaining consent. This was to ensure their consent was informed.

Participants could choose their method of interview (telephone or video call) and the date, time, and location of their interview. All participants' wishes regarding this were respected. Participants were informed before the interview that they could request to stop the interview at any time should they wish. No participants requested this, except for temporary disruptions, such as answering the door.

3.3.3 Non-maleficence and beneficence

Non-maleficence (doing no harm) and beneficence (doing good) were strived for throughout the study. There were few anticipated issues surrounding non-maleficence, though there was potential for participants to recall difficult working conditions, and therefore become distressed. Some participants recalled distressing situations in their interviews, such as caring for critically ill patients, working during COVID-19, difficult working conditions, workplace bullying and harassment, and mental health difficulties.

Where participants described stress, reported struggling or disclosed mental health difficulties, participants were offered signposting to various support services, including clinician-specific mental health support services. All but one participant who disclosed mental health difficulties, stress and/or struggling with some of their experiences, declined signposting to support services, reporting they had support networks already in place. One participant requested signposting so they too could signpost to colleagues who may need support. An email detailing support services and their contact information was sent to this participant at their requested email address.

Not only should non-maleficence be embedded into the treatment of research participants, but it should also be considered for the research team. Support networks for those carrying out the research are essential to ensure no harm is done to those researching, as subject matter can contain distressing content. In this study, supervisory support was available where needed when this occurred (see section 3.3.6 for an example of such).

There was no significant benefit for participants who took part or to 'do good' (beneficence). This was made clear in the participant information sheet which stated:

> *'What are the possible benefits of taking part?*
>
> *We cannot promise the study will help you but the information we get from this study may help understand how different health care professions work and how they respond to the challenges they face in their day to day working life,'* Participant Information Sheet, Final Version 3.0, p.2.

3.3.4 Justice

Justice (fair representation of findings and research design) represents equity and distributive justice (Green and Thorogood, 2018) in the treatment of participants and throughout the research process, from study design to dissemination. In this study, all potential participants were offered the same opportunity to participate as others. Furthermore, the study design and aims were presented transparently in the participant information sheet. For example, one method to operationalise justice was to ensure benefit of taking part was not overemphasised. The statement outlined in section 3.3.3 (non-maleficence and beneficence) made clear that there would be no particular benefit to taking part, but participation would provide the research team with an understanding of the challenges that this healthcare profession face.

Transparent representation of the study is also important to ensure participants are not exploited. For example, careful planning of how the researcher would identify themselves and engage with the participants is needed, to avoid covert research

methods which could be problematic for this concept of justice (Hennink, Hutter and Bailey, 2011). I was explicit in my identity and research aims, describing myself as a PhD student and physiotherapist (see section 3.3.5) and presenting the aims of the research, requirement from participants and publication plans from the outset.

Participants were not offered any incentive to take part, and this was stated in the participant information sheet. The method of recruitment (see 3.2.2) relied upon email distribution lists, social media, and membership of CSP specialist interest groups. Therefore, it is important to note that this may have introduced an element of inequity into the recruitment process, as these methods rely on access to computers, mobile phones, and/or the internet and CSP membership.

3.3.5 Dual role and the insider/outsider perspective

In healthcare research it is common for the researcher to have a clinical background as a healthcare professional (Holloway and Galvin, 2017); their research question and interest spurred by 'intellectual curiosity' of a practical issue experienced in their working practice (Lofland *et al.,* 2006). Indeed, this was certainly the case for this study.

I am a female in my early 30s who is a registered physiotherapist. I qualified as a physiotherapist in my early 20s and have worked in numerous clinical roles in the NHS and in a broad range of specialities, in both community and acute settings. Throughout the design and operationalisation of this study, I made the decision to make explicit my background as a physiotherapist. This was acknowledged in the protocol, ethics

applications, participant information sheets, and all other documentation relevant to the study. It was a conscious decision to introduce myself as both a PhD student and physiotherapist when inviting potential participants to take part, such as in email invitations and study advertisements. The explicit disclosure that I was a physiotherapist, provided an instant location of myself as an insider, as 'one of you.' Stating that I was a physiotherapist, provided an opportunity for shared understanding, terminology, education, and background. I had hoped that this would help to build rapport with my participants and assist in the uptake of participants to take part.

My shared experience with participants reflects an insider perspective, and I was explicit in my acknowledgement and hope that this would help to build rapport and relationships with participants. The contrasting position is that of 'outsider' where one's characteristics of background is differing to those of the participants (Holloway and Galvin, 2017). Davies (1973) uses the analogy of the outsider as 'Martian' and insider as 'convert' whilst emphasising the need for one to ascribe both roles throughout the research.

Arguably, there are distinct advantages and disadvantages to each perspective, or as Merton (1972, p.33) suggests assets and liabilities. These can infer significant ethical considerations, for example, being a physiotherapist researching other physiotherapists. Occupying an insider perspective can provide easier access to a setting, mutual respect, and improved rapport with participants due to a shared understanding (Hockey, 1993). Furthermore, an understanding of discreet or tacit practises and language may be beneficial; however, this could also solicit a

myopic focus, and these 'regular' or accepted events go unnoticed or unchallenged (Mercer, 2007).

Nonetheless, insider status or group membership does not automatically provide benefits or access to a group and vice versa (Corbin Dwyer and Buckle, 2009); though in healthcare research, having *'access to specialist and esoteric language is an important marker of group boundaries'* (Allen, 2004, p.20). The outsider can experience greater issues obtaining access and building rapport, though may be better placed to observe 'taken for granted' actions (Asselin, 2003). Asselin (2003) calls for insider researchers to move towards outsider status in order to research with 'eyes open.' Lofland *et al.* (2006) suggests the countervailing 'pull' between insider and outsider is a form of 'productive tension' which is inevitable; the insider status providing benefits to access and rapport building and the outsider providing distance to be able to theoretically analyse (Davies, 1973). Despite its discussion as two dichotomous entities, it is widely suggested that realistically, researchers will constantly move between insider and outsider, which occupies two ends of a continuum (Mercer, 2007; Corbin Dwyer and Buckle, 2009).

I had experiences of being co-located as an insider and an outsider. Having 'insider' characteristics, for example, identifying myself as a physiotherapist, had little benefit in identifying and recruiting the initial research site. The initial research site had expressed interest in hearing about the study, but follow up contact, including emails and telephone calls, were met with no response. Eventually, the pursuit of recruitment of this site had to be abandoned due to time constraints. However, occupying insider status with an alternative research site proved beneficial,

as I had previous contact with this site in another capacity and was able to arrange a meeting with senior management staff, who then agreed to participate.

Furthermore, I had experience of being co-located as an insider and an outsider in relation to power dynamics and perceived hierarchy by those whom I was interviewing. Although locating myself as an insider/member of the profession from the outset, there were changes in power dynamics and how I was perceived dependent on whom I was speaking too. For example, I experienced differing rapport and relationship building dependent on my perceived age and level of experience. For those who were newly qualified or had similar length of experience working in the NHS, participants commonly referred to my experience. For example, phrases such as *'as I am sure you know,'* and *'as you will have experienced,'* were commonly used by those who seemingly perceived me as more of an equal in terms of age or experience. Contrastingly, some who were much older than me and had been working in the NHS for much longer periods, referred to how they perceived my age or experience. I did not disclose my age or length of experience to participants unless asked. There was one participant in particular where these dynamics were observable. My reflections on this are presented in this extract from my research journal:

'They were a highly specialist and respected physiotherapist at a high-profile hospital. I was apprehensive going into this interview as I had a lot of respect for this person and their knowledge base. In some respects, for this reason, I found it slightly harder to control the interview or bring them back to topic. However, although it felt uncontrolled and tangential during the interview

itself, upon reviewing the transcript, it was hugely relevant and informative. However, you could tell there were parts where there were assumptions made about me by the participant; for example, they repeatedly used phrases such as 'you're too young to remember' and 'you seem very young to me.' There were often interruptions of my questions, perhaps from an eagerness to answer the questions or the participant's communication style, either way, this could represent an implicit acknowledgement of power and thus, assumptions about my age, professional history, and experience,' Research Journal Extract, May 2021.

This extract reflects how assumptions can be made on both the part of the researcher and participant, and this can affect the interview journey. Interestingly, this interview took place over the telephone, and I had no prior face-to-face or virtual contact with the participant. Therefore, they made a judgement on my work experience and age based upon my voice and email communication.

As I carried out interviews with participants of varied banding[5] and length of time working in the NHS, I noticed an internalisation of hierarchy within myself. Before interviews with participants who were of significantly higher banding than myself, or were in positions of seniority, I found myself feeling more apprehensive about the interview and how I represented myself. Having worked as a band five and six during my time in the NHS,

[5] NHS salary bands range from band 2-9. Band 8 also includes subdivisions (8a, 8b, 8c and 8d). Band 5s are considered to be junior physiotherapists and include newly-qualified members of staff. Band 6 and above are considered senior roles. Therapy assistants and support workers typically work between bands 2 and 4.

I felt often junior to those whom I was interviewing. Reflecting upon my clinical time in the NHS, I did often feel hierarchy within the profession, commonly associated with what banding you were. Although I attempted to acknowledge and curb my intimidation from very senior members of staff, this could have affected my ability to guide the interview and bring participants back to topic. However, this feeling was also dependent on the individual themselves. All participants were hugely helpful and engaging; though there were some interviews where I felt the inferior presence, which may have been based on the participant's perception of my place within the professional hierarchy. Having said this, this was not always the case and some who could be considered professional elites did not instil this feeling of hierarchy in me. Furthermore, this acknowledgment of my internalised perception of hierarchy, could have been useful when interviewing those who I had considered to be on equal footing, such as those who were working at similar levels to where I had. These interviews certainly felt more free-flowing and the power dynamics felt more equal; reflected in the participant's perceived acknowledgement of my level of experience as described in this section.

3.3.5.1 Being a researcher and a clinician in COVID-19

Perhaps the most powerful representation of the dual-role of researcher-clinician and the conflicts that can occur as both, was my time working clinically during COVID-19 whilst simultaneously attempting to complete my PhD study. At the time of the onset of COVID-19 in the UK, I was in the midst of navigating a complex ethical review process (as discussed in section two of this chapter: 3.1). As a registered healthcare professional, I felt a

responsibility to return to clinical practice to help with the efforts to manage COVID-19. I joined an NHS Trust as a bank physiotherapist and began working part time alongside my PhD studies.

Interestingly, I found that I thought carefully about how I represented myself to my new colleagues, reflected in this extract from my research journal:

'I have found myself explaining that I am at university full time, rather than stating at the outset that I am doing a PhD… I feel I do not want to label myself as 'other' and be perceived as less than a clinician. I think this comes from my previous experience of reactions from clinicians about my education in the past. There is somewhat a stigma of clinicians interested in research or studying. Whilst studying for my Masters, I had colleagues describe my studying as a 'cop out,' time off, saying I probably sleep all day, I just don't want to work, that clinicians who 'can't hack' working in the 'real' world work in research, or that clinicians who go into research/academia think they are better than those who work clinically,' Research Journal Extract, April 2020.

However, this was not the reaction I had from my new colleagues; their reaction was quite the opposite. When asked about what I was studying and I informed them of the PhD, the reaction was very positive; my colleagues were interested in the subject matter and often described it as topical and relevant. I noted in my journal how one colleague reported they would be interested in how the concept of austerity would be linked to the lacking Personal Protective Equipment provision and problems in

supply chains that the hospital had experienced since the onset of COVID.

Being a researcher and a clinician during COVID-19 prompted me to reflect on my previous experiences as both insider (clinician) and outsider (researcher), and how this had the potential to impact my findings. Moreover, it prompted me to recognise my dual role and constant occupation of both insider and outsider perspectives throughout my research study and clinical work.

3.3.5.2 Shared experiences with participants

Another observation I made during my dual role as clinician-researcher, made me think about my study in a wider context. As I worked on the wards during COVID-19, new phrases began to emerge on the frontline as the cash injection from the government started to be felt. There was six weeks of free social care for those being discharged home who needed some extra support, which came out the 'COVID-fund' or what some others referred to as 'the bank of Boris.' As I noted in my research journal, discussions with family members surrounding the funding of COVID-19 in both my personal and professional life, had references to the 'finding of Theresa May's magic money tree'[6]. This influx of funding created conflicting feelings for me and my colleagues on the frontline:

'The injection of cash and write off of millions of pounds worth of debt has undoubtably been necessary and lifesaving. Though it

[6] 'There is no magic money tree' was a term Theresa May used when responding to a nurse's question regarding the lack of inflation in their pay check compared to their wages in 2009, on BBC Question Time (The Independent, 2017).

has left me and colleagues asking, "why hasn't the NHS received this funding and support previously, if it had been there?"'
Research Journal Extract, May 2020.

This appeared to be a common feeling to the participants interviewed as presented in chapter five: qualitative interview analysis.

Furthermore, the experiences of those whom I interviewed initiated a cascade of reflection upon the entirety of my career. I realised that much of my own experience as a junior physiotherapist was reflected in the junior physiotherapists own working lives. For example, being 'thrown in at the deep end' and constantly attempting to juggle a caseload and continuing development. There was one participant's statement that particularly struck me and triggered a re-evaluation of my experience. This (senior and long-serving) participant described how the pressures of their work, competing priorities, lacking resources, and growing complexity *'eats away at your professional confidence.'* My reflection on shared experience is presented in this research journal extract:

'A great deal of self-realisation of my own experiences came to light during data collection and analysis, where I found participants articulated situations that I had been in myself, in a way that I could not articulate myself. I found myself saying internally 'Yes! That's exactly how I felt, that's exactly how it feels.' I reflected upon how I had perceived my entire career. Where I had internalised limitations on my practice as my own personal failure, I came to recognise as lacking resources, time, and supervision… The result of this, was just doing the best you

*can with what you had, which also chipped away at **my** professional confidence too… I felt my experience to be validated, though it is no way the participant's job to validate or reassure me of my own insecurities, I did feel reassured that had not just happened to me,'* Research Journal Extract, October 2021.

3.3.5.3 Reflecting on reflecting

Prior to my final years of PhD study, when asked about my motivations for researching austerity and its impact on physiotherapy work, I would have explained how I carried out a survey into a particular treatment modality and how a lack of resources was commonly cited as a reason as to why this NICE recommended intervention was not used (Tucker, Moffatt, and Drummond, 2017). Whilst this is entirely true, my journey over the 3-4 years of PhD research, returning to clinical practice during COVID-19, and a growth in research and personal confidence also uncovered professionally and personally rooted reasons for researching austerity and resources.

As I came to realise that I had experienced austerity and lacking resources myself, on a daily basis, I was apprehensive that this would be perceived as adding an element of personal 'bias' into my research. As I grew in understanding and confidence, I came to recognise the importance of transparency and depth in acknowledging my own experiences and how these would shape my research outputs. Furthermore, the concept of bias and the pursuit of an objective research environment is rooted in the positivist, quantitative paradigm, of which, this research is not. Nonetheless, attending to my subjectivity initially felt uncomfortable and difficult, which I feel is rooted in my

biomedical, health sciences, and quantitatively based education as a healthcare professional.

As discussed previously, reflexive thematic analysis places researcher subjectivity at the centre and requires making one's position explicit; in fact, Braun and Clarke (2020) describe this as essential for successful reflexive thematic analysis. Furthermore, they refer to Elliot *et al.* (1999) and their recommendation to 'own' your perspective, i.e., outlining one's values, assumptions, and experiences to make clear one's understanding of phenomena and thus interpretation of data. Thus, the presentation of reflexivity and disclosure of my own perspectives contributes to the quality and clarity of analysis in this study.

3.3.6 Researching austerity

A methodological and ethical issue that was anticipated in the planning of this study was the act of researching austerity itself. This concern was rooted in the potential ethical and personal conflict in researching austere healthcare settings whilst being a qualified healthcare professional. There is little guidance for the early career researcher on researching the concept of austerity. Whilst there are a wide range of studies into austerity and its implications for health, education, policing and housing to name a few, there is little published methodological literature pertaining to researching austerity.

The literature that does exist suggests the act of researching austerity amplifies and adds another 'layer' to the usual ethical and emotional difficulties common to ethnographic research (Hall, 2017). Hall (2017) discusses the concerns and dilemmas faced whilst researching the impact of austerity on the personal

lives of a group of families; outlining the issues that arose during the design and research process, such as whether to compensate participants. Whilst it is not possible to fully predict the methodological and ethical issues of researching austerity, it is anticipated that the researcher may experience a form of 'moral distress' whereby one is limited to what they can do as a result of exogenous constraints (Jameton, 1984; Morley, Ives and Bradbury-Jones, 2019). It was anticipated that this in some ways, may be shared with participants who may be limited in their fulfilment of professional responsibilities as a result of insufficient resources and austerity (Tucker, 2017; Morley, Ives and Bradbury-Jones, 2019). Furthermore, this could have caused individuals to reflect on their personal experiences of austerity, not just their professional experience.

In the initial ethnographic design of the study, it was anticipated that I may have experienced significant discomfort in being present in an environment where resources (including staff) were limited, and I, as a qualified physiotherapist would have been competent to assist staff to address shortages. None of the anticipated issues in researching austerity arose during the study due to the abandonment of the observational component. However, the interviews demonstrated the importance and utility in researching the concept of austerity. Furthermore, this study has the potential to contribute to the paucity of literature surrounding methodological considerations when researching the concept of austerity.

Despite having not completed the observational component, I did experience discomfort and forms of moral distress during the interviews. The interviews certainly drove my passion for

highlighting the experiences of physiotherapists working in an era of austerity. Several issues and experiences were raised (as discussed in more depth in chapter five), which caused feelings of discomfort, unease, distress, and shock. This was not something I had anticipated to the extent to which it was experienced. For example, participants described bullying, harassment, poor mental health, ethical quandaries, and injustice and inequality in service provision. Although not experienced first-hand in an observational capacity, there were several raw accounts of upsetting real-life experience described in detail. This highlighted the importance of having access to a supervisory team with expertise in both dealing with practical and ethical considerations, and in pastoral support in processing the accounts relayed. The extract from my research journal following a particularly emotional interview and debrief with my supervisors reflects the depth of feelings provoked:

'The anger and injustice I feel hearing these examples… I feel angry that voices are not being listened too. I feel angry that the persons who often have no voice are most affected... I was shocked and mortified to learn of the threats (though implicit) to those who attempted to raise concerns and whistle blow,'

Research Journal Extract, April 2021.

Furthermore, something which I had not anticipated, at least to the extent in which I felt it, was the responsibility I felt. I needed to seek expertise from my supervisory team regarding whether I had any practical responsibilities for reporting this. The responsibility I felt for my findings is reflected in this research journal extract:

'I feel a great responsibility to make the participants' voices heard. I want to highlight the issues that have, perhaps naively, shocked me. I want to provide a reflective representation of the participants' experiences. I feel a responsibility to be a voice for the participants, in the hope that they are heard,' Research Journal Extract, April 2021.

Section Two: Planned Ethnography and Ethics

This section will outline the planned ethnography and discuss the ethical review process which ensued. The onset of the COVID-19 pandemic and the implications will be discussed. A summary to the chapter will conclude the chapter.

3.0 The planned ethnography

To explore the research question, a single site organisational ethnography was proposed, taking place in an acute NHS organisation in England. The planned ethnography sought to complete approximately 150 hours of participant observations and semi-structured interviews with approximately 30-40 members of staff. Document and artefact analysis was planned where appropriate, using policy, management and professional documentation, and posters displayed in clinical settings which were relevant to the research question.

Participants were to be recruited via the physiotherapy department at the research site. Initial scoping meetings with the senior therapy management team were completed to negotiate access to the setting, and as outlined in section 3.2.1, two managers volunteered themselves as clinical gatekeepers. To

recruit participants, participant information sheets were to be distributed to all physiotherapists working in the research site and potential participants were to be invited to contact the researcher should they have any questions or wish to participate.

The specific location/setting/teams within the research site to be observed was to be determined upon the agreement of clinical gatekeepers and senior physiotherapists (such as clinical/team leads) to facilitate access to the setting. All physiotherapists in the team who consented to take part would then participate in observations and/or interviews. Once consent had been agreed, sensitisation visits were to be planned to introduce the researcher to the teams and clinical settings where the observations took place. Both formal and informal interviews were planned; the former being semi-structured interviews away from the observation environment, and the latter, informal discussion with participants during observations.

The planned ethnography experienced significant delays due to a complex ethical review process and was ultimately abandoned due to the challenges posed by the COVID-19 pandemic. These will be discussed in the following sections.

3.1 Fitting a square into a circle: qualitative ethical approval in a quantitative system

As Librett and Perrone (2010) suggest, the 'bottleneck' for most ethnographers during the ethical review process is that of informed consent (Librett and Perrone, 2010, p.734). The difficulty in gaining ethical approval has been associated with the discrepancies between ethnography and the predictive, anticipatory regulation format in which most ethics committees

and Institutional Review Boards (IRB) operate (Murphy and Dingwall, 2007; Boulton and Parker, 2007; Roberts *et al.,* 2013; Stevenson *et al.,* 2015). Research Ethics Committees (REC) and IRBs have been criticised for the heavy reliance and adherence to positivistic ethical paradigms based on biomedical experimentation to judge quality and ethicality in qualitative research (Murphy and Dingwall, 2007; Librett and Perrone, 2010; Stevenson et al., 2015; c, Sørensen and Glasdam, 2016).

The incompatibility of such paradigms to ethnography in particular are linked to several considerations: differing power relations (participants generally have more agency compared to their biomedical counterparts), the emergent nature of ethnography (inability to explicitly predetermine research processes and outcomes), informed consent as an iterative, continuous process, rather than an episodic, contractual agreement, and the differing harm/risk in comparison to biomedical research (Murphy and Dingwall, 2007; Boulton and Parker, 2007).

Murphy and Dingwall (2003, 2007) argue that these ethical regulations are simply 'ill-suited' to assess ethnographic proposals (Murphy and Dingwall, 2007, p.2224); other authors go onto suggest that the amendments often required to achieve approval shape and change the research focus, question, and design irrefutably, limiting academic freedom and knowledge production (Murphy and Dingwall, 2007; Stevenson *et al.,* 2015; Mapedzahama and Dune, 2017). The primacy of ethical regulation is in no way questioned and it is not suggested that ethnography is without ethical dilemmas, but that the framework used to evaluate these challenges is not fit for purpose in

ethnography (Murphy and Dingwall, 2007; Librett and Perrone, 2010; Stevenson *et al.,* 2015). For this study, it is the issue of informed consent that caused concern for the NHS REC. Initial submission of the Integrated Research Application System (IRAS) form resulted in a withdrawal, secondary to a concern raised by the Health Research Authority (HRA) representatives that every person present in the field of observation would need to be consented in a written format. Initially, verbal consent to the researcher's presence was proposed, as is often used in ethnographic research.

An amendment to the protocol was made to stipulate that no patient interactions would be observed. However, HRA still required every individual who falls within the ethnographic gaze (including incidentally) to be formally consented. This would have been both impractical and impossible due to the fast paced, fluid, and transient nature of the semi-public hospital setting. On discussion, it seemed the only feasible movement past this issue was either to concede and collect written consent from all individuals entering/exiting the area (leaving little time for the research itself), to change methodology altogether (such as pursuing interviews alone with no participant observation) or to complete a Confidentiality Advisory Group (CAG) application to obtain approval to conduct research without gaining consent from all patients/service users in the area due to the possibility of incidental contact with confidential information. After deliberation and a concern surrounding the potential loss of in-depth observational data, the latter option was pursued, the application was withdrawn and resubmitted with a CAG application.

A similar issue was experienced by Mapedzahama and Dune (2017) who, to meet their ethical board's requirements, submitted a 'non-participant' consent form due to the 'accidental' observation of other persons in the area of observation. The authors questioned the ethicality itself of consenting persons who are not involved in the research (Mapedzahama and Dune, 2017). Stevenson *et al.* (2015) questions the paradigm in which NHS RECs operate, suggesting it is *'one size fits all'* (p.2) and its preference towards the positivist, quantitative paradigm risks the quality and ultimate completion of qualitative research (particularly ethnographic research). They go onto outline how during the process of ethical review in their study the *'research question and design were re-shaped to reflect the predictive ethical paradigm within which the committee operated'* (Stevenson et al., 2015, p.8). Nonetheless, whilst the authors acknowledge that this required them to clarify aspects of their design, it also narrowed the scope of the study (Stevenson *et al.,* 2015); arguably reflective of this study.

Having said this, the CAG application process acknowledges circumstances in research design which are common and seemingly ably negotiated via their Precedent Set Criteria Pathway (a set of eleven categories CAG have identified as commonly arising issues) (HRA, 2018); for example, research in health and social care settings where incidental contact may occur, such as qualitative studies. Despite this, the mismatch between the predictive biomedical ethical paradigm and ethnography (Øye, Sørensen and Glasdam, 2016) was highlighted in the CAG application itself. A requirement to define how each principle of the General Data Protection Regulation and

Data Protection Act 2018 would be abided by- despite no confidential patient information being collected or processed as this was not the focus of this study. However, this was not deemed adequate information as to how the principles would be respected. This is an example of the 'insuperable barriers' created for researchers when the anticipatory regimes of consent in clinical and biomedical experimentation are applied to ethnography (Murphy and Dingwall, 2007, p.2230).

The issue of outlining how data (which was not being collected) would be processed, was also an issue for Lee *et al.* (2021), though they were able to negotiate this challenge by seeking written approval from the NHS Trusts' Caldicott Guardians for accidental disclosures of confidential information. This was something suggested to their research team by CAG, alongside an alternative of seeking CAG approval. Interestingly, this was not an option posed in this study, with the only option proposed a full CAG application. Had this been an option, this may have facilitated timely completion, as for Lee *et al.* (2021) this meant ethical review was achieved within five months (compared to the 12-13 months of this study)[7]. Interestingly, Lee *et al.* (2021) suggests the introduction of the Data Protection Act 2018 has added more extensive directives than its predecessor (The Data Protection Act 1998) and thus, there are new considerations for researchers and approving bodies.

It must be made clear that the researcher in no way questions the importance of protecting research participants and ensuring all research is conducted ethically. The example that this study

[7] Lee *et al.* (2021) made their ethics application during COVID-19 (July 2020).

provides is of the practical difficulties of applying biomedical, positivistic ethical criteria to judge ethnographic work; restricting the discovery of nuances and subtleties of institutional and organisational behaviour that observational data can provide. The call for a revised process of ethical review of ethnographic research proposals is supported (Murphy and Dingwall, 2007; Boulton and Parker, 2007; Librett and Perrone, 2010; Roberts *et al*., 2013; Stevenson *et al*., 2015; Øye, Sørensen and Glasdam, 2016; Mapedzahama and Dune, 2017) which takes into account the iterative, emergent nature of ethnography, the importance of data it can produce and to facilitate ethnography's completion, rather than abandonment.

Whilst the study ultimately had to abandon the observational (and problematic[8]) component due to COVID-19, the complexities of undergoing additional approvals and time required to do so, almost culminated in the abandonment of ethnography altogether. Should these issues not be resolved, many more studies may be abandoned and/or be forced to acquire questionably appropriate and practical methods to overcome these barriers (see Mapedzahama and Dune, 2017).

3.2 The COVID-19 pandemic and implications for study

In addition to the delay experienced as part of the complex ethical review process, a further delay was encountered to ethical approval due to the COVID-19 pandemic, to allow for COVID-19 research applications to be prioritised. Following a delay, ethical approval was achieved in July 2020. In the face of uncertainty

[8] As perceived during the ethical review process described.

amidst the pandemic, the clinical gatekeepers forwarded invitations to take part in semi-structured interviews to staff at the research site via email.

However, due to the pandemic and method of invitation, uptake of the study was poor. Access to the research site to begin the observational component of the study was also restricted for infection control reasons. Therefore, to accommodate for the ongoing uncertainty of COVID-19, a substantial amendment was submitted to change the recruitment methods to allow for recruitment of participants outside of the research site. This was approved, following an additional 35-day delay in data collection due to the time required for the REC to review the amendment. Once this was achieved, invitations to take part in the interview component of the study were extended to existing clinical networks and advertised on social media. This facilitated a greater uptake to the study, though remained below the anticipated participant numbers predicted prior to COVID-19.

Negotiations with the clinical gatekeepers and research site took place between July 2020 and January 2021 regarding the participant observations. Attempts were made to mitigate risk where possible and the issue of access was escalated to divisional members of the research site. Due to ongoing delays in reaching a decision due to fast-changing government guidelines, ambiguous guidance for non-COVID related research, and growing funding and time constraints, a decision was made alongside the supervisory team to abandon the observational component of the study in January 2021. Therefore, the study consisted of interviews and document analysis only, as discussed in section one of this chapter.

Summary

This chapter introduced and outlined the philosophical and epistemological underpinning of this study, locating it within a qualitative, interpretive paradigm. The use of semi-structured interviews and document analysis is presented and justified, alongside their respective methods of analysis, reflexive thematic analysis, and a critically informed interpretive discourse analysis. Ethical considerations, both for the planned and actual study design were discussed. In presenting this methodology, the reflexivity and positionality of the researcher, and their influence on the study design, data collection and analysis, has been demonstrated throughout. The following chapter presents the analysis of documents collected. The thesis will then present the qualitative interview analysis.

Chapter Four: Critically Informed Discourse Analysis

4.0 Introduction

This chapter presents the critically-informed discourse analysis of publicly facing documents. The analysis will explore the concept of austerity in discourse and in relation to the physiotherapy workforce, including strategies of response to austerity, both across healthcare and specific to the physiotherapy profession.

The analysis will demonstrate how neoliberal ideology is reproduced at micro, meso and macro levels of the healthcare ecology. Furthermore, state use of the discourse and ideology of professionalism to extend neoliberal values into the public health sector will be demonstrated. The effect on the physiotherapy profession in relation to their professional behaviours (and to maintain their position within the healthcare professional ecology) will be discussed.

4.1 Documents analysed

A total of 86 documents were collected and analysed and are presented in Table 4.1:

Discourse collected from government, the NHS and it's at arm's length bodies	
Document Title	**Author/Publisher/Year**
NHS 2010 to 2015: from good to great preventative, people-centred, productive.	Department of Health (2009)
The NHS quality, innovation, productivity and prevention challenge: an introduction for clinicians.	Department of Health (2010a)
Equity and Excellence: Liberating the NHS.	Department of Health (2010b)
Liberating the NHS: developing the healthcare workforce.	Department of Health (2010c)
Principles and rules for cooperation and competition.	Department of Health (2010d)
Value for money in the NHS.	House of Commons Health Committee (2010)
Improving NHS Productivity: More with the same not more of the same.	Appleby *et al.* (2010) (The Kings Fund)
Allied Health Professionals: Workforce Risks and Opportunities	Centre for Workforce Intelligence (2011)
Allied Health Professions Service Improvement Project.	Department of Health (2011)
Working together for a stronger NHS.	HM Government (2011)
Can NHS hospitals do more with less?	Hurst and Williams (2012) (The Nuffield Trust)
Health and Social Care Act 2012: fact sheets.	Department of Health (2012a)
Securing Best Value for NHS Patients: Requirements for	Department of Health (2012b)

commissioners to adhere to good procurement practice and protect patient choice.	
Health and Social Care Act 2012	Published under the Conservative-Liberal Democrat coalition government (2012)
Thinking about rationing.	Klein and Maybin (2012) (The Kings Fund)
NHS (Procurement, Patient Choice and Competition) Regulations 2013: Department of Health response to legal opinions.	Department of Health (2013)
Making the most out of Allied Health Professions (AHPs).	Centre for Workforce Intelligence (in association with the Department of Health, Public Health England, and Health Education England) (2013)
Implementation of the Health and Social Care Act 2012-uncorrected evidence. (May)	House of Commons Health Committee (2013a)
Implementation of the Health and Social Care Act 2012-uncorrected evidence. (July)	House of Commons Health Committee (2013b)
Focus on: Allied health professionals. Can we measure quality of care?	Dorning and Bardsley (2014) (QualityWatch, in association with The Health Foundation and The Nuffield Trust)
Financial failure in the NHS: What causes it and how best to manage it.	Murray *et al.* (2014) (The Kings Fund)
The NHS productivity challenge: Experience from the front line.	Appleby *et al.* (2014) (The Kings Fund)
2010 to 2015 government policy: NHS efficiency.	Department of Health (2015)

Better value in the NHS: The role of changes in clinical practice.	Alderwick *et al.* (2015) (The Kings Fund)
Understanding NHS financial pressures: how are they affecting patient care?	Robertson *et al.* (2017) (The Kings Fund)
The health care workforce in England: make or break?	The Kings Fund *et al.* (2018) (The Kings Fund, The Health Foundation and The Nuffield Trust)
Approaches to better value: improving quality and cost.	Jabbal and Lewis (2018) (The Kings Fund)
Publicly facing discourse collected from the CSP website	
Document Title	**Author/Publisher/Year**
A question of culture: practical approaches to a good workplace.	Allen (2015)
Fair pay for quality physio: join us at the TUC-led rally on 18 October.	Barker (2014a)
Making the commitment- Jill Barker and the industrial relations committee.	Barker (2014b)
Health is everyone's business: proposals to reduce ill health-related job loss.	Beswetherick (2019)
In perspective: Physiotherapy Works!	Browning (2014)
Patient-reported outcome measures (PROMs) following secondary care NHS musculoskeletal physiotherapy.	Bullock and Scott (2019)
Physiotherapy works: cardiac rehab.	CSP (2011a)

Physiotherapy Works: dementia care.	CSP (2011b)
Physiotherapy Services in Wales: Delivering under pressure. Freedom of Information Request.	CSP (2012)
All together on 18 October: Britain needs a pay rise.	CSP (2014)
Information paper: history of the support worker within the CSP.	CSP (2015)
Meeting the challenges in primary care: roundtable discussion.	CSP (2015)
Physiotherapy staff march arm in arm with other health professionals in huge trade union demo.	CSP (2015)
Physiotherapy Works for your community. Parliamentary Briefing.	CSP (2015)
Future shape of the physiotherapy workforce: Position statement.	CSP (2018a)
Future shape of the physiotherapy workforce: Information paper.	(CSP, 2018b)
Think physio: act local.	CSP (2016b)
Mid Essex CCG physio cuts plan contradicts evidence.	CSP (2016c)
Physiotherapy Works: Fitness for Work.	CSP (2016d)
CSP members march in Birmingham for the NHS.	CSP (2016e)
CSP welcomes publication of NHS Wales Workforce Review.	CSP (2016f)
Trade Union Act 2016.	CSP (2016g)

CSP position statement on apprenticeships.	CSP (2018d)
CSP recommends NHS pay offer to members.	CSP (2018e)
PM's warm words must be matched by end to quick fixes, says CSP.	CSP (2018f)
Influencing toolkit.	CSP (2019a)
Advanced practice physiotherapists in GP practices: a how to guide for implementation.	CSP (2019b)
CSP's position on the Home Office 'Shortage Occupation' List.	CSP (2019c)
Impact Report 2019.	CSP (2019d)
Think Physio: act local. The NHS Long Term Plan and Older People.	CSP (2019e)
Optimising capability in the physiotherapy support worker workforce.	CSP (2020a)
Support workers as an integral part of the physiotherapy workforce. A policy briefing from the CSP.	CSP (2020b)
Policy statement on advanced practice.	CSP (2020c)
Rehabilitation and COVID-19 CSP Policy Statement.	CSP (2020d)
Championing Community Rehabilitation: An Influencing Toolkit for CSP Members.	CSP (2020e)
Guidance on CSP expectations of delivery of the Physiotherapist Degree Apprenticeship.	CSP (2020f)

Information paper: supervision, accountability and delegation.	CSP (2020g)
Spending Review 2020: CSP continues to press for fair pay for health staff.	CSP (2020h)
First Contact Physiotherapy: principles of effective and sustainable FCP services.	CSP (2021b)
NHS pay - what is happening and how you can get involved.	CSP (2021c)
Rallies and demonstrations.	CSP (2022)
Comment: It pays to belong.	Eaton (2015a)
Comment: From big to small 'p' politics.	Eaton (2015b)
Editors comment: time for change.	Eaton (2018)
Advice line: what's a fair pay rise for physiotherapy staff?	Finch (2016)
Your comments: 19 October 2016.	Frontline and various (2016)
Fair pay: join the London march on 18 October.	Frontline Staff (2014)
In perspective: Greek tragedy?	Gainsborough (2014)
Obesity- tackling an unsustainable problem.	Hitchcock (2014)
The effects of a new Tendo-Achilles Pathway (TAP) on an orthopaedic department.	Hutchison *et al.* (2020)
Health Select Committee Sustainability and Transformation Plans Inquiry. Evidence from the Chartered Society of Physiotherapy.	Middleton (2018a)
The Lord Darzi Review of Health and Care. Evidence	Middleton (2018b)

from the Chartered Society of Physiotherapy.	
TUC congress: CSP speaks out on post Brexit workers' rights and the link between poverty and obesity.	Millett (2016)
In perspective: austerity alert.	Orr (2014)
Managing pressures in practice.	Owen (2016)
Let's embrace our unique offer to general practice.	ten Hove (2017)
Physiotherapy should be added to the shortage occupation list.	Yeldham (2020)
Written evidence submitted by The Chartered Society of Physiotherapy (RTR0072).	Yeldham (2022a)
Written evidence submitted by the Chartered Society of Physiotherapy (EPW0058).	Yeldham (2022b)

Table 4.1: Summary of documents collected for analysis.

4.2 Analysis

4.2.1 The (non)construction of austerity in discourse

Despite the 2008 financial crisis being hugely influential in the state of the nation's finances, there was very little reference to the crisis and subsequent austerity measures in NHS policy. Instead, documents used terms such as financial pressure, burden, or challenge, in relation to failed workings of previous governments or NHS organisations, and thus framed reforms as methods to repair failing systems. Furthermore, financial pressure was linked to rising treatment costs, the aging

population and service demand. Policy appeared to avoid recognising the financial crisis and austerity. Rather, austerity was constructed through implicit references to cost saving, such as emphases on increased productivity, efficiency, and value.

Despite being unspoken in governmental NHS discourse, austerity was recognised and legitimised by political leaders. Examples include David Cameron's statement regarding the *'the age of irresponsibility [is] giving way to the age of austerity,'* at the Conservative Party Conference (Cameron, 2009) and George Osbourne's acknowledgment of cuts to the public sector in an interview (Osborne, 2014). Examinations of discourse have shown how political leaders use discursive devices such as moral storytelling to legitimise austerity (Kelsey *et al.,* 2016). In the UK, storytelling was used to construct austerity as the only option in responding to the 2008 financial crisis, normalising it as 'common sense' (Kelsey *et al.,* 2016). The rhetorical work of political leaders was reproduced through media, contributing to the acceptance of austerity as the only possible solution (Kelsey *et al.,* 2016).

Considering the amount of rhetorical work undertaken by political leaders regarding austerity in the UK (Fourton, 2017; Kelsey *et al.,* 2016), one must question its absence from discourse surrounding the NHS. This omission is probably due to negative connotations, particularly considering the NHS's long history of financial challenges (Klein, 2013). The government described the NHS as protected from widespread cuts, assuring that no reduction to the budget would be made (HM Government, 2011). However, austerity within the NHS was more nuanced. The government used the rhetoric of growth in NHS funding year on

year, however, in real terms (i.e., taking inflation into account), the growth in funding equated to near-zero increases, as outlined in the 2010 Spending Review (Appleby *et al.,* 2014). Coupled with increasing demand on the NHS, this represents a more insidious process of austerity.

Austerity is therefore constructed in the documentation examined as financial challenges, performance, stability, and sustainability. It is related to methods to promote the above, such as productivity, efficiency, and value. From the documentation analysed, restructuring of systems of organisation within the health service were observed, driven by the organising logic of neoliberalism. These became apparent through the strategies of response following the 2008 financial crisis.

4.2.2 Strategies of response to financial crisis

Several strategies to address financial pressures in the NHS were identified and grouped into overarching themes: macro-level restructuring (acceleration of, and legislation for markets and competition within the NHS, decentralisation, devolution of state responsibility), increasing productivity and efficiency, constraining financial outputs (reducing management numbers, pay freezes), and workforce (professional restratification and labour substitution). A summary of where each theme is represented, evidenced, or discussed is presented in Table 4.2:

Strategy	Reference
Macro-level restructuring - Acceleration and legislation of markets and competition within the NHS - Decentralisation and localism - Devolution of state responsibility	Department of Health[9] (2009, 2010b, 2010c, 2010d, 2012a, 2015) House of Commons Health Committee (2010, 2013a, 2013b) HM Government (2011) Hurst and Williams (2012) Health and Social Care Act (2012) Alderwick et al. (2015)
Methods to increase productivity and efficiency - Focus on creating value e.g., QIPP	Department of Health (2009, 2010a, 2010b, 2010c, 2011, 2012a, 2015) House of Commons Health Committee (2010) Appleby et al. (2010) Health and Social Care Act (2012) Alderwick et al. (2015) Hurst and Williams (2012) Centre for Workforce Intelligence (2013) Chartered Society of Physiotherapy (2018b) Jabbal and Lewis (2018)
Constraining financial outputs - Reducing management numbers and costs - Pay freezes	Department of Health (2009, 2010b, 2015) House of Commons Health Committee (2010) Centre for Workforce Intelligence et al. (2011)

[9] The Department of Health changed its name to the Department of Health and Social Care in 2018.

	HM Government (2011)
Workforce - Retention - Culture, health and wellbeing - Professional restratification and labour substitution	The Kings Fund et al. (2018) Specific references to methods of professional restratification and/or labour substitution: House of Commons Health Committee (2010) Appleby et al. (2010) Centre for Workforce Intelligence (2011, 2013) Department of Health (2011) Chartered Society of Physiotherapy (2018a, 2018b) The Kings Fund et al. (2018)

Table 4.2: Strategies used in response to the financial crisis.

4.2.2.1 Manifestations of neoliberalism

From the analysis, strategies which appeared to extend the dominant organising logic of neoliberalism (see 2.2) were observed. Its three main features of free markets and competition, decentralisation, and individualism, were visible in NHS discourse in the examined documents between 2008-2018. The year 2018 is used here as an end-range point due to the change in the trajectory of these features in more recent NHS discourse, which are discussed later. These main features must be supported by an institutional framework, and the role of the state is to *'create and preserve an institutional framework appropriate to such practices,'* (Harvey, 2005, p.2). This was demonstrated in NHS discourse, and most specifically, legislated in the form of the Health and Social Care Act 2012.

Free markets and competition

The NHS internal market has been in existence for some time (Ham, 2009), and is commonly associated with the Griffith's report (1983) and the work of Alain Enthoven (1985) (see 2.2). However, the Health and Social Care Act 2012 and its supporting documents (Department of Health, 2010b, 2010d, 2012a, 2012b, 2013) represented a formal legislation and extension of free market practices and competition into the publicly-funded health sector. More specifically, in the section 75 regulations (Health and Social Care Act, 2012).

This, alongside the devolution of the Secretary of State's responsibilities to '*provide or secure'* a comprehensive health service (The Kings Fund, 2015), caused contention across the health sector due to concerns surrounding the reconcilability of such measures with the NHS Constitution (The Lancet, 2011; Timmins, 2012; Pollock et al., 2012). Despite this, and the limited, varied evidence for use of competition in the health sector (Hurst and Williams, 2012; The Health Foundation, 2019), these policies were legislated. The government legitimised such action by suggesting that it would stimulate innovation, efficiency, productivity, and improvements in care quality (Department of Health, 2009, 2010a, 2010b, 2010c, 2012a, 2012b; HM Government, 2011). Further, it was suggested these methods would provide freedom for service users and healthcare professionals, creating greater choice (Department of Health, 2010b, 2012a, 2012b; HM Government, 2011).

In a House of Commons Health Committee meeting, this lack of evidence was acknowledged but use of competition was legitimised in the UK by reference to other countries:

> *'…when one looks at countries like France and Germany, their systems have a greater level of competition between health providers, which you would normally expect to increase efficiency. I do not think a cast-iron piece of research has proved that fact, but it is something that I would put forward as a hypothesis,'* (House of Commons Health Committee, 2010, Q8, Mr Haldenby).

Interestingly, the use of language here demonstrates how competition's link to efficiency is construed as a fact, despite the speaker preceding this with a statement that no evidence has 'proven' this fact.

The critique of lacking evidence-based policy could fall into the remit of naivety in the reality of policymaking, as described by Cairney (2015). Conversely, this statement could be an example of bounded rationality, whereby policymakers have limited and incomplete information and must make decisions based upon uncertainty and ambiguity (Cairney, 2015). Nonetheless, this excerpt provides an example of both principles of bounded rationality and the influence of policymakers' own value and belief systems in the influence of policy decisions. In this case, in the form of the promotion of competition within the NHS.

Decentralisation

A similar process of legitimisation is used to justify decentralisation. Decentralisation is both explicitly and implicitly referenced too across the documents examined. It was evident

through the processes of restructuring NHS organisations; for example, the abolishment of Strategic Health Authorities to facilitate localism, and the formation of Clinical Commissioning Groups (CCGs). Decentralisation of the public sector was to be expected, as the coalition government in power at the time were explicit regarding their belief that decentralisation was key to improving public services (HM Government, 2010).

For the coalition government, decentralisation meant lifting the bureaucratic burden, increasing local control of finances, empowering communities, diversifying public services, and improving public scrutiny of the government (HM Government, 2010). The opening up of the market to allow diverse providers competing for services, formation of CCGs, and increased accountability are prime examples. With this, came the devolution of responsibility to clinicians, and the rhetoric of placing more power in the hands of clinicians on the frontline (Department of Health, 2009, 2010a, 2010b, 2010c, 2012a; HM Government, 2011). Arguments of empowerment, freedom, controlling bureaucracy, and improved services are again used by government to legitimise these changes. Whilst this could be perceived as an introduction of decentralisation, both centralisation and decentralisation have seen variation in their implementation and use throughout the history of the NHS (Klein, 2013).

Individualism

Similarly, emphases on individualism were evident in the form of reallocated responsibility. The mandated improvement of productivity and efficiency were reframed strongly as the

responsibility of individual clinicians, reshaping expectations, and attempting to appeal to the moral responsibility of professionals; something also observed by Moffatt, Martin, and Timmons (2014). Individualism was also mandated for service users, with an emphasis on increased responsibility for one's health, responsible use of health services, and active citizenship. All of these were presented as methods to sustain the NHS (Department of Health, 2009; Health and Social Care Act, 2012). Again, the same processes of legitimisation used for introducing competition and broad decentralisation were evident.

4.2.2.2 The discursive turn

As mentioned, 2018 is used as an endpoint when identifying specific neoliberalist features of the discourse examined. This is because a discursive turn was observed in more recent policy. Emphases on competition waned towards 2018, and by 2019, it was rarely mentioned (The Health Foundation, 2019). This sets the scene for the removal of the *'the overly rigid competition and procurement regime applied to the NHS,'* (NHS England, 2019a, p.10). Accompanying this was an emphasis on '*collaboration, rather than competition, as an organising principle*,' (House of Commons Health and Social Care Committee, 2019, p.17), revocation of section 75 regulations, and the return of some centralised elements (House of Commons Health and Social Care Committee, 2019). However, this has been met with some apprehension due to the perceived centralisation of power (House of Commons Health and Social Care Committee, 2019). Combining with this was a greater focus on the collective needs of the workforce; for example, nurturing health and wellbeing, recruitment and retention, culture and working conditions (NHS

England, 2019; NHS England, 2020). This was something which became much more recognised during the COVID-19 pandemic (NHS Check, 2020; NHS England, 2020a; Kotecha, 2021).

It must be noted what is meant when referring to a return of collectivist elements. Whilst government discourse emphasised personal responsibility to sustain the NHS, recent policy showed a shift in how NHS staff were addressed. Discourse had referred to *'you',* addressing staff directly and allocating responsibility; in recent policy, the workforce was textured (Fairclough, 2010) using more inclusive language, emphasising *persons* rather than *employees* (NHS England, 2020). For example, references to *'we'* instead of *'you'*, 'Our NHS People,' and the 'We are the NHS' recruitment campaign. Whilst this may be an attempt to improve recruitment, this too could be a method of responsibilisation and a further method of strengthening the collegiate values of professionalism, enhancing their numbers to future-proof their additional role as agents of change.

4.2.3 The use of the ideology of professionalism within government discourse

NHS discourse published by the government and its arm's lengths bodies (e.g., NHS England) during the time period analysed appealed to the discourse and ideology of professionalism to extend the neoliberal, austere agenda into the public health sector. Healthcare professionals were constructed as agents of change to deliver the reorganisation of the NHS at an operational level and arguably, to reaffirm values of professionalism to sustain and reassert control at a distance, allowing for an ongoing, self-governing decentralised system.

This was achieved through organisational restructuring and the formation of CCGs, which placed the responsibility of financial allocation, distribution, and procurement on frontline clinicians. Furthermore, improving productivity and efficiency was reframed as an individual, personal responsibility and any failure to do this, was a personal failure and a threat to the sustainability of the NHS, demonstrating an attempt to appeal to the moral responsibilities of healthcare professionals. For example, it was assumed professionals did not already consider financial aspects as part of their role, and explicit allocation of this task was stated:

> '*You may think that money is someone else's business, but we believe that addressing financial inefficiencies is a key personal, professional and moral responsibility because it allows us to free up resources which can then be used to treat more patients, more effectively*,' (Department of Health, 2010a, p.5).

> '*If we do not respond to this challenge, there is a real risk that the need to cut costs will overtake all our best intentions to improve care for our patients,'* (Department of Health, 2010a, p.19).

These changes were legitimised through descriptions of improved care quality, more efficient, sustainable services, and greater patient choice through the transfer of power to the clinicians '*closest to the patients*,' (Department of Health, 2010b, p.4). Emancipatory language was used frequently in earlier documentation to demonstrate how the proposed changes would benefit both patients and those expected to deliver reforms-healthcare professionals. The terms free/freeing/freedom,

liberate/liberating/liberation, relinquish/release, and empower/empowerment/empowering were used to justify the devolution of responsibility onto clinicians. Documents described how these changes would allow the NHS to be run from the 'bottom up,' removing existing, unnecessary bureaucracy (Department of Health, 2010b).

The terms empower and liberate/liberation were used repeatedly, and the term free/freedom was used 38 times in one document (Department of Health, 2010b). Fourton's (2017) study of austerity rhetoric in political discourse in France and the UK suggested the high frequency use of terms and/or phrases demonstrated the scale of rhetorical work being performed to convince the listener. The repetition of emancipatory terms identified in the documents analysed here is too an example of the scale of rhetorical work performed to justify and facilitate the desired action.

The promise of liberation and freedom is a common method of legitimising neoliberal market ideologies (van Dijk, 2006; Boltanski and Chiapello, 2005). In this context, the freedom referred to is in relation to free market ideologies, free enterprise, and freedom from state intervention (van Dijk, 2006). Whether this is a method of persuading or manipulating the reader is dependent on a number of conditions. Van Dijk (2006) explores the manipulative power of discourse, suggesting a key difference between methods of persuasion or manipulation lies in the power and role of those being persuaded or manipulated (van Dijk, 2006).

Persuasion, a legitimate form, can be used to present evidence and represent why action needs to be taken, and generally does not possess the negative connotations associated with manipulation (van Dijk, 2006). In persuasive practices, addressees are generally free to act whether they accept the persuader's arguments or not, whereas with manipulation, the addressees typically occupy a passive role and their ability to act freely in response to the arguments presented is limited or absent (van Dijk, 2006). Manipulative practices are also evident if the information presented is absent, vague, or fragmented (van Dijk, 2006). Whilst this describes a delineation between both legitimate and illegitimate forms of manipulation, this boundary is blurry, and is context and addressee dependent (van Dijk, 2006). Not all persons will be manipulated to the same extent and a higher awareness of discursive mechanisms may render those persons less prone to manipulative discursive practices (de Saussure and Schulz, 2005; van Dijk, 2006).

This is essential to consider when analysing the ability of healthcare professionals in the NHS to respond to health policy reform. Not all professional groups will be able to respond in the same way, and even within a profession, not all members of the same profession will be able to respond. Whilst an understanding of discursive practices may mean an individual is less vulnerable to manipulation, this does not mean they will be able to react to this. For example, despite any ability to resist manipulative practices, the professions in this context would be required to operate within whatever institutional frameworks were imposed by state. However, methods of response, resistance or acceptance may be observed at the micro level (see Hoyle and

Grant, 2015; Kerasidou, Kingori and Legido-Quigley, 2016; Tucker, Moffatt, and Timmons, 2020).

It is suggested that the methods used by the state in the documents analysed present elements of manipulative discourse; for example, evidence for some policy changes (e.g., competition) were presented as beneficial, despite wider evidence (and stakeholders) questioning this. There were unsubstantiated claims and sparse use of evidence, in direct comparison to the documentation collected by independent bodies, where empirical studies were used to analyse state response, causes of financial failure, and methods to address them (for example, Appleby *et al.,* 2010; Klein and Maybin, 2012; Murray *et al.,* 2014). Furthermore, although professional concerns were voiced (Nursing Times, 2011; The Lancet, 2011; Royal College of General Practitioners, 2012), the policy was legislated and resisters were expected to work within whatever institutional framework was imposed, reflecting an imbalance of power between state and professions. This, alongside the selective use of evidence, is suggestive of manipulative methods of legitimisation by the state to achieve compliance in its social agents (the professions).

The implementation of neoliberalist and austere policies and practices, despite contestation (Timmins, 2012), ambiguous evidence (Hurst and Williams, 2012; The Health Foundation, 2019), and warnings from think tanks (Appleby *et al.,* 2010), reflects the ideologically-driven basis of policy making (Øvertveit, 1998; Paton, 2014). The documents analysed represented complex discursive practices of persuasion and manipulation to extend the goals of neoliberalism and enduring austerity, whilst

attempting to sustain the public's perception that the NHS is protected from such measures.

The use of language and methods of legitimisation reflects an appeal to the values of professionalism. In particular, freedom to exercise autonomy, control of one's work, and a recognition of the esoteric, tacit knowledge possessed by clinicians and therefore, their ability to make decisions whilst being located closer to the patient. Furthermore, these changes would offer an element of market control, something inherent to occupational groups' professional projects (Larson, 1977). All of these have been challenged in contemporary social, political, organisational, and economic contexts (Freidson, 2001; Evetts, 2003; Waring, 2014; Noordegraaf, 2015). Therefore, whilst not a return to the 'golden age' of professionalism (Freidson, 2001; McKinley and Marceau, 2002), the promise of greater autonomy and freedom to control one's work may be appealing to healthcare professionals, thus stimulating action and accepting the role of change agent. Nonetheless, this is accompanied by some trade-offs, such as increased regulation and accountability. These discursive practices are a contemporary example of the interdependence between the state and the professions. The professions could not exist without the state, which provided a platform for professionalisation (Alaszewski, 1995; Johnson, 1995), but the state also is reliant on the professions to transform *'theoretical imaginaries'* into *'practical imaginaries'* (Fairclough, 2010). The neoliberalist 'imaginary' i.e., 'how things could be' or 'possible worlds' (Fairclough, 2010, p.266), could see the operationalisation of changes in structure, relations, and actions (Fairclough, 2010). Therefore, the state could use the

professions as facilitators in this process. For example, reduced state intervention can be actualised through healthcare professionals taking on the responsibility for planning, organising, and delivering the public health system.

4.2.4 Physiotherapy in the context of austerity discourse and implications for practice

As healthcare professionals were rhetorically constructed as agents of change through the transfer of power and responsibility, it must be noted which healthcare professionals this is referring too. Whilst government documents appeared to speak to all frontline clinicians or healthcare professionals, doctors appeared to be the main recipient of this increased power and responsibility through the formation and requirements of the CCGs. CCGs[10] required as standard, GPs, a nurse, secondary care specialists and lay members (NHS England, 2014), leaving the AHP workforce and their specialisms unrepresented. Physiotherapy, and other AHPs, were generally absent from earlier documentation, reflecting a wider absence from policy. Dorning and Bardsley (2014, p.3) state: '*Yet despite the size and importance of the AHP workforce, AHPs are rarely the subject of major policy debates and there is a concern that their contribution to care is often hidden, overlooked or potentially undervalued.*' This is despite a vast contribution to NHS services. For example, in 2012/13, AHPs collectively provided 7.5 million episodes of outpatient appointments, with physiotherapy and

[10] As of July 2022, the responsibilities of CCGS were transferred to Integrated Care Systems (ICS). ICS are groups of organisations including the NHS, local authorities and third sector organisations who work together to deliver integrated care (British Medical Association, 2022a).

occupational therapy being the largest providers (Dorning and Bardsley, 2014).

The physiotherapy profession has been no stranger to threats to their market security, with campaigns to prevent decommissioning evident (CSP, 2016a; Tucker, Moffatt and Timmons, 2020). However, documents published around 2018 onwards showed an increased presence of the profession in policy, alongside a specific statement of how the UK physiotherapy professional network (the CSP) saw the future of the profession (CSP, 2018b, 2018c). This shift demonstrated a 'unique selling point' for physiotherapy in that it can provide wider system cost savings, through labour substitution in the musculoskeletal portion of the GP workload, freeing GP appointments whilst delivering the service at a lower cost (CSP, 2018c; The Kings Fund et al., 2018). This provided an opportunity for the profession to capitalise on needs for long-term cost savings by extending their jurisdiction to achieve implicit market control, thus rendering themselves competitive. Physiotherapists (and pharmacists) were explicitly identified in some documentation as examples where AHPs can deliver savings (House of Commons Health Committee, 2010; The Kings Fund et al., 2018), raising their profile in the process.

Before exploring this in greater detail, it is important to examine how austerity was referred to in the discourse taken from the CSP's publicly facing website, before identifying the strategies of response to austerity at the macro/national level, as presented by the profession's professional body.

4.2.4.1 Austerity in CSP discourse

Much like the government and NHS discourse, the discourse collected from the CSP had no specific definition of austerity, though it was often referred to. The CSP discourse assumed the reader had an understanding of austerity. The discourse did however identify the impact of austerity and contemporary healthcare challenges on physiotherapists:

> *'…members are working in extremely difficult times, particularly those in the NHS, where austerity measures are beginning to impact on the level of service they can provide,'* (Eaton, 2015b).

The CSP suggested physiotherapy services were *'increasingly likely to be subjected to change, reorganisation and cuts'* as a result of the financial crisis (CSP, 2016b). Cost saving measures had the potential to impact on both the profession and patient care. Physiotherapists were experiencing downbanding, decommissioning, and rationing of physiotherapy services; all as cost saving measures. For example:

> *'As part of its austerity drive, the CCG is considering stopping GPs making referrals to MSK physiotherapy altogether, replacing them with a telephone advice service, or offering a single assessment and one follow up,'* (CSP, 2016c).

Further cost saving methods were identified, including the use of 'vacancy control processes.' This was used in Welsh Health Boards to hold vacancies and delay recruitment as a method to deliver cost savings, which had consequences for the remaining workforce:

'Health Boards are using vacancy controls as a financial technique, to add time into the recruitment process and thus maximise potential savings… it results in continued strain on services as vacancies must be carried by the existing workforce… this widespread practice of vacancy management is resulting in services being spread more thinly,' (CSP, 2012, p.3).

This technique was not supported by the CSP:

'The CSP maintains these are false economies…' (CSP, 2012, p.4).

The result of the cost saving measures described above and rising demand, was understaffing, high (unmanageable) workload, stress and job dissatisfaction, lacking resources, and service inequity and fragmentation. The CSP described how many physiotherapists felt unable to carry out their role:

'Only one in five NHS physiotherapists in England feel they have enough colleagues to do their job properly. 37% of physiotherapists reported having enough staff to do their jobs satisfactorily,' (Yeldham, 2022b, p.5).

Physiotherapists showed a downward trend in their perceived ability to manage competing demands and resources; and ultimately, the quality of patient care had declined:

'Only 33% of physiotherapy respondents stated being able to meet all the conflicting demands on their time at work in 2021… the number of [physiotherapists] reporting having adequate materials, supplies and equipment to do their work declined from 52.5% to 46.4% over the same period… In 2021, the number of

physiotherapists being satisfied with the quality of their organisation's patient care is 69%...' (Yeldham, 2022b, p.5).

This, alongside high levels of stress, workloads and understaffing, were identified as reasons for physiotherapists leaving the NHS (Finch, 2016). These factors have also contributed to deteriorating working conditions:

'CSP regional steward James Allen said: "For too long NHS staff have been working under extreme and increasing pressure… constant demands for efficiency saving are now making working lives intolerable. It's a truly dangerous scenario,' (Millett, 2016).

Physiotherapists were approaching the CSP for support, with some contacting the CSP's professional advice line when faced with exponential pressure in the workplace:

'… members feel as they're asked to do more work with few or no additional support or resources. The situations themselves vary – from being asked to provide cover for absent physiotherapy colleagues or to take on additional nursing duties to ensure adequate staffing on a ward. Another example might be a proposal to shave 10 minutes off the standard physiotherapy appointment in order to reduce numbers on the physiotherapy waiting list.' (Owen, 2016).

Interestingly, Owen (2016) outlined employers' duty of care to employees, which included not causing harm to employees due to workload, and the impact deteriorating employment and working conditions had on patient care:

'The quality of care therefore depends on the quality of employment. If one part of the partnership fails, the other suffers – to the detriment of people using the service,' (Owen, 2016).

Nonetheless, there was clear evidence that employee harm due to unmanageable workload was taking place, as outlined in this chapter and as evidenced by the CSP discourse (e.g., Finch, 2016, Owens, 2016, Millett, 2016, Yeldham, 2022b).

4.2.4.2 Strategies of response to austerity in CSP discourse

The discourse collected from the CSP provided insight into the role the professional body had in responding to austerity. Much of the analysed discourse reflected the CSP's function as a trade union for the physiotherapy profession. This involved campaigning on behalf of and alongside its members in relation to employment issues (such as pay and working conditions), industrial action, and campaigning against austerity. The CSP had extensive engagement with trade union rallies and demonstrations, which members were encouraged to attend (Barker, 2014a; CSP, 2014, 2015, 2016, 2022; Frontline and various, 2016; Frontline staff, 2014). The discourse collected from the CSP also demonstrated its role as a professional body, with a professional advice service, publication of guidelines and standards, and a network of regional stewards who could be approached for support. These tools all could be used for advice and support in the workplace, particularly when members were challenging aspects of their work. For example, quality assurance standards outlined how resources were needed to deliver safe and effective physiotherapy services and thus:

'… it is this element of the standards that makes them a potentially valuable tool for challenging situations where doing more is not possible without additional support or resources being put in place,' (Owens, 2016).

The CSP acted as a voice for the profession at a national level, engaging with policy, commissioning and providing evidence to government committees, such as the Health and Social Care Committee (Middleton, 2018a, 2018b; Yeldham, 2022a, 2022b). The CSP acted to raise the profile of the profession, and used this platform to advocate for the presence of AHPs at board level and in local, regional and national decision-making, something which rarely occurred as standard:

'Unlike for doctors and nurses, at present in England, unlike Wales, there is no requirement to include AHP directors at board levels within trusts or [Integrated Care Systems]. This creates a glass ceiling for physiotherapists and other AHPS and limits the input of AHPs into workforce strategy and planning at local level,' (Yeldham, 2022a, p.2).

The CSP appeared to acknowledge the threat contemporary healthcare and austerity posed to the profession's future:

'In a world of change and financial austerity, are you confident that, in the future, patients and the public will be able to access the full range of your skills and services?' (Browning, 2014).

Thus, the CSP placed responsibility for the profession's future on every member, and published guidance on influencing to raise the profile of the profession:

'Decisions are made by those who show up… Imagine what could be achieved for the profession across the UK if all 58,000+ CSP members were able to spare a minute each day,' (CSP, 2019a).

The CSP deployed a range of both reactive and proactive response strategies to austerity and the challenges of contemporary healthcare. The CSP heavily endorsed and promoted the role of First Contact Physiotherapy. When it came to the future development of the profession, the discourse analysed focussed predominantly on the development of FCP in musculoskeletal and primary care settings, though there were a small number of references to other aspects of physiotherapy, such as community and dementia care (CSP, 2011a, 2011b, 2015, 2020). First Contact Physiotherapy complemented the CSP's construction of physiotherapy's 'unique selling point.' A key component of this was the ability to deliver cost savings, something they identified as preeminent in contemporary healthcare (Browning, 2014).

The profession's ability to relieve GP's of a portion of their workload offered a professional opportunity and the profession has capitalised on this '*unique offer'* (ten Hove, 2017):

'The aging population, the shortage of GPs and economic austerity all present us with a unique opportunity to transform MSK [musculoskeletal] services, to position physiotherapy expertise at the front end of the MSK pathway,' (ten Hove, 2017).

The competitive edge (in terms of the professional ecology) this gave the profession was explicitly recognised:

*'**No other profession can make this particular offer to general practice.** So rather than shy away from using our unique brand of physiotherapy, let's absolutely own it, be rightly proud of it and promote it,'* (ten Hove, 2017, emphasis added).

Having said this, this jurisdictional expansion has been interpreted as moving away from physiotherapy's core jurisdiction by physiotherapists themselves:

'I have had feedback from physios that this new way of working is not physiotherapy. While I agree it is not core physiotherapy treatment, I believe it is absolutely part of the whole physiotherapy offer. The skills, knowledge and experience that the physiotherapy profession brings to these new and emerging roles is predicated on your development as a physiotherapist,' (ten Hove, 2017).

The cost savings of this role were used to justify the development and commissioning of First Contact Physiotherapy:

'As well as costing less than doctors, physiotherapists in these roles reduce costs of unnecessary prescriptions, referrals to consultants, x-rays and scans. This new model of care has the potential to address the immediate crisis in general practice and most importantly deliver a better GP service as part of a modern primary care system… Every £1 spent on physiotherapy produces a £1.50 return on investment,' (CSP, 2015).

Whilst it is clear the CSP are campaigning heavily (and arguably successfully) to establish the role of FCP into everyday practice, what is less clear is the impact this competitive edge has on physiotherapists. These roles essentially work beyond their traditional jurisdiction but may not be renumerated at a higher

rate or in line with doctors pay. In fact, this is partially used as a justification for the role by the CSP, in that physiotherapists are cheaper than doctors (CSP, 2015). Therefore, how physiotherapists perceive the value of their professional work and the risk of labour exploitation remain unexplored. This is pertinent to explore given the growing traction this role is gaining in policy and practice.

Beyond FCP, the discourse collected from the CSP demonstrated further use of cost savings as a unique selling point for the profession. The CSP presented the profession as good for the economy (Beswetherick, 2019), as they deliver clinically and cost-effective care (CSP, 2016d). The profession is presented as beneficial to the economy for their ability to return people to work, and maintain people in work (CSP, 2016d; Beswetherick, 2019). Although much fewer references are made in comparison to MSK and primary care, the benefit and cost savings physiotherapy offers to other settings were identified, including dementia care, cardiopulmonary rehabilitation, fitness to work, and community (CSP, 2011a, 2011b, 2015, 2016).

In addition to the national and macro level strategies of response, the discourse collected from the CSP also presented strategies at local service level. There was evidence of physiotherapists proactively planning and embedding clinical and cost effectiveness into their treatment pathways in light of austerity:

> *'At a time of austerity in the NHS, it is essential to have carefully designed pathways that are monitored in terms of cost effectiveness,'* (Hutchison *et al.,* 2020).

Furthermore, innovations in care and outcome measurement were foreseen as important for the profession's future in light of the ongoing threats to their services, as outlined in 4.2.4.1:

> *'A collaborative approach to the development of a national database which evaluates MSK physiotherapy care is recommended. This may provide powerful evidence of physiotherapy's effectiveness and support the profession during healthcare commissioning at a time of financial austerity,'* (Bullock and Scott, 2019).

As discussed in relation to FCP in this section, professional reorganisation was used both as a proactive and reactive strategy to respond to and reconcile austerity and contemporary healthcare challenges. Additional components of professional reorganisation included changing division of labour, increasing labour substitution and greater delegation, and the change, challenge and protection of professional boundaries, to which our attention shall now turn.

4.2.4.3 Professional reorganisation

As mentioned, the CSP recognised the threat to the profession's market security, suggesting the profession risks marginalisation and the growth of other professions at physiotherapy's expense, should opportunities not be grasped (CSP, 2018c). Thus, they allocated responsibility to every member to demonstrate the relevance and value of physiotherapy, suggesting *'there is much to gain from doing so,'* (CSP, 2018c, p.2). A great proportion of opportunity seizing and professional reorganisation that took place in the discourse examined was the jurisdictional expanding and encroaching role of FCP, as discussed in the previous section.

In addition to this, and to facilitate qualified physiotherapists engaging in professionalising activities, was the changing role of the support worker.

Support workers work in a variety of settings alongside qualified physiotherapists to deliver care. In the discourse analysed, support workers were taking on tasks and roles of greater risk and complexity. Physiotherapists were advised to delegate more to support workers, as they pursue professional project extending activities:

'The necessary corollary of working to the height of capability and scope is to let go of roles that can be performed as clinically-effectively, and more cost-effectively, by others. Support workers will be critical in this: they are already playing an increasingly direct and hands-on role in patient care…with greater delegation from physiotherapists,' (CSP, 2018c, p.4).

The CSP outlined how support workers could be 'optimised' to work at the height of their capabilities to contribute to the development of the profession:

'Now more than ever we must capitalise on their knowledge, skills, passion and ability to work at the height of the scope of their roles, in order to maximise the significance of the profession to new ways of working and new models of care,' (CSP, 2020a).

'The non-medical workforce within health and care will need to have expanded and developed to work to their potential. This will mean recognition of the value of delegating greater responsibility for unregistered staff (including physiotherapy /allied health profession support workers and health care assistants) and of more registered non-medical staff developing advanced practice

skills (including physiotherapists, other allied health professionals, nurses),' (Middleton, 2018b).

Whilst the upskilling and changing role of support workers may hold professional benefits (e.g., releasing physiotherapists to carry out other tasks), it is also accompanied by risk and ethical considerations. The regulation of support workers is unsupported by the CSP, due to the regulatory processes already in place for qualified clinicians and the costs involved (CSP, 2020a). Therefore, regulating safe practice would be reliant on rigorous governance processes and supervision from physiotherapists (and potentially, an element of self-regulation by support workers). Furthermore, despite the CSP's recommendations on the changing support worker role, from the discourse analysed, there appears to have been little to no consultation with support workers themselves regarding these changes.

Support workers already experience disparity and confusion regarding their role descriptions and remuneration:

'61% of surveyed support workers reported their current level banding was not reflected in the duties and responsibilities they were asked to undertake and 61% also reported that their current job description was not accurate or only partially reflected their role,' (CSP, 2020b).

Considering much of the support workforce work between NHS bands 2 and 4 (the CSP reported they were aware of some support workers working at band 5 level), it appears support workers may be expected to take on greater responsibility and risk without reflection in their banding and payment. Considering many support workers occupy precarious employment conditions

(Saks and Zagrodney, 2020), occupy a lower position in the healthcare professional hierarchy, and already experience confusing roles, tasks and pay conditions (CSP, 2020a), they may be at risk of exploitation. This is an ethical and moral concern due to its ability to potentially perpetuate social inequalities and exploit the role of lower hierarchy, lower paid support workers, while the professions extend their professional project and become more elite. The impact on health and wellbeing, and job satisfaction would also be of concern, as the CSP reported support workers generally experienced worsening trends compared to their registered colleagues in the NHS workforce satisfaction survey[11] (Yeldham, 2022b). Despite this, in the realms of physiotherapy professional development, they would be expected to take on higher risk, responsibility, more complex work, and all with potentially less supervision.

In addition to within profession reorganisation, there was evidence of a recognition of the overlapping capabilities of physiotherapy and other professions and that some tasks can be carried out by more than one profession, which the CSP suggested can increase efficiency (CSP, 2018c). There was some acceptance of the need to relinquish tasks to competing occupational groups:

'Physiotherapy staff will increasingly need to work in partnership with other occupational and professional groups who are also likely to grow in number. This includes, for example, other specialists in exercise - from gym instructors through to graduate

[11] Support workers in this survey were grouped with other support staff from other professional groups (Yeldham, 2022b).

sports therapists. All the above requires the physiotherapy workforce to be willing to make full use of its capabilities and have the confidence to let other parts of the workforce perform tasks where they can do so as effectively and safely, and more cost efficiently,' (CSP, 2018c, p.4).

Although this could be perceived as the profession conceding to threats to their jurisdiction, it appears to be associated with trade-offs. For example, the relinquishing of these tasks was framed as a way to allow physiotherapists to extend their jurisdiction in the development of First Contact Practitioners and advanced practice. Nonetheless, there was also evidence of attempts to protect professional boundaries. For example, whilst they support greater interprofessional flexibility, they also opposed creation of nurse-therapist or generic therapist roles (CSP, 2018c):

'The CSP opposes this and does not believe that generic therapist and nurse-therapist roles would be a positive development for patients or services. Treating these professions as interchangeable would reduce the impact and value of their professional expertise,' (CSP, 2018c, p.5).

Instead, overlapping roles were deemed acceptable within an individual's scope of practice.

Furthermore, whilst promoting the role of advanced practice (and arguably highly specialist) roles such as FCP, they suggested a culture shift towards generalist practice was indicated, with physiotherapists working as 'expert generalists':

'In our existing system, clinical staff become narrower in their fields of expertise as their careers develop. While there continues

to be an important role for specialists, there also need to be equal value placed on generalists, with a broader depth of knowledge, to meet the needs of the population that have increasingly complex and multifactorial in cause,' (Middleton, 2018b).

Although there is no definition of what an expect generalist would look like, it appears to suggest therapists working in 'front door' positions, such as A&E, being able to deal with high levels of complexity, and assessing patients whose condition is representative of a broad range of specialisms. This ability contributes to the perception of physiotherapy as a flexible, broadly skilled, cost-effective profession, again conducive to their market security within the NHS.

What these methods of restratification and changes in division of labour represent, are explicit mechanisms to secure the profession's place within the NHS and amongst the significant restructuring that has accompanied neoliberal, austere systems of organisation. This is broadly reflective of the '*competitive jostling and readjustment'* to professional jurisdiction that occurs in the healthcare ecology (Abbott, 1988, p.33). Those who do not adjust became liable to failure, dependency, or subordination (Abbott, 1988); something which it appears the physiotherapy profession, at least on a discursive level, is attempting to avoid.

The CSP's rhetoric is not without intrinsic conflict as the problem of professionalism plays out in the discourse analysed. For example, despite the recommendation and endorsement of professional reorganisation which encroached upon other profession's jurisdiction, the CSP attempts to protect the

professional boundaries of physiotherapy to promote its professional longevity and make it competitive. For example, the focus on physiotherapy's unique selling point was often coupled with techniques to make the profession's specific skillset known to commissioners. An example of where professional boundaries were reproduced through language is demonstrated in the following extract:

'…you need to think in terms of physical activity, and then the term "physical" leads you to physiotherapy, rather than "sport" leading you to other professions,' (Middleton in Hitchcock, 2014).

Maintaining professional identity despite expanding boundaries and relinquishing tasks to non-registered healthcare workforce was important to the CSP to maintain its importance and claim to expertise, particularly when challenged by the role of advanced practice, which was occupied by multiple healthcare professions:

'The CSP opposes the separate regulation of non-medical practitioners at advanced practice level… Separate regulation would erode professional identity… Ultimately it would undermine what physiotherapy has to offer as a profession,' (CSP, 2020c).

Having said this, recent events in light of the COVID-19 pandemic may represent a further shift in the perception of professional boundaries in the physiotherapy profession. For example, the CSP reflected upon rehabilitation needs after COVID-19 and how the rehabilitation workforce must be expanded:

'There must be an expansion in the rehabilitation workforce – including more physiotherapists with advanced practice skills and more support workers trained and deployed to add capacity…

There needs to be an inclusive approach to the rehabilitation workforce, which includes the role of care assistants, sports and leisure professionals and colleagues from the third sector.' (CSP, 2020d).

This presents both the ongoing desire of professional boundary preservation through extending advanced practice and upskilling of support workers, but also the relinquishing of traditional jurisdictions to meet demand in a resource-restricted setting, which has only been exacerbated by COVID-19 (BMA, 2020).

The analysed discourse represents the problem with (subordinated) professionalism as a concept and in practice. This is limited by the analysis of a specific dataset of discourse collected in this study; however, the analysed discourse represents how the professional body of the physiotherapy profession in the UK criticises aspects of the competitive ecology, but also relies on this to sustain their professional boundaries as a subordinated profession. For example, it has been demonstrated how the profession attempts to resist austerity and elements of competition in the delivery of health services, though it also relies on capitalist modes of production and competition to sustain itself as a profession. The discourse analysis suggests the profession has capitalised on austerity and challenges in contemporary healthcare to extend their professional project, through their ability to offer cost savings through professional reorganisation. This, looking contextually to the wider policy, has appeared relatively successful, given the increased recognition of physiotherapy in policy publications (House of Commons Health Committee, 2010; The Kings Fund *et al.,* 2018).

4.3 Summary

The analysis of documents has allowed for the identification of complex practices used in NHS discourse to reconstruct healthcare professionals as agents of change. More specifically, they show how healthcare professionals were recreated as agents that extended the neoliberal agenda and austerity measures into the publicly-funded health sector. The state used the discourse and ideology of professionalism to appeal to its values and hence, motivate compliance and subsequent action by healthcare professionals. A reconstruction of professional responsibilities was imposed by the state, as part of the delivery of the government's aims and facilitating arm's length control, whilst also reconstructing the responsibilities of the state. The manipulative methods used by state can be observed by examining non-government and government discourse comparatively, and shows how evidence was used selectively, alongside specific use of language (e.g., emancipatory language) to incentivise, legitimise, and motivate change.

For the physiotherapy profession, the professional body allocated a responsibility for professional development and the profession's future on each of its members. The profession engaged in trade union action to actively oppose austerity, whilst recognising the threats austerity posed to its professional sustainability. The profession was reorganising through jurisdictional encroachment and advanced practice roles in the form of FCP. The profession also relinquished tasks to support workers and other professional groups, acknowledging the threat to their professional boundaries. Having said this, the profession was also attempted to protect and preserve their professional boundaries. There was

evidence that the profession was capitalising on an increased recognition of the profession's ability to deliver cost savings in an era of austerity. This was an example of a profession, at a discursive level, making themselves competitive and sustaining themselves within a growing competitive, market-based, neoliberal system. Which in turn, reproduces the goals of government to extend neoliberalism in the public sector.

Chapter Five: Qualitative Interview Analysis

5.0 Introduction

This chapter presents the analysis of the qualitative interview data. Participant demographics are outlined, followed by the themes which were constructed from their interview data. Each of these themes are discussed and extracts from participant transcripts are used to demonstrate themes where appropriate. A summary of the analysis concludes the chapter.

5.1 Participant demographics and introduction to themes

Twenty-one participants took part in the study. Participants ranged from junior (classified as band five), to senior roles (band six and above). Participants worked in a range of settings including primary, secondary, and tertiary care[12] in both acute and community settings. Participants worked with a broad range of patients and service users, in both adult and paediatric populations. Some participants were specialised in one area, such as profound and multiple learning disabilities (PMLD); whereas others worked across several specialties or were rotational members of staff. Participants had a vast range of NHS experience, from one year to upwards of 30 years. A summary of participant demographics is presented in Table Five:

[12] Primary care refers to first contact care, such as GPs, dentists, and pharmacies; secondary care refers to hospitals, including elective and emergency care, and tertiary care refers to specialist centres/services (NHS Providers, 2015).

	Current Banding	Years worked in NHS	Work Setting	Specialism
Participant 1	Band 6	3-5 years	Acute (Secondary Care)	Respiratory/ Medicine/Critical Care
Participant 2	Band 6	6-10 years	Acute (Secondary Care)	Respiratory/ Medicine/Critical Care
Participant 3	Band 5	Less than 3 years	Acute (Secondary Care)	Rotational
Participant 4	Band 5	Less than 3 years	Acute (Secondary Care)	Rotational
Participant 5	Band 6	6-10 years	Community (Secondary Care)	Falls Prevention
Participant 6	Band 8	21+ years	Acute (Tertiary Care)	Paediatrics
Participant 7	Band 6	21+ years	Community (Secondary Care)	Adult Community
Participant 8	Band 8	16-20 years	Community (Secondary Care)	Paediatrics
Participant 9	Band 7	21+ years	Mixed	Paediatrics
Participant 10	Band 8	21+ years	Community (Secondary Care)	Paediatrics
Participant 11	Joint banding 7 and 8	21+ years	Acute (Secondary Care)	Paediatrics
Participant 12	Band 6	3-5 years	Acute (Secondary Care)	Paediatrics
Participant 13	Band 6 and other not defined	21+ years	Acute (Secondary Care)	Hands and Plastics
Participant 14	Not asked/ undefined /unclear	21+ years	Acute (Secondary Care)	Clinical Academic
Participant	Band 7	21+	Community	Paediatrics

15		years	(Secondary Care)	
Participant 16	Band 6	6-10 years	Acute (Secondary Care)	Paediatrics
Participant 17	Band 8	21+ years	Acute (Secondary Care)	Critical Care
Participant 18	Band 7	11-15 years	Acute (Tertiary Care)	Respiratory Outpatients
Participant 19	Band 7	21+ years	Acute (Tertiary Care)	Respiratory Outpatients
Participant 20	Band 7	3-5 years	Primary Care (e.g., FCP)	Musculoskeletal
Participant 21	Retired - Band 7	21+ years	Community (Secondary Care)	Profound and Multiple Learning Disabilities

Table Five: Summary of participant demographics.

Broad themes were constructed from the data and sub-themes were categorised within overarching themes as appropriate. Five parent themes were developed: 1) austerity as reality in the NHS, 2) austerity's impact on clinical reasoning and decision-making, 3) dynamics of the professional ecology in contemporary healthcare, 4) other countervailing powers to physiotherapy professional work, 5) the COVID-19 pandemic and physiotherapy. These themes and their sub-themes are discussed in greater detail using extracts from participant transcripts as exemplar statements that reflect the theme in which they are located.

5.2 Austerity as reality in the NHS

For almost all the participants, austerity was a daily experience on the frontline of care. All but one participant (P9) reported that they were familiar with the term austerity, though the use of this

word was always outside of the workplace. Participant 9 described plentiful resources and funding; though they also described similar working conditions to other participants, such as reduced access to equipment and training, and greater complexity and size of their caseload. However, they linked these challenges to other societal changes, such as consumerism and the self-informed patient who could challenge medical knowledge (discussed in 5.5).

Cost savings were made through both implicit and explicit means. Regardless of the mode of cost saving, the impact on physiotherapists' working lives was evident. Austerity measures were seen to affect those most vulnerable and in greatest need inequitably. These issues are explored in the following sub-themes: 1) the (non)construction of austerity, 2) forms of austerity measures, and 3) perpetuating inequality and sense of injustice.

5.2.1 The (non)construction of austerity

Austerity as a term was scarcely used on the frontline of care. Rather, austerity was implied or associated with alternative phrases, such as references to cost saving, budget cuts/caps, increasing value, 'doing more for less,' a lack of investment, and emphases on productivity and efficiency. For many, although the term austerity was absent from the 'shop floor,' they were aware of the concept and its presence in wider society and the media:

> *'It wouldn't be a term that would be used openly at work because… there's always a spin isn't there?'* Participant 10.

When asked if the term austerity was used in clinical practice, participant 5 stated:

'No not at all. I can say that with confidence. The only time you hear austerity is when you've got politics on the TV, across the bench. They're throwing the word at each other to gain political points. I don't [think I've] ever heard that in my working day,' Participant 5.

Participant 14 linked the absence of austerity in practice but its presence in the media to the political goals of the government, in what they suggest as concealing the reality of austerity in the NHS:

'I don't think we use the term austerity in clinical practice. We see in the media, don't we? We're really aware of it. Although this government would have you think that it's not austerity, is it? It's you know, everything is being really well invested,' Participant 14.

Rather than an explicit presence, austerity was observable to physiotherapists through its practical implications, such as restricted resources. This became apparent through service pressures and subtle changes in provision:

'I don't really see it. It just comes through as very pragmatic "we've got to cut costs here or we're going to start losing members of staff." The wider political and economic doesn't really trickle down, just "don't give that walking aid out, don't use that, don't use this,"' Participant 1.

Participant 10 suggested austerity was nuanced, but observable in policy:

'It's not explicit. It comes in different guises, doesn't it? … in the next, the five year forward plan or whatever plans, there'll be

some tagline in there that goes "there it is," there's the line about money and about doing more for less or working harder, smarter or whatever. It will be a new one each time and [pause] you can see it,' Participant 10.

The absence of explicit references to the term austerity in clinical practice reflects the findings of the discourse analysis (chapter four), in that 'austerity' was rarely used in governmental and public discourse regarding the NHS.

5.2.2 Forms of austerity measures

Both implicit and explicit means of cost saving were identified by participants. Some forms of austerity measures, such as rationing, exhibited both implicit and explicit modes of cost saving. Rationing was also used as a method to cope with depleting resources (discussed in 5.2.2.2.1).

5.2.2.1 Explicit cost saving measures

Despite the term austerity being notably absent on the frontline of care, explicit attempts to generate cost savings were reported. Participants described a requirement to deliver yearly budget cuts at between 5-10% per year, which had a significant impact on services:

'Cost improvements came in and everything went to hell in a handbasket really. We lost all of our budgets for most of, almost everything,' Participant 21.

Participants described having to evidence how these cost savings had been met to the commissioners; they described how these cuts would be made:

'We've had to cut our budget by 10% each year and obviously we don't always do it by losing people, we've lost some services… Obviously the cut is difficult because you're cutting a service that actually wasn't… we weren't abundant anyway,' Participant 15.

Meeting these requirements was getting progressively difficult, as cuts had to be made year-on-year. Consequently, difficult decisions had to be made:

'Certainly recently, it's just there's nothing to cut that wouldn't really affect children and that's the thing, you don't want to affect their lives and we don't want to give them a lasting effect because you've cut a service, it's not fair. So, it is difficult,' Participant 15.

'I think [the CIP[13]] was 5% every year. And after the sixth or seventh year, I said, "it has to be finite; it cannot be infinite. You cannot keep doing this because we're already now 30% down from what we had,"' Participant 21.

For others, explicit cost savings were also requested as and when:

'We used to get these sporadic emails that would say, "We really need to save X million pounds, if anyone can think of any way to save money, please let us know," [laughs],' Participant 18.

Cuts to services were also made where demand overwhelmed capacity:

[13] Cost Improvement Programme.

'We're just told if you can't meet the needs of the children then we need to cut part of the service. And that I think just brings guilt on the therapists,' Participant 15.

Feelings of frustration and guilt were a common consequence of direct requests to save money. After a request to increase productivity and cut their budget, participant one described feeling disheartened:

'I just remember thinking at that time, I already never go home on time, I already can't get anything for my patients, I already can't get anything done, and you're telling me you want to take more money away from me and give me more patients in this time,' Participant 1.

Interestingly, participant 15 suggested that the required budget cut began 'before austerity,' though this would be dependent on their perception of when austerity began, it appeared they related the commencement of budget cuts in the NHS to prior to the 2008 financial crisis:

'I think we all think of that [10% cut] now as austerity, but I think it actually might have started before austerity. I think actually we started to lose that 10% before austerity really kicked in. But for us it didn't really change things because we were already losing the 10% anyway, so I don't think it's made things any harder than that 10% drop,' Participant 15.

5.2.2.2 'It's by stealth': implicit cost saving measures

There were common modes of cost saving which were not explicitly identified as such. For example, rationing and changes in employment and service structure, such as downbanding,

decommissioning and deliberately holding job vacancies. These are discussed in the following sub-themes.

5.2.2.2.1 Rationing

Rationing was both a method to create indirect cost savings and as a strategy to cope with rising demand and restricted resources. Rationing was used to limit access through strict selection criteria when demand for services exceeded supply. It was also used to ensure all patients were seen, arguably with a reduced service, as resources were spread thinly. Rationing was also used to deliver the explicit cost saving measures outlined in 5.2.2.1.

Multiple and simultaneous forms of rationing routinely took place in physiotherapy professional work. The frequency and duration of treatment was often reduced to cope with demand. Physiotherapists felt they did not offer the same intensity of treatment that they offered 10-15 years prior. Participant 14 suggested there was a mismatch between resources and demand and therefore:

'I think everyone accepts that unless we increase your taxes and pay more, there are really difficult decisions to make…. we have contracted things so much,' Participant 14.

Constricted treatment time impacted on the quality and value of treatment as sessions were condensed:

'It is resource-led a lot. There is a real pressure. If you've got your half an hour slot, that half an hour slot has to include absolutely everything,' Participant 13.

Difficult decisions were made in relation to reducing treatment frequency and/or duration. This commonly was accompanied by professional and ethical conflict as physiotherapists reconciled the needs of individual patients with the needs of the overall service:

'I think all therapists would probably say that it's not appropriate, you need to see them more often. But it's difficult. There was quite a lot of pressure not to because you have other parts of the service to meet as well,' Participant 15.

The provision and availability of equipment was a significant issue. Equipment was regularly rationed. All participants described lacking or inappropriate, damaged equipment, meaning patients' assessment and treatment was often dictated by equipment availability. Specific pieces of equipment, all of which were central to rehabilitation, were commonly identified as problematic; for example, hoists, rotundas[14], walking frames, crutches, orthoses, specialist seating, wheelchairs, and bariatric[15] equipment. Consequently, rehabilitation was hampered, as it was necessary to share equipment across the hospital, inevitably creating greater demand:

'…if you've got lots of patients that need it, there are going to be some days when they physically cannot get out into a chair because there isn't a time slot available for it, which is really frustrating when you're trying to progress patients on and you just don't have the equipment to do it,' Participant 2.

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[14] Rotundas are manual handling equipment used to assist patients in transfers from a seated to a standing position and to another seated position (e.g., from bed to chair) without the need to step.
[15] Bariatric equipment is specialist equipment that has a higher weight capacity for patients who are classified as obese.

These pressures meant:

'Not every patient could have the same experience of rehab,' Participant 4.

Some participants attempted to request extra equipment, though this was usually unsuccessful. Lacking equipment had safety implications for both patients and staff. For example, patients may have to wait to return to bed and staff often deprioritised their own safety to ensure patients' needs were prioritised:

'You tend to put manual handling to the back of your mind, kind of putting your body on the line a little bit because you want these patients to be getting up and going, regardless of what you've got,' Participant 4.

In community settings, requests for specific pieces of equipment were problematic. Wheelchair services were repeatedly cited as being particularly troublesome. Many linked the rise in difficult interactions with wheelchair services to the entrance of private providers into the NHS. Strict criteria and rationed budgets meant physiotherapists repeatedly spent time defending patients' needs:

'How many letters do you have to write? How many fights do you have to have? If I personally have to write a letter to wheelchair services and say, "you are failing in your duty of care, not giving this child in wheelchair." It takes time, and that's me, one child. What about in the community when you've got three or four children and the same wheelchair services being stubborn and difficult?' Participant 6.

Strict criteria regarding what wheelchair services would provide and to whom was a common issue; what was unseen was the consequences for patients:

'There's always a lack of flexibility with wheelchair services. They have a list of criteria, and they can't see the child… you're not allowing them to fully access their environment or to function as their peers do,' Participant 6.

'The criteria at the moment is very strict about what wheelchairs we will give to kids and often that wheelchair is the difference of them getting to school and not getting to school,' Participant 12.

Whilst the implementation of tightened referral and provision criteria was associated by some to a distinct increase in wheelchair referrals (a 500% increase was cited by participant 21), it was also deemed inappropriate to not provide equipment. So much so, participant 21 facilitated a meeting between a service user and wheelchair services, to demonstrate the human impact of their budgetary decisions:

'He went off in his electric wheelchair [laughs] and he literally pinned them against a wall, deliberately, he wasn't that bad of a driver [laughs] and wagged his finger and went "you are shit, my chair hurts, why can't I have a new chair?"' Participant 21.

The use of rationing by denial and/or selection (Klein and Maybin, 2012) to manage resources was also observed for those who were required to create cost savings and manage high caseloads. For example, participant 15 described how their service ceased to see children in mainstream education over the age of 11 for

conditions such as dyspraxia[16]. Limiting access to care had inevitable consequences:

'What we have had to do is limit access. So, a lot of parents, especially for cerebral palsy children, are cross. They don't feel like they get enough therapy,' Participant 15.

For those based in specialist centres and reliant on community physiotherapists to deliver their patients' care, their expectations were low:

'It's hard for the community physios. I'm not blaming them, if their budgets are tight, they've got to make you know decisions and they're not easy decisions, but I have kids with SMA[17] on treatments that really need to have intensive physio [that are] never going to get it NHS,' Participant 6.

This was linked to the lack of funding in community services:

'They're not getting the level of input they need, not because the services don't want to, they're just not funded enough,' Participant 6.

In acute hospital settings, time spent in hospital was also rationed. An emphasis on discharge as soon as being deemed 'medically fit' was suggestibly linked to creating capacity for the throughput of patients:

[16] Dyspraxia is a condition affecting physical coordination in children (NHS, 2019).
[17] Spinal Muscular Atrophy (SMA) is a genetic condition causing muscle weakness (NHS, 2020).

'…you've got kind of one over, two over, send them home… just send them home, send them home, send them home,' Participant 1.

'On the wards it was literally go around, do the bish bash boom. They're medically fit. Why can they not go?' Participant 7.

Emphasis on discharge once deemed medically fit was so embedded in the acute setting, it became an organisational culture:

'There was a discharge coordinator's hub with the most morbid sign above the entryway saying, "every patient has a bed, it's in their own home," [laughs],' Participant 1.

Rationing, in all its forms, meant physiotherapists were having more difficult conversations with patients. For example, where financial responsibility was devolved onto the patient:

'You've got to have that really uncomfortable conversation of "this would probably be beneficial for you, I can let you try one whilst you are here, but you are going to go and buy one." And that's a really hard conversation to have with people that have grown up their entire lives with a service where everything is provided,' Participant 1.

Many participants described the need to ration services as providing the 'bare minimum' or a 'skeleton' service, as anything above this is not feasible:

'I feel like a lot of the time we are just giving them the barebones to get through. It's very difficult to give the level of care that we would like too,' Participant 2.

'You're doing the bare minimum… your best just isn't feasible, so you just have to do what needs to be done. Bare minimum,' Participant 12.

For some, providing as little contact as possible was written into the service specification:

'Our service spec, the tender that we went for describes our service as "providing minimal contact to patients." So, it's trying to provide care I suppose in as short as possible time and the most effective way… I think the driver for that is an economic driver…. it's very focussed on kind of efficiency I suppose,' Participant 20.

5.2.2.2.2 Downbanding, decommissioning and deliberate vacancies

Downbanding was where posts were demoted from their existing banding to a lower banding, for example, downgrading a band 7 to a band 6. Often, clinicians would be expected to carry out the same role, but at the lower banding and pay scale. Both direct and indirect forms of downbanding were described. Indirect downbanding occurred where physiotherapists had left the organisation, and the money allocated to their role would be reallocated to a lower banding, often with greater working hours. Participants described how their own or others' roles had been downbanded, or were working at a higher banding than which they were employed:

'I'm a seven, however, the job role is of a band eight level. But everything has been downbanded in the last kind of four to five years,' Participant 9.

'Our Band 7 is pretty much working as a Band 8 but is in a Band 7 role, because there's not enough resources there to create that Band 8 role for her,' Participant 16.

For others, downbanding was a direct practice, where they were informed that their roles would be downgraded. One participant experienced a mass downgrading across the allied health professions, including physiotherapists, occupational therapists and speech and language therapists. Whilst this could be perceived as an explicit cost saving measure, in this case, operational reasons for downbanding were cited, rather than a mode of cost saving. Hence, this method of cost saving was implicit for staff until they carried out their own investigation. This participant's experience was entrenched in power dynamics, where downbanding (and job loss) were seen as such a lucrative method of cost saving, management pursued this practice to the point of bullying and harassment (discussed in 5.4.2.3).

Decommissioning also took upon direct and indirect forms. For example, partial decommissioning and simultaneous downbanding within a community service meant those working within the acute hospital setting would plan for a lack of community services. For participant 5, decommissioning was a direct (and repeated) experience. Therefore, generating cost savings and evidencing the services' value was a priority to sustain it:

'…our service has been under the threat of decommission[ing] at least twice since I've been there. That's why saving money [has] always been something that's at the forefront of my mind to show the essentialness of a falls prevention service… there's still

a chance it's going to happen, so we're not out of the woods yet,' Participant 5.

The ongoing threat of decommissioning meant ongoing apprehension for participant 5, both for their patients and their own employment security.

A practice termed 'running with vacancies' was commonly used to implicitly save money. This would be where services were purposefully and knowingly running with vacancies to recoup funds:

'[I've seen] when gaps or vacancies become available, not filling them; I've often seen an entire role go unfilled for a year,' Participant 12.

In some circumstances, management would not allow vacancies to be advertised, which had implications for the service:

'We've got jobs that we can't advertise because you won't let us advertise them to save money, to recoup that money while they're waiting… And because there's only maybe one Band 7 in an entire area that means everybody else is now covering that area as well. And you only need one person to be off sick because your staffing's so low,' Participant 21.

Furthermore, not backfilling (or partially backfilling) secondments and maternity leave was a common practice:

'So normally to save money we would be asked to hold a vacancy, so have a rotation without a Band 5 or if a Band 6 was on maternity leave or was off sick or had a secondment, they wouldn't be backfilled,' Participant 17.

'We don't have back-pay or back-cover for maternity leave anymore and it's a quite a female-orientated profession, paediatrics. So, if anyone goes off on maternity leave, there's a big gap. So, it puts a lot of pressure on the other staff,' Participant 15.

The remaining workforce were expected to absorb the extra workload; this created stress and precarity within the team should any member of staff go off sick. Furthermore, there was an understanding that each department would have to carry a vacancy at some point, and this responsibility rotated:

'It's horrible. It's a lot of pressure. It can be quite stressful, particularly in winter pressures... But you know, it's almost like you have to take your turn. So sometimes it's like well they had a vacancy on the last rotation, or they weren't backfilled for that, so it's your turn sort of thing [laughs],' Participant 17.

Paradoxically, participant 17 described an over-recruitment in their most recent recruitment drive as they anticipated attrition from roles and money that had been saved from carrying vacancies would be used to recruit these persons, something they described as *'a massive juggling act.'*

Participant 19 described how the hours allocated to their role were cut when they returned from maternity leave part time, which took a long time to recover. However, they were hopeful that this practice was reducing. Requests for more staff were protracted over extended periods, with services being run by perceivably not enough staff:

'I've been asking for another full-time person for three or four years. So, I've been holding the service myself, so it's sort of by stealth,' Participant 19.

Carrying vacancies was also used to recoup finances from explicit cost saving measures, such as the 10% cut described in 5.2.2.1.

Additionally, when physiotherapists left the organisation, their role would not automatically be refilled. Instead, physiotherapists had to evidence that the role was still required:

'There's also a big process for that [filling roles]. So, you have to fill in a form, you have to justify why you need that post filling again, etc,' Participant 17.

'Every time there's a vacancy, they have to go to a panel to say is this still required when people leave. Which I totally understand that. But it seems to be that you have to jump through ever-increasing hoops,' Participant 19.

5.2.3 Perpetuating inequality and sense of injustice

Despite being free at the point of access and designed to ensure access to all dependent on health need, not ability to pay, there was nuanced inequity to access. This disproportionately affected the most vulnerable populations. Austerity was directly linked by some to the perpetuation of already existing inequalities; for which, many articulated a sense of injustice and felt a personal responsibility to defend these persons. Austerity has been suggested to have increased inequality in the UK (Oxfam International, 2013), and this was evident in the findings.

Participants referred to a 'postcode lottery' and fragmentation of NHS services, where one's treatment, access, and experience of

rehabilitation would be dependent on where one resided in the country. This was met with a sense of injustice:

'The fact that there can be so much inequity between boroughs in this country still blows my mind, [that there] can't be some things in health that are a given. You know, like a personal healthcare budget, that it doesn't matter if you live in London or you live in Leeds or you live in Wales,' Participant 10.

'I would definitely think in terms of where you live, there are definitely gaps in services… if you're within a certain area, there is more available to you then if you live outside, it's kind of like a post code lottery, isn't it?' Participant 12.

This variation was not necessarily from county to county, but also differed within a county. For example, patients from the city area may have had different access or treatment compared to those that lived outside of the city. Participant 13 questioned the underpinning for this inequity:

'There's a lot of postcode lottery, you know, whether people from [names city] couldn't access it or people from [names county] yet, you know you can see the NHS sort of austerity if you like or you know GP commissioning groups controlling things at that time,' Participant 13.

This participant discovered inequity between neighbouring communities when their service merged with a nearby organisation and found the other organisation's patients had access to what was perceived as a superior treatment method. Consequently, they were attempting to secure this treatment modality for their own patients but anticipated this would be a difficult process. As a result, they often had difficult

conversations with their patients, who were noticing this inequality:

'Some of them tell you they've always paid their National Insurance and you know why should they have something different to other people? And there's not really an answer to that as a clinician,' Participant 13.

Participant 12 suggested that the inequity in provision across areas would make them evaluate their location, should they ever require certain care:

'There could be so much available to you or so little. I often think to myself if I had a disability or if I had a child with a disability, where would I want to live? It's not uniform, even though everyone is paying the same tax and all that, it is completely on where you live and what's available to you,' Participant 12.

There was a gradient of inequality between hospital and community settings. Hospitals were suggested to have more funding, despite the emphasis on early discharge and reliance on community services to continue care; comparatively, community settings were perceived to be underfunded. Those working in hospitals were suggested to be cushioned from the severity of austerity and the requirement to engage in business-like behaviour compared to community services:

'Hospitals seem to be a little bit more insulated from it potentially because I guess the way that they're funded is a bit more general [laughs], whereas we're specifically commissioned to provide a service where they go so far as to work out how many follow-ups each patient should have. So, I think maybe the hospital

physiotherapists are a little bit more insulated from that kind of pressure to be efficient in the delivery of the service,' Participant 20.

Participant 9 questioned whether their experience of adequate resources was due to working in the Scottish NHS compared to the English NHS. Nonetheless, another participant who also worked in the Scottish NHS described a vastly different, austerity-affected experience, despite also working in an acute paediatric department. Although this is a very small subset of the participant demographics, it could suggest a similar variation in both experience and service delivery in Scotland.

There was disparity in how different populations of service users were treated. Specialties which were not deemed to be innovative or as some participants described, 'sexy,' were more likely to be poorly funded. For example, healthcare of the older person:

'I honestly think that some of it is this belief that you know it's not a sexy specialty… it's being poorly funded. It's being poorly researched,' Participant 14.

Where funding was directed towards innovative interventions, such as Selective Dorsal Rhizotomy (SDR)[18], patients who were not deemed appropriate would not receive the same physiotherapy input as those who were funded to receive SDR, despite having the same diagnosis:

[18] Selective Dorsal Rhizotomy is a surgery used to reduce spasticity (muscle stiffness) in cerebral palsy (NHS England, 2019c).

'I find that quite frustrating… when the same group of patients, they go down one stream, yet gold standard and they go through a different stream and they're almost like second class citizens,' Participant 11.

Other conditions, such as Primary Ciliary Dyskinesia (PCD)[19] was not considered to be funded and therefore were denied treatment:

'When I used to work as a cystic fibrosis physio, we used to be told not to see the PCD patients in clinic unless they were particularly unwell because we were not funded for it… PCD patients got a raw deal really,' Participant 18.

Those with PMLD were also at risk of poorly funded services:

'The problem with LD [Learning Disabilities] is it's such a tiny service that most Trusts don't really want it, because we're quite expensive. [Laughs]. And we see a very small number of people that generally are not valued by society,' Participant 21.

Paediatric services were suggestibly better funded than adult services, and it was more acceptable to spend longer periods of time and treatment with the paediatric population. There was less emphasis on discharge, and although not without difficulties, access to funding and equipment was suggested to be better:

'Staffing in paediatrics is much better, time to complete admin stuff is much more approved of… taking your time with these patients is more acceptable… my sessions with a child in the hospital are so much longer than an adult one, because the

[19] Primary Ciliary Dyskinesia is an inherited lung condition which causes a build-up of mucus in the lungs and airways (Asthma and Lung UK, 2019).

adults, you're just getting in and out. In adults it's like, well, they're functional so, you know, discharge them… It's just a completely different perception. It's very night and day,' Participant 12.

For adults with PMLD, the transfer from paediatric to adult services demonstrated the variation in service delivery:

'It's okay in paediatrics because they're young, they're little, they're children, they're pretty, they're gorgeous you know, it's the aw factor. But when they get to adults basically nobody gives a monkey's. Nobody cares. It's just so difficult, and they're the forgotten thing,' Participant 21.

This was concerning for participant 21, as physiotherapists often acted as advocates:

'Your client doesn't have a voice. Sometimes literally. I only had one client that could talk… They're a voiceless community... the service[s] haven't grown with them and that's the problem… the money goes into paediatrics but when it gets to 19, just stops,' Participant 21.

Those who had migrated to the UK and/or whose first language was not English were at risk of unequal access, due to language and cultural barriers. Participant 6 described how a family from Somalia did not access their appointments as they could not read their appointment letters:

'Nobody bothered to see if she could read or write. They just assumed she could because her spoken English was so good. She couldn't read and write… So, we don't look after our immigrant

families now… we accept them and then neglect them,' Participant 6.

Those of lower socioeconomic status were potentially excluded from engaging with healthcare as technology advanced. For example, growing use of video consultations relies on the assumption that people can access electronic devices:

'…you're aware a lot more of patients with resources, versus patients without resources or some people who are trying to do everything on one phone for all the family,' Participant 13.

The socioeconomic position of patients and their ability to thus engage with health promotion activity and enjoying a meaningful life was highlighted:

'In terms of looking at kind of the impact of austerity on physiotherapy, I think it's thinking about the impact of austerity on patients. And thinking about the barriers that they then have to recovery or to living a kind of meaningful and enjoyable life,' Participant 20.

This affected physiotherapists' ability to deliver their desired intervention in the context of patients' social and economic resources:

'The knock-on effects in terms of our job when we're trying to support people, whether it's the physios in hospital trying to get people discharged that are struggling to access social services and sort of having a shortage of social workers. Or whether it's me sat in a pain clinic trying to explain to someone why they should exercise and they're telling me that they can't eat. It [austerity] might have maybe opened up new roles for us, but I

think in terms of the difficulty of dealing with patients who've been directly affected by it, often it feels like there's not very much you can do. Because their problems in their lives are so out of your control, the problems are societal,' Participant 20.

5.3 Austerity's impact on clinical reasoning and decision-making

Austerity and lacking resources directly impacted physiotherapists' clinical reasoning and decision making. Resource-led clinical reasoning was common, and rationing had become a cultural norm. Resource-led clinical reasoning was regularly practiced across the specialities, though was particularly evident in acute hospital settings such as general medicine, admissions, and healthcare of the older person.

The term resource-led clinical reasoning is used to conceptualise behaviours where resource allocation took precedence over patient need, not through want, but necessity. Decisions regarding patient care were often shaped around physiotherapists' resources:

'A lot of our decisions are based around what is available and what do we have time to do, rather than actually basing it on what does that patient need,' Participant 2.

Decisions regarding discharge were shaped around hospital capacity:

'You do end up moulding your opinion based on what resources are available, and if there's that patient in A&E, as long as they're not medically unwell, they're leaving,' Participant 1.

Treatment plans would be reasoned with finances in mind:

'It begins to be about, "ok, what becomes the cheapest option versus what is the best option?" It seems a lot of decisions that get made come down to cost,' Participant 1.

Resource availability shaped the decisions that physiotherapists made, how they reasoned those decisions, and reconceptualised how patients' mobility was assessed. Participants' accounts of their decision-making processes in acute, discharge-focussed settings, were triangulated to develop a novel model of resource led clinical reasoning. This presents the issues physiotherapists considered when developing management plans for patients where resources were a primary concern. Many of these considerations were posed as questions to oneself, with an internally undertaken risk-benefit analysis, to arrive at their decision regarding ongoing treatment. This is presented in Figure Two:

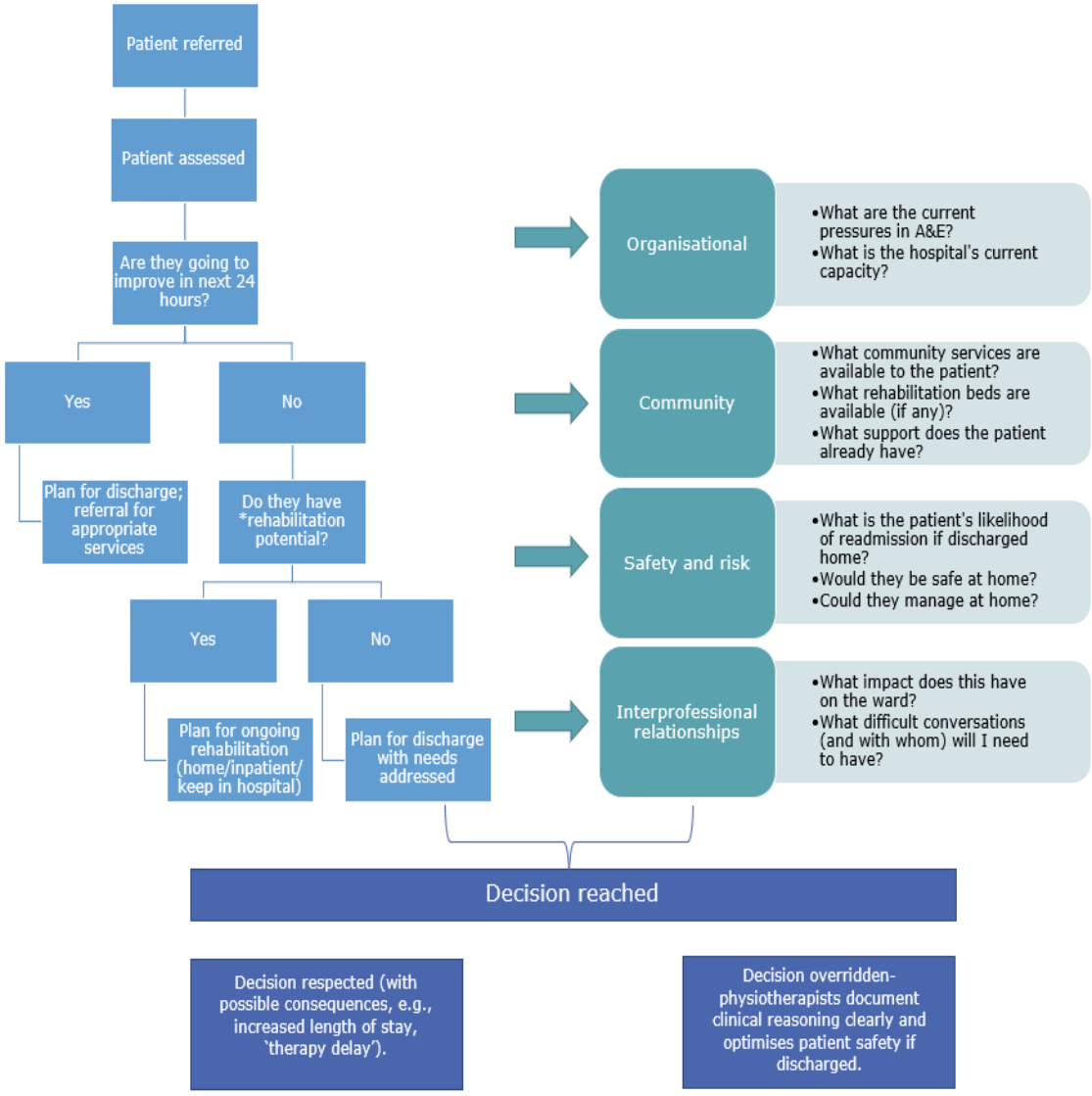


Figure Two: resource led clinical reasoning.

*a problematic concept, discussed in greater depth below.

A hierarchy of patients' ability to mobilise was established, based upon the equipment that was available on the ward. In the absence of gym spaces, rehabilitation-conducive staff levels, and specialist therapy equipment, participants suggested limitations were placed upon patients' abilities. Furthermore, this hierarchy

of mobility was normalised, and patients' ability was assessed against this. Whilst this was important for the wider healthcare team to know how to safely mobilise the patient, it had the ability to limit their potential to rehabilitate. This hierarchy is presented in Figure Three; the pyramid format represents an independently mobile patient at the apex, and the greater levels of assistance required to mobilise as one progresses down the pyramid.

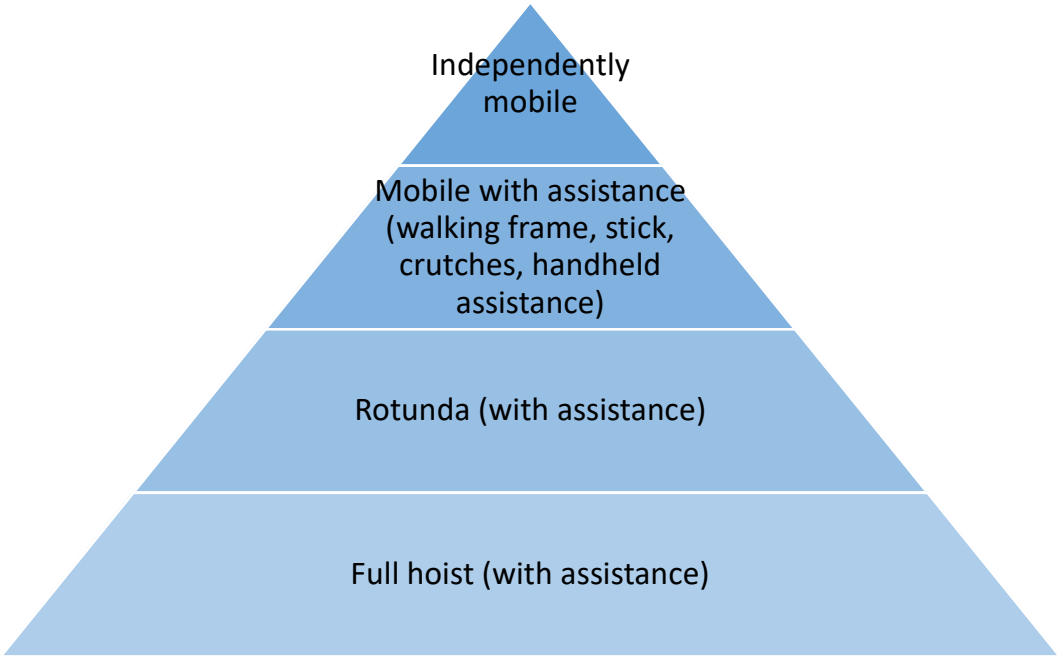


Figure Three: hierarchy of mobility in acute ward settings.

One participant suggested lacking resources to progress mobility meant the progression from rotunda to full hoist was problematic. Despite the potential to be able to stand with assistance, if unable to do so safely without practicing in a rehabilitative setting, the patient was rendered bedbound. This itself, created greater care burden and implications for patients' mental and physical wellbeing.

Furthermore, equipment availability dictated patient mobility. For example, one organisation had ceased stocking three and four-wheeled-walkers[20] as a cost saving measure. The need to reconcile patients' mobility with organisational criteria was so normalised, it created tension when this was resisted:

'My colleague snapped at me the other day and was like "well they can't dictate what walking aid they use," and I went, "well, really, they can, because that is their normal?"' Participant 1.

There was an acceptance of lacking resources and little hope for improvement:

'I think it will always be underfunded. I don't think we will ever have the resources that we think we need,' Participant 3.

The need to ration one's work was normalised and to cope, physiotherapists had to:

'…work out what we don't want to do, there's never more money,' Participant 15.

For some, rationing had become so normalised, it was embedded into practice to the point where it was a subconscious action. Some suggested it occurred more than one realised, and was reconceptualised and/or represented as something other than rationing:

'How many times have I said, "that's not something we offer here," and actually, that's another way of saying we don't have

[20] A walking frame with three or four wheels which can be used indoors and outdoors. Some also have a seat for patients to rest when needed.

the resources to do that. It's probably something you come across more frequently than you remember,' Participant 16.

The reconceptualization of rationing-as-other was apparent in the concept of 'rehabilitation [rehab] potential.' Rehab potential was used to justify decisions regarding patients' onward discharge destination and level of ongoing therapy, for example, inpatient rehabilitation, community therapy, or no further input. Rehab potential was a judgement on whether a patient would improve with further therapy. For some, this decision was one which subconsciously prioritised resources, or was presented as a decision based upon a clinically reasoned judgement on potential to improve, but was really a rationing decision:

'Clinicians make what they think are clinical decisions based on what they've got, when in reality, they're actually rationing decisions. And so, what they then say is, "I don't think you're going to improve with rehab," but what they really mean is, rather than saying "I've worked with your mum, she's doing really, really well, she really needs more rehab but actually, we haven't got the resources in the community." We don't say that. A senior clinician might say that, but I think a more junior therapist doesn't actually realise that there's this sort of unconscious bias in what they're doing, and so therefore, people say, "you've got no rehab potential,"' Participant 14.

For participant 14, this was an endemic and socialised normalisation and reconceptualisation of rationing:

'We've become conditioned to say you don't need anything rather than saying actually you do need something, but it's not funded,' Participant 14.

In participant 14's view, junior physiotherapists were more vulnerable to making this statement, as they had yet to see the consequences of these decisions. Furthermore, they suggested that all patients had potential to improve in some way, but restricted resources and pressure to discharge made physiotherapists reconceptualise this as having no rehab potential.

This could demonstrate a changing notion of rehab potential, driven by resource led clinical reasoning, to a concept of resource-contextualised rehab potential. This itself, potentially reconceptualising the role of physiotherapists in these acute settings, where their role's primary focus appeared to be on facilitating discharge.

5.4 Dynamics of the professional ecology in contemporary healthcare

The participants' accounts demonstrated attempts by the physiotherapy profession to negotiate and sustain professionalism within a fluid system of professional ecology (Abbott, 1988). Contemporary, austere healthcare challenged the profession, and it attempted to reconcile these through changes to the nature of professional work and organisation. Attempts to do so had varying success, and autonomy was challenged when working within an interprofessional hierarchy. These concepts are explored in the following subthemes: 1) physiotherapy's pursuit and sustainment of a professional project; 2) power, hierarchy, and professional work as a profession allied to medicine; 3) the perceived future of the physiotherapy profession.

5.4.1 Physiotherapy's pursuit and sustainment of a professional project

The profession had evolved over the participants' career span. Professional status was cemented through credentialist, university-level entry. For those who had entered the profession prior to academic accreditation, this shifted the profession from a vocational to an academic pursuit:

'Things have changed since it was a degree because it's a degree, and that gives you the kudos as everybody else who has a degree. We didn't have degrees. We have pieces of toilet paper saying we were [a] physiotherapist, that was it. In that respect, I think we were more dedicated, because it wasn't about the degree, it wasn't an academic course,' Participant 6.

Participant 7 linked academic accreditation to a changing culture of financial and hierarchical reward, rather than on professional development:

'Everybody is much more oriented towards getting the next grade, grades have become exceptionally important in the NHS… They're literally now doing their rotations to get to the next pay packet. And for me that is just sad. That's really how I see it has changed. You're not working in the NHS to become very skilled; you're becoming [rubs fingers together] money,' Participant 7.

Physiotherapy's culture of professional practice was compared to nursing by a participant who had worked within the nursing directorate for many years. They suggested physiotherapy was being 'left behind' compared to other professions. They linked this to lacking evidence of cost and clinical effectiveness (see 5.5.2) and lacking 'organisational permission' to innovate.

Participant 14 described organisational permission as embedded practices for innovation, such as journal clubs, regular training and continued professional development (CPD), and service development. These activities were regularly abandoned to cope with demand to facilitate discharge:

'…they [training] always get bumped, because it does come down to "we've got all these patients to see… we could get someone home today." And that's more important than upskilling your knowledge, understanding the latest evidence base,' Participant 1.

Physiotherapists were often expected to address their own training needs when CPD was cancelled:

'…in my experience… it's on you to be competent, which I don't think is right. I got told I was doing this on call and when it was starting and I was like "well, I don't feel ready," and I got told, "you just have to deal with it, here's a list of things you need to do,"' Participant 3.

Lacking training was linked to a culture of 'busyness' in physiotherapy:

'This belief that you know physios are so busy all the time, that we haven't been given permission to go [and do it], which I think is a real shame… we've been a degree profession for a very long time, you know we're highly capable… That kind of culture of change, it doesn't feel as strong in therapy, in physio as it perhaps does in other professions,' Participant 14.

It was suggested the nursing profession had better leadership, and had been more creative and 'business savvy':

'From a leadership point of view, I think nurses have been much more creative because they've been given the permission and they've worked in shared governance models, they've adopted a very kind of collective leadership approach to actually innovate and make change,' Participant 14.

Thus, physiotherapy was vulnerable to reconciling the challenges of contemporary healthcare and professional work unsuccessfully.

Physiotherapists' scope of practice was changing. Scope of practice was expanded through encroachment into medicine's jurisdiction through advanced practice roles (discussed in 5.4.1.1). Participants described greater standardisation of care and 'box-ticking,' rather than meaningful rehabilitation. For example, participant 18 describe how short-term, discharge focussed goals were often pursued:

'What are we trying to do here? Are we trying to say that you're better from this one thing that you've come in with and therefore it's acceptable that you can go home? Or are we trying to say we want to get ***you*** *as a whole individual better? … We get very much caught up in [the] short-term…. it was all very much about can you use your crutches? Can you walk up and down the stairs? Great, tick, right you can go home. Not* ***will*** *you use your crutches?* ***Will*** *you do your exercise?'* Participant 18, participant emphasised in bold.

The ability to practice physiotherapy was increasingly limited by the removal of physical spaces in which physiotherapists practiced. For example, gym spaces had been turned into bed spaces to increase hospital capacity (prior to COVID-19). Lacking gym spaces not only impacted physiotherapists' ability to work to

their scope of practice, but also meant less communal working. Instead, physiotherapists described more one to one working, to counter throughput and large caseloads. This impacted on job satisfaction:

'When I first joined the NHS there was a much stronger feeling of fun and much more enjoyment. It was just a very different feel. Now, everything's kind of, time is justified… There is still an element of that relationship that's just missing…more of the fun side of it, when you really do let loose more with patients and have fun. All of our patients are in single rooms more or less, so you're only ever working with that patient and that other therapist that you might need for support. You don't have these lovely big rooms where you all work together and there's lots of fun in the environment and chit chat… it doesn't feel like that anymore,' Participant 9.

Physiotherapists were moving away their 'hands-on' roots to 'hands-off' treatment. Emphasising self-management was commonplace, with some actively discouraged from using manual techniques:

'I was pulled aside and told not to do manual techniques on someone after they saw me doing some soft tissue release. So, again it's just that ethos, it nearly feels like we are deskilling ourselves at times, that we don't do these things because it feeds into a person's perception of what they need, and then they just keep coming back,' Participant 12.

There was both confusion and scepticism regarding the underpinning for these changes in professional culture:

'It's changed a little bit more into we can explore these things with you, but how can we help you kind of manage your own? I don't know whether that's because of the strain that the NHS is under, that we push more towards that or actually whether it's a natural progression in the healthcare system because of the lifestyles that we're leading, if that makes sense?' Participant 16.

'It's almost convenient at times the evidence points towards the most cost-efficient option. The really cynical part of me wants to ask, "is it that there is no evidence for it or is it that there is some evidence, but it's easier to justify it if there's not?"' Participant 1.

Physiotherapists generally felt they acted less as support networks for patients and their families due to time restrictions, which some felt was integral to their role. Consequently, some families were increasingly accessing private physiotherapy, as they were unable to access the support they needed in the NHS. Participant 15 found this ethically challenging, which affected their perception of their role:

'The ones that can afford it are [going private] and the ones that can't afford it just feel like they're floundering… I think we're kind of losing that role that I went into in the first place,' Participant 15.

Physiotherapists' roles were increasingly focussed on assessment, triage, and treatment prescription, rather than prolonged and intensive involvement themselves:

'I would say my specialism would be assessment and triage. I've not really had the opportunity to develop sort of really extensive rehabilitation skills,' Participant 20.

'I feel like I'm an issuer. I feel more like I've worked as a consultant and less like a nurse if you know what I mean … it's more issuing, I issue stuff and send them off with a programme,' Participant 15.

Cumulatively, participants described feeling physiotherapy had become dehumanised and depersonalised:

'We're losing sort of our personal face of physio and becoming more prescriptive… our physiotherapy role used to be to really know the children and be the person that knew them and could then influence what happens to them sort of thing. And I feel like we've lost that, we're just one more person that they get passed to,' Participant 15.

'I think everyone's really lost that human interaction of working in healthcare,' Participant 1.

The loss of meaningful work and changing jurisdiction created a professional identity crisis for some. So much so, members of the profession found it confusing:

'I find it a very confusing profession, even as one. I struggle to describe what we are at the moment really… [it] is quite an unusual profession if you think about it too hard [laughs] because actually when I think about what our specialism is as a physiotherapist, I'm not entirely sure. There's not many physiotherapy roles that couldn't be done by a different profession,' Participant 20.

Participant 20 questioned whether their confusion stemmed from physiotherapy's process of professionalisation:

'Is it actually just kind of you know, it's just something that has kind of I suppose come about from historical jobs that we were doing. And from the fact that we were quite well kind of organised as a profession?' Participant 20.

Other participants also reflected on the profession's process of professionalisation and the impact this has had on the nature of their work:

'I think we've become a bit wayward. We're tried to fill a gap with a very narrow set of skills. We've created a rod for our own back, and we've created this very narrow picture of what we do and this kind of misappropriation. So almost when you go to practice outside of that really narrow gap, you get a lot of pushback. You kind of get pushed back into that gap of what you do. It becomes more of an algorithm profession, it takes away the therapy of it,' Participant 1.

Extended jurisdiction and specialisation impacted on how this participant perceived their role and autonomy:

'As a profession we have specialised and divided ourselves into such narrow scopes even within the profession… we're missing the big kind of people part. We've become mini doctors, without the authority, without the standing, without the sway,' Participant 1.

This expansion of jurisdiction created further confusion regarding the role of the physiotherapy profession:

'It's muddied the waters even further in terms of who we are as a profession because we're coming away from those sort of four

pillars. Being a physiotherapist now is very different to how it would have been even kind of ten years ago,' Participant 20.

Extended roles and jurisdictional encroachment are discussed in 5.4.1.1.

The movement away from what physiotherapists perceived as their role, loss of meaning, and confusion regarding the role of the profession, created a mismatch between professional expectations and reality. Participant 20 reflected upon the profession extensively, and questioned:

'I sometimes think if I was going to start everything from scratch, would physiotherapy even be a thing you invented?' Participant 20.

Participant 1 also questioned physiotherapy's existence in contemporary professionalism:

'It's that thing you know, if we didn't have physio as a profession, would we start it in today's circumstance? Would it even get off the ground? … I am not sure it would… and if it won't take off, how do we sustain it?' Participant 1.

Participant 1 felt passionately that the profession had been dehumanised by wider constraints, emphases on quantifiable outcomes and had moved away from meaningful rehabilitation. So much so, they stated:

'I would quite like to see physiotherapy burnt to the ground [laughs]. Burn it!' Participant 1.

5.4.1.1 Restratification, changing division of labour and delegation

Professional restratification and changes in division of labour were observed. How and to whom tasks were allocated had evolved, with greater delegation throughout the interprofessional hierarchy to non-qualified members of staff. Greater levels of responsibility, risk, and complexity were expected at each level within the profession and at the level of support workers or therapy assistants.

For senior physiotherapists, managerial responsibility was increasingly devolved to them, meaning they adopted a dual manager-clinician role. They often carried the same (or more) clinical caseload as other senior therapists in their team, with additional managerial responsibility for the team itself. It was expected that these additional tasks be completed within the same number of working hours. For those in this dual role, it was common to experience stress and conflicting demands on their time. They described a feeling of 'just doing enough':

'It's a running joke that I'm always turning up places without things or not being where I should be. And you kinda wanna go to people, I remember a time when I was as organised as you and it's not because I'm not, it's just because there's only so much you can kind of fit in without dropping the ball,' Participant 10.

As senior therapists undertook greater managerial responsibility, those further down the banding took on the brunt of workload:

'They [band 5 and 6s] do literally become the workhorses, as they always sort of have been, they really are the workhorses,' Participant 17.

Junior therapists were expected to take on more responsibility, make complex decisions, work unsupported, and with a greater degree of autonomy, due to high workload, staff shortages and restratification at senior level. Junior physiotherapists often made decisions which they felt they were unequipped for in the absence of senior therapists:

'…you are kind of put into scenarios that you've not yet acquired the experience and it often falls back on junior members of staff to have to step up and over those roles temporarily,' Participant 12.

Participant 20 described their experience as a newly qualified therapist, where they independently ran a triage clinic, acting as patients' first point of contact:

'[It was] really frightening. One of the most stressful situations I found myself in as an adult was having these really rapid throughput of patients… it was very much trial by fire,' Participant 20.

Sequentially, therapy assistants and support workers were delegated tasks normally associated with qualified physiotherapists. Clinicians were increasingly assessing and then prescribing exercise/treatment which was carried out by support workers. In some specialities, support workers would carry out 'simple' mobility assessments and discharges, without any input from a qualified physiotherapist. For some, increased delegation was a method to cope with workload:

'…we're skilling them up to a greater level than we would have done earlier in my career. I think because of the pressures in the department… we're getting them to remove plasters and do roles that I think historically, I potentially would never have asked a physio assistant to do,' Participant 11.

'We're probably delegating a lot more than perhaps we did before. I think it's seen, as you know, a quick fix that they can then just go on and assess the next patient because it's become this kind of treadmill, this continual, there's always something else to do,' Participant 14.

In addition to assisting with workload, support workers were associated with financial savings due to their lower banding and thus, reduced cost. The growth in the use of support workers to deliver physiotherapy meant a proliferation in their numbers.

For some, delegating tasks to support workers felt like a relinquishment of their professional boundaries and undermining of their skills, meaning it was difficult to allow them to undertake certain tasks:

'Even personally the idea years ago of having an assistant doing the rehab on a critically ill patient would have filled me with horror. I mean you know I'm honest, when my Band 7 thought about the idea, I was like, "oh my gosh," sort of recoiled in horror, you know?' Participant 17.

However, having been implemented, the rehabilitation support workers was something participant 17 now felt they could not function without:

'I totally eat my words of not having them you know… it was just hard because I suppose you're protective of your roles,' Participant 17.

Boundaries were also blurred inter-professionally. Physiotherapists described commonly carrying out tasks normally associated with occupational therapists and nurses, particularly in the community setting. Some felt overlapping and flexible professional boundaries were important for efficient and holistic care, whilst others recalled colleagues who were fiercely against this. For participant 19, there was only benefit to this collaborative approach:

'It's really important for everybody to know different roles rather than being protective, because at the end of the day, I don't feel that my job is under threat as a physiotherapist, but other people can do physiotherapy, if that makes sense,' Participant 19.

Physiotherapists were encroaching into medicine's traditional jurisdiction. For example, undertaking additional training and qualifications to independently prescribe, inject Botulinum Toxin (Botox) for spasticity management, and First Contact Practitioner roles. Four participants worked in extended scope roles, one as a part-time FCP (participant 20), one Botox injector (participant 11), and three independent prescribers (participants 8, 11 and 19). Whilst it was acknowledged that these roles saved money, this was not the motivator for those who pursued advanced practitioner roles. Rather, it was due to personal and professional interest, and to increase their services' efficiency and effectiveness:

'I was having to ring consultants or the GPs all the time to get antibiotics or nebulisers etcetera. Whereas now, it's much quicker and I can write to the GPs to put something on a repeat prescription. I can adjust medications and can do that for the whole team. It was about efficiency within the service and providing the best service,' Participant 8.

'It has helped my clinical practice, helped my patients no end… it meant I didn't have to keep asking a doctor or asking a GP to prescribe… we can give patients the best treatment they can have and just like a one-stop shop,' Participant 19.

For the Botox injector, effectiveness and efficiency were also the motivator for obtaining this qualification. They suggested the medical teams' assessments, injection dosage and site would often be sub-optimal when compared to physiotherapists'. Furthermore, as all children were having injections under general anaesthetic, they often had an extended wait and thus, their presentation would change during this time. They suggested ambulant children would often need dosages 'fine-tuning,' which was not being carried out by the medical team, ultimately making their treatment inefficient. They suggested:

'What we were finding was that a) they were injecting the wrong muscles or b) they were just giving too much or not enough. So, we basically said look, sod it, let's be injectors so that we can have a process where we identify children for injection and we bring them in on the day of injection,' Participant 11.

Participant 11 described how patient feedback had been overwhelmingly positive. Nonetheless, the consultants had a mixed reaction:

'There were two consultants that were really very, very, very supportive. There was one in particular who wasn't overly excited about therapists getting involved in the toxin injections, but he was quite anxious about any role that is taken away from the rotating junior medical staff,' Participant 11.

Nonetheless, once this consultant observed how 'slick' the service was, they became very supportive of the service. Support from other professions was integral to the success of physiotherapists expanding their jurisdiction:

'The consultants have been fantastic. They've always been amazing. They've been really strong advocates for this service,' Participant 8.

Participant 20 experienced initial reticence towards their FCP role by GPs, including their husband who was a GP:

'They were talking about first contact practitioners, and he came home said "I just can't understand the point." Which obviously, I felt great about [laughs]' Participant 20.

It was suggested initially GPs struggled to understand why FCPs would be of use, and this was compared to the expansion of pharmacists' roles to undertake medication reviews, which participant 20 reported GPs were glad pharmacists could take *'that really annoying job of their hands.'* However, with physiotherapy FCP, the perception was:

'There was a sense that we what we would be doing is taking the easier patients, so making their diaries harder,' Participant 20.

However, after some time working alongside FCPs, participant 20 suggested that both their husband and their wider team came to

feel the role was hugely beneficial and improved the interprofessional working relationship.

Once implemented, a common issue surrounding advanced scope roles was adequate remuneration and reflection in the banding of the job roles. Most advanced practice participants described difficulty in obtaining accreditation and recognition of the level of specialism in their banding. Of the four with advanced scope roles, two were band 8a and two were band 7. For participant 11, it was a matter of principle:

'It was more of principle that we have that recognition of the 8a element, there is very little financial difference to it… We wanted that accreditation to our roles, to be able to, not be on a par with the neuro rehab consultant, but actually carry some weight that we did know what we were talking about,' Participant 11.

The process of obtaining band 8 accreditation was described as a battle:

'We've had to fight to get the 8a stuff… it was really painful. Because obviously money is tight. But it wasn't a money thing, it was sort of out of principle that we were doing something over the normal role of a physiotherapist,' Participant 11.

Although arguably successful, they had to compromise, with their role being partially uplifted to a band 8a and the remaining hours were static at band 7:

'It wasn't easy to get it, but we got it in the end, and it didn't actually cover all of our hours, but the fact that we got it for some of our hours, we sort of stood back and agreed to shut up [laughs],' Participant 11.

Participant 19 also met resistance in attempting to re-band their role to a band 8a; their nursing colleagues felt the role should not be uplifted:

'It's quite difficult to re-band something you're already doing. There was a lot of resistance from their nurses, from the head of nursing, saying that you should be able to do that job at band 7,'
Participant 19.

Participant 20 reported that as they were fairly early on in their career, having progressed from a newly qualified physiotherapist to advanced practitioner in four years, banding was less important. However, they felt banding should reflect the risk and complexity of prescribing:

'For me working as a prescriber as well, there is more risk than I would expect to have as a band 7 working in secondary care,'
Participant 20.

They highlighted that physiotherapists were carrying out advanced roles were cheaper and therefore, adequately remunerating them with higher banding and pay may be questioned:

'We are being used in a role that would traditionally be in a medical role but not really being compensated for that [laughs]. … I think probably the only reason that we're able to do it is because we're not being compensated to that level, but at the same time, there is kind of a question of fairness there,'
Participant 20.

Nonetheless, these roles remain cheaper than a GP:

'We are working as I suppose a GP or not as high up as a consultant, but maybe a junior doctor level where we're doing a complete assessment of the child, so again, we're massively cheaper than that patient going to see a GP,' Participant 8.

The reasons behind professional restratification were suggested to be financial, efficiency-based, reflective of wider healthcare and the natural progression of the professional ecology. Changes across the professions, not just physiotherapy, were foreseen.

5.4.2 Power, hierarchy, and professional work as a profession allied to medicine

Power and professional voice where common concepts, and physiotherapists were located within a fluctuating spectrum of power dynamics. This included feeling powerless and unable to influence change or using their power to negotiate work constraints. Inter-professional hierarchy, particularly between physiotherapy and medicine, had both reductive and promotive effects on physiotherapists' decision-making and perceived value. In extreme cases of power imbalances, workplace bullying had a harmful effect on physiotherapists' professional and personal lives. These concepts are explored in the following sub-themes: 1) negotiating interprofessional hierarchy; 2) power to reconcile professional work and constraints to professional work; 3) power imbalances and workplace bullying.

5.4.2.1 Negotiating interprofessional hierarchy

Physiotherapists worked within varying degrees of professional hierarchy, existing between both medicine and physiotherapy, and management and clinicians. A key catalyst for when hierarchy was felt most keenly, was patient discharge. This was

commonly related to physiotherapists attempting to resist discharge on the grounds of mobility or safety, in the face of organisational pressure to create capacity. As pressure to discharge grew, physiotherapists repeatedly resisted discharge:

'It just feels like you're banging your head against a wall as a therapist to say, "you can't send them home, they won't cope, they will come back," and I feel like I'm having more and more of those conversations,' Participant 1.

These conversations would be difficult:

*'It's always a challenging conversation because there's a bit of an affront… You kind of get this really offended reaction like "how dare you find information that contradicts **my** position?"'*
Participant 1, emphasis from participant in bold.

Some described being fearful of approaching these conversations, particularly those perceivably higher up the hierarchy:

'If you're having to broach that subject with the medical or nursing staff, and you know that person has been earmarked from a medical viewpoint as being fit for discharge, but they're just not quite there yet from a mobility point of view or a safety point of view, then you're nearly shaking being like, oh, God. They're going to kill me! [Laughs],' Participant 12.

Junior physiotherapists appeared to experience interprofessional hierarchy more strongly. Juniors viewed medicine at the apex, with *'everyone else [falling] on a fairly equal playing field,'* (Participant 3). Juniors felt they were expected to work around doctors' decision-making, though they would articulate their own autonomous decisions.

When discharge was resisted, this was noted as a 'therapy delay,' consequently placing an element of blame and responsibility for limited patient flow. As junior therapists often made these decisions, they described other, often senior (but not always), healthcare professionals (such as bed assessors[21]) attempting to curtail their decision-making:

'[The assessors] sometimes can make it really hard work, so you might have a patient that you think it's obvious needs to go to rehab, they make it hard for them to say yes, to have that community bed if that makes sense?' Participant 4.

Whilst their decisions were generally respected, though not without consequences for their working relationships, some described being overridden:

'It sounds awful, but I think as a response to therapy sometimes you do get the "oh well, it's the doctor decides, the doctor says they're going to go home so that's what matters,"' Participant 1.

Consequently, participant one questioned their professional worth:

'It does feel a lot like your professional opinion isn't as valid as it used to be … it does sometimes get to the point where you go "well, what is the point then? Why did you ask me to assess this person if you were just going to ignore what I said anyway?"' Participant 1.

[21] These persons would be responsible for managing patients' discharge destination and often involve management of bed capacity across a range of settings (e.g., hospital, community, rehabilitation beds).

Longer-serving physiotherapists reflected on interprofessional hierarchy as something to accept and negotiate. This offered an opportunity to negotiate constraints in some circumstances (see 5.4.2.2), and in others, acceptance was reached:

'We'll have told the families X, Y, and Z and they might not believe us, but the consultant comes along. We've told them to say X, Y and Z. They say X, Y and Z and the patients believe them. So, it is the old thing that the consultant will always be believed more than the therapist,' Participant 11.

Participant 11 linked this to how powerful physiotherapists' professional voice was:

'I think certainly in high powered meetings, I don't think the physio voice is as strong. I think in a confrontational type setting, I don't think the physio voice is as strong. On a day-to-day basis a confident, competent physio can be very empowering. But I think there are times where you just have to sort of accept that it will only be believed or understood or taken from a consultant,' Participant 11.

Participant 14 linked a less powerful voice for the physiotherapy profession with the size of the profession and lack of leadership:

'I don't think our voice is as powerful because we're a smaller profession, and we haven't got people at the top shouting for us,' Participant 14.

Although not expressed by participant 14, gender may also play a part in this. For example, physiotherapists described having little voice in 'high-powered' meetings with the traditionally patriarchal medical profession. Gender had very little explicit

reference in the interviews, except one participant suggesting the Agenda for Change pay-scale helped to address gender imbalance as renumeration was based upon merit and competence, rather than gender. However, this does neglect the implicit means of gender imbalance, as the ongoing (but improving) gender pay gap in the NHS shows (Appleby and Schlepper, 2019). Furthermore, implicit references to gendered discriminatory practices (such as not backfilling maternity leave) were identified. Therefore, gender did influence aspects of physiotherapists' professional work.

Attempts to establish autonomy and thus independence from hierarchical and patriarchal medicine occurred in training. Participant 18 described how buzzwords were used to establish independent practice, though this was not necessarily effective:

'When I trained there was always this big sort of thing about you had to say these buzzwords about being an autonomous practitioner and that you were responsible for your own decisions. And a consultant couldn't come in and say I want you to do X amount of hip flexor exercises. But I think it was still quite an old-fashioned sort of model,' Participant 18.

Physiotherapists suggested the level at which hierarchy was experienced varied depending on speciality. For example, cardiology and critical care were named as hierarchical specialities, whilst those where rehabilitation was integral, such as stroke and neurology, had more equal footing for all healthcare professionals. Participant 19 suggested that increasing appreciation for the profession meant interprofessional hierarchy

had flattened; though for others, as demonstrated, hierarchy played an ongoing role in how they practiced.

Hierarchy between management and clinicians was experienced. Whilst some had good relationships with management, others suggested they were *'disjointed from reality,'* Participant 12, particularly when adding pressures to their existing workload. Some experienced gatekeeping to certain tasks or activities. For example, following the TUPE (Transfer of Undertakings [Protection of Employment] Regulations)[22] of their service into another NHS organisation, participant 8's usual channel of communication with the CCG was cut abruptly:

'Prior to moving over, I had direct contact with the commissioners, and since we've moved over, I asked, can I attend the commissioners' meetings etc? I'm not allowed to, so it's very hierarchical. I'm not allowed to attend those meetings,' Participant 8.

This participant experienced consequences to resisting this decision, in what they felt was in their patients' interests:

'The Commissioner wanted to speak to me directly about the service that I set up 10 years ago, but the higher management… [pause]... I got in quite a lot of trouble for speaking to the Commissioners directly,' Participant 8.

Interprofessional hierarchies impacted on physiotherapists abilities to negotiate organisational and structural constraints.

[22] A TUPE is where employees rights are protected during the transfer of an organisation from one employer to another, or where a service is transferred to a new provider/employer (Advisory, Conciliation and Arbitration Service, 2008).

Their ability to reconcile these challenges is explored in the following subtheme.

5.4.2.2 Power to reconcile professional work and constraints to professional work

The challenges of contemporary healthcare discussed thus far affected physiotherapists' ability to consistently fulfil their professional responsibilities. When asked if they felt able to carry out their role, there were mixed responses. Some felt they were, but with caveats:

'As a general rule we are able to conduct our role, I just don't think we are able to conduct it to the level that we'd like,' Participant 2.

There was a misalliance between organisational and personal expectations:

'…you know what gold standard is and as good as it is, you know it could be better,' Participant 10.

'…you often can't do your very best, you know? You're just told you need to do the minimal,' Participant 12.

'I think if you're struggling in terms of staffing, equipment etc, you aren't necessarily doing what you were taught at university to do… and I think when you can't do that, sometimes you question, what can you do?' Participant 4.

For some, perception of fulfilling their role was observer-dependent:

'I feel I'm not delivering my role as a physiotherapist. According to the commissioners, yes, I'm delivering my role. ***I*** *don't feel*

like delivering my role,' Participant 5, emphasis from participant in bold.

For some, the feeling that they were not meeting their own personal and professional perception of their role, created personal and ethical conflict:

'It's frustrating, it's quite upsetting cos I feel like I came into a caring profession and I'm not doing my best. Or [voice breaking], I'm doing the best I can with the resources I have, but it does make me wonder if that was my relative, do I think that's enough? And I don't think it is,' Participant 2.

An inability to meet personal expectations of one's role also conflicted with the underpinning values of the NHS:

'It feels like you're not providing a service that is coherent with the ethos of the NHS, from cradle to grave,' Participant 1.

Reconciling personal, professional, and ethical challenges were context dependent; motivation to reconcile resources and responsibilities fluctuated:

'Isn't it rubbish to say that you feel like you're not the best physio you can be, not through lack of trying but through lack of resource, lack of support, lack of money. I think anyone could feel constricted by it. And I think it's how you deal with it. It's whether you kind of rise to the challenge and think okay, well I'm going to do this with what I've got or … I find that for myself I get just frustrated sometimes that I can't do what I believe is the best option for a patient based on those things. And I guess that probably a lot of other physios would feel like that as well,' Participant 16.

Some felt powerless to influence change, often due to repeated, and failed, attempts to improve service delivery, meaning they may not attempt again in the future:

'It's quite a use of time when you think you have to kind of weigh up am I actually going to be successful, do I bother?' Participant 2.

'It's not going to happen, so it's become the norm for me. So don't ask, don't get is not a phrase to me, it's just don't ask,' Participant 5.

'Everybody gets rejected these days. So, as a result, we have given up applying,' Participant 11.

Repeated failures created disheartened clinicians:

'When you keep asking and asking and asking and nothing happens, that can get you down a bit,' Participant 4.

For others, failure motivated persistence:

'The NHS teaches you to be very resilient about just keeping on and keeping on really. Not to lose faith, even if you've been asking for something for three years [laughs],' Participant 19.

For those who felt powerless, they practiced methods of self-preservation, including acceptance of one's limitations and boundary setting. For example, some committed to doing their best and acknowledging what they could control:

'I've personally had to take a step back from it and rather becoming quite invested and being that really vocal advocate and saying "well, really actually no that's not ok," I've decided to adopt the stance of a little more of self-determination, sort of

saying "well they're going to make that decision, I'm going to give them all the tools and all the reasons about why they shouldn't make that decision, but they are going to make it anyway and there is literally nothing I can do about that,"' Participant 1.

'There was a time when I think as a profession oh, we've got to do more, we've got to do more. We've got to see more, and I think we have finally realised that there is a brick wall and when you hit that wall you just keep going. But you can't push through it if the money is not there. The money's not there. Don't drive yourself potty, get on and do what you can do,' Participant 6.

Participant 5 accessed support to help them set boundaries with their workload to protect their mental health:

'I've seen a lot of psychological services for my own self development, [which] really helped me re-file my priorities [and] not take those constraints on as well… Because I can conscientiously say I'm doing 7 and half hours work a day and you know, sorry if anyone hasn't been seen today. I'll see them tomorrow, you know, that sort of, I'm not taking it home with me,' Participant 5.

Physiotherapists adjusted the level of risk they deemed acceptable:

'I've got accustomed to that risk I suppose over time and that depends on how you as a person can deal with that stress and that risk, which isn't how you should work, is it? It should be about if you're capable of doing the job, not that you're capable of managing this level of stress and risk,' Participant 10.

This participant had normalised a higher level of risk, though suggested this was not ideal. Ultimately, their patients' safety overrode everything else, including their own personal health and wellbeing.

Physiotherapists commonly adopted dysfunctional working patterns; many regularly worked over their contracted hours, which was unpaid. Physiotherapists described feeling a great responsibility for their patients and therefore worked above their paid hours (and on days off) to ensure patients received care. Participant 11 suggested the NHS relied on the goodwill and commitment of staff:

'I just work longer hours to get the job done. I don't know whether it's almost sort of expected in the NHS is probably not quite true, but I think that's probably how the NHS survives [laughs] is everybody doing above and beyond really,' Participant 11.

Working unpaid overtime was particularly common in community settings, where the flexibility of remote working and electronic record keeping meant clinicians used their day to see as many patients as possible, and then completed notes in their own time in the evenings:

'What I end up doing and all the therapists end up doing is trying to fit say four or five children in a day but then doing all the paperwork in the evening at home… we're all sitting up there working sometimes doing notes until like half 10/11 at night and you can see other people are working. So, I know it's not just me,' Participant 15.

The internalised pressure to work over their contracted hours was not due to managerial or organisational pressure, but rather, due to guilt if patients were not seen; this impacted on work-life balance:

'It's that endless cycle that if you don't do it, you end up not seeing children and feeling bad that you haven't seen them and that you need to get to them. And if you ***do*** *do it, then you end up feeling bad at home because you're working in the evening and putting pressure on your own family, and it becomes difficult at home. It's very hard to have a sensible work-life balance,'* Participant 15, emphasis from participant in bold.

Interestingly, there was pressure from management for physiotherapists to not work over their hours and to go home on time. However, this was not deemed feasible:

'I've already been told off for having too much, building up too many excess hours and in the end, I said that I can either work my hours or I can do my job, but I can't do both,' Participant 18.

Most physiotherapists had normalised working over their contracted hours. For participant 15, the impact on their family and work-life balance had become severe. This, alongside a debilitating level of professional guilt, prompted a decision to leave their speciality altogether:

'There just comes a point where you can't do it anymore… generally my guilt from not seeing people enough and being able to do a good enough job, I do feel we don't do as good a job as we used to... you end up shortcutting all the time and not doing as good enough job. [It] eats away at your professional confidence; you just feel like you're not doing well enough. But if

I did a better job, then I would take it away from my family. And it was really difficult. So, in all honesty, I've actually made the decision to leave unfortunately, I'm going to go,' Participant 15.

This decision cascaded further guilt and frustration for participant 15, however, they simply could not continue to work at this level.

Professional frustration was commonly addressed through utilising support systems such as peer support and supervision. This was seen as essential to manage and negotiate the challenges of contemporary healthcare successfully and prevent detrimental effects on health and wellbeing. For some, other mechanisms of relief were required, such as returning to education for a break from clinical work, something that happened early on in their career for participant 4:

'I kind of got into a position as a junior where I just wasn't enjoying the profession anymore. I didn't want to continue in the same job and learn to hate it, so I needed to just take some time out, just to basically miss the profession again and just to re-evaluate what I wanted to do,' Participant 4.

For others, they would continue to push for change, even if it were to impact them negatively:

'Everyone wants the NHS to succeed, so everyone will do whatever they can to make it work to be honest. Even with less staff or less resources you still just gotta try and push for things to work, whether that be the detriment of the staff,' Participant 8.

For some, there were proactive methods to circumvent the challenges posed. Physiotherapists used professional networks

with more powerful professions to achieve their professional or service goals. Physiotherapists would submit funding applications with consultants as this was associated with greater success:

'We will do it as a consultant and therapist team approach. But do we have a voice? No, I would say. We have tried to change the outcome of it on a number of occasions, but we haven't succeeded as yet… If you are negotiating at that sort of level, I think a physio would not carry the same weight as a consultant,' Participant 11.

Working relationships with consultants were also used to negotiate time off for participants pursuing further education, such as PhD study.

Long-term employment and seniority had its benefits, as flexibility was awarded, and networks were used to access equipment:

'At my level, I sort of know a bit more about how to go about getting something if I think we need it. To be honest some of it is around who you know, not what you know as well,' Participant 17.

For junior physiotherapists, establishing a relationship with the nurse ward manager was essential:

'If you could get the ward manager on board, she'd normally fight your battles so that was quite key,' Participant 4.

Their own professional reputation was used by longer serving physiotherapists to negotiate challenges. Some reported becoming a regular complainant and making themselves

unpopular, as this created an aura of difficultness which could overcome issues with little effort:

'I am not averse to making myself unpopular. So much so that I heard someone that said: "You've got a funny influence on this wheelchair service." I said, "what do you mean?" She said, "well, I've heard that the head of wheelchair service once said: "Oh my God, it's her. Just give her what she wants,"' Participant 6.

This was such an effective strategy, that this physiotherapist would place their name on applications for patients that they were not involved with, as this would ensure the application would be successful. Physiotherapists would also encourage complaints from patients to assist in applications for equipment:

'We don't recommend the parents fight with wheelchair services anymore. We tell them to go straight to the CCG and complain to them. Actually, that's having a lot of effect, but that's not a nice way to do things,' Participant 6.

This technique was also used to provide evidence that they were not able to meet demand:

'We've tried to sort of ask them basically to complain, so that it goes up to management, so that we can prove that we're not able to do what we can do,' Participant 15.

Physiotherapists would circumvent funding decisions through applications to charities and third-sector organisations, and some paid for equipment from their personal finances. Creativity was essential to negotiate constraints. Some bargained with others to achieve what they wished, for example:

'This might be a silly example but for some reason you know, some of the surgeons they love incentive spirometers[23]. We know there's no evidence for them you know, they like them, blah-di-blah-di-blah, so we just change it and say right, well we can have one box of incentives spirometers, but we'd like another box of acapellas[24] rather than two [boxes of incentive spirometers]. So that we sort of get the other bit of kit… So rather than getting like loads of one thing, we get sort of what we want but we still keep them happy with a few spirometers [laughs]. So yeah, it's not manipulating but just sort of massaging what we need,'

Participant 17.

Physiotherapists used their professional privilege and clinical reasoning to resist constraints on the grounds of their specialist knowledge. Physiotherapists would use clinical reasoning to override organisational caps on the number of treatment sessions and justify this through autonomous decision-making. They would use their specialist knowledge to justify non-compliance to organisational caps and be prepared to defend their decisions:

'…having to be very strong in your own clinical reasoning and saying, "well no, I'm going to have to see you again because I think there's these clinical reasons," and be sure about that because you may well be asked by your line manager,'

Participant 13.

However, this was not completed by all members of staff:

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[23] Incentive spirometers are devices which facilitate deep breathing; they provide visual feedback to patients when taking a deep breath.
[24] An acapella is a device which provides vibration to help patients clear mucus from their lungs.

*'There's a new band six in the in the department who I heard her say to a patient, "oh, well, I'm not **allowed** to give another treatment slot," and I thought to myself, well, actually… as a professional you always are allowed, you know? You're the prescriber… you're an independent treater,'* Participant 13, emphasis from participant in bold.

It is important to note that there was no strict dichotomy between those who felt powerless and those who made attempts to circumvent and/or resist exogenous constraints. Some felt more powerless than others, though the ability to negotiate challenges can be seen as a spectrum. This spectrum of ability was dependent on the context of the decision, and physiotherapists' assessment of how successful their attempt would be. For some, power imbalances and a total inability to respond culminated in vulnerability to workplace bullying and harassment. This is explored in the following subtheme.

5.4.2.3 Power imbalances and workplace bullying

Two participants experienced the extremes of power imbalance, skewed towards management or their senior colleagues; this resulted in bullying and harassment. This had a hugely detrimental effect on their, and others, mental health and working life. For participant 5, a demanding caseload working in the musculoskeletal [MSK] department as a junior predisposed them to anxiety and stress:

'The NHS pressures for MSK- 40 minutes and 20 minutes- its back-to-back to back-to-back. It's like I said, relentless... I don't think it was healthy for me. That anxiety, that stress, that fresh

"I've got to see this patient, finish by then, document, because somebody else is waiting," and so on and so on,' Participant 5.

Workload constraints and what they described as poor management and lacking supervision, lead to bullying and harassment. This had a significantly damaging, long-term effect on their mental health:

'I really did struggle, saw some really quite dark days from that. When I look back, it's… I wish I had that opportunity to have that peer support time and sit down and discuss my problem patients as opposed to being poorly managed and then bullied and harassed. Instead of having that support, it was "you've not treated that patient properly," or you know, "you've been rushing that patient." [With more support] I'd have learnt more, I'd have been more relaxed, supported and composed,' Participant 5.

After this experience, participant 5 moved organisations and into the community, where they described greater flexibility and a team who were more supportive and pastorally-minded. They reflected upon how their pre-existing anxieties were perpetuated during their time working in a high turnover environment:

'My anxieties were there anyway, but I think it was exacerbated by constraints, time pressures, lack of support, the poor management,' Participant 5.

It was clear the immense impact their experience had on their personal and professional life. Importantly, their account highlights the human impact high workload and organisational expectations, in conjunction with inadequate management and senior support, can have on both personal and professional life.

Participant 21's experience of bullying was directly linked to cost saving measures by senior, non-clinical management. They described how a service redesign meant job losses and downbanding across the workforce. Whilst this was characterised as a cost saving measure, this was not how it was presented. Participant 21 reported staff were told the redesign was due to large waiting lists (though there was no waiting list) and that the workforce were not delivering enough patient contact. However, this was disproved by the workforce who ascertained the facts regarding their contact numbers:

'When they announced the down-banding, their senior speech and language therapists who are all 8As, all resigned en masse. One of them put in a Freedom of Information request on contact numbers, which they had to give. And it turned out we were doing a third over the contacts we were commissioned to provide… So, contacts wasn't a reason, and waiting list wasn't a reason. They were the two reasons we were given,' Participant 21.

The measure created huge disruption and distress. Many left the organisation as they could not financially afford to be downbanded and for those remaining, morale rapidly declined:

'I'd never seen a group of staff sort of globally within a district be so demoralised. With just somebody leaving every day. You just couldn't keep up with it. it just all kicked off and just got worse and worse and worse,' Participant 21.

This was not participant 21's first experience of service redesign and bullying:

'They wanted to get rid of my post because it was a Super[intendant] 1. So, they obviously wanted me out [laughs]. They just made things very, very difficult. I won't go into it now, but it was a sustained campaign to get rid of the post and get rid of me,' Participant 21.

This experience was repeated for their colleague in the most recent service redesign, where a campaign to remove the band 8a physiotherapy manager included rumour-spreading in an attempt to damage their reputation. This had a devastating effect, and they left the organisation:

'This Trust did the same to her to get rid of her so they could have the post. So, they could have the money from the post. I mean she just walked… I said, "you look awful," and she went, "I was sitting up last night working out what would be the best way to kill myself." She said, "I just can't take this anymore." And it was all because they just didn't want that post because they wanted the money. They had a go at all the 8As, physio, OT, speech and language, really had a go at them all, so eventually they all left,' Participant 21.

Contact with this individual outside of work uncovered the lasting effect on their health:

'She said, "I'm just able to sleep through the night. I just used to wake up with panic attacks the whole time thinking [gasps] I need to do this; I need to do this because they've given me this deadline and then they're threatening me with this and they're threatening me with you know." Just awful. Absolutely awful. Just sheer bullying,' Participant 21.

They described how power was skewed towards management, as whilst clinicians were downbanded, senior management were promoted. Inevitably, staff attempted to resist the redesign, though this was ultimately unsuccessful:

'We went, "this is not workable, this is unsafe to the Nth degree," they went, "well, do your own then." So, we did our own... we put together another proposal that would save the money but by moving it round in different ways but keeping your level of skill and your clinicians. And proposed that and put it to the team that were redesigning it, none of whom worked in learning disabilities, none of them were clinicians. None of them knew what they were doing. And then they invited two people from our sort of team to go. They both went to talk, and they went, "right, well we'll discuss that," and they said, "okay, well what we want to say is …" they said, "no, no, no, you've presented now, you can leave." So, they weren't allowed to stay around for the discussion. Which is just bizarre. Come and discuss this, but you can't,' Participant 21.

Staff made attempts to verbally resist the measures, though these were disregarded:

'At the meeting where they said you know, "we're losing you, you've lost your job, you've lost your job, you've been down-banded," blah-blah-blah, which was done completely off the bat with no warning for a lot of the people there. They said, "we've had meetings and we have had discussions with you." And the OT shot her hand up and went, "no you haven't!" [Laughs]. "Yes, you've attended the meeting." She said, "yeah but we weren't

allowed to discuss anything." "Well, you have attended the meeting." And that was it,' Participant 21.

Instead, they resisted the measures in re-establishing their role:

'They said, "well, it's okay because you'll be doing the same work. And that is when I went, "err, no. If you want a band 6, you get a band 6,"' Participant 21.

This participant made attempts to warn commissioners, the organisation, and the managers of the dangers of job losses and downbanding, though these warnings were ignored. Growing concerns amongst staff prompted an exploration into whistleblowing. However, they were so concerned about the history of bullying and their employment security, this was not seen as an option. Staff also explored reporting to the Care Quality Commission CQC)[25], but were concerned about doing so. Therefore, staff were cognizant of the route of reporting concerns:

'So, the implication was if you spoke out of turn, and outside the Trust… we were going to contact CQC but actually on CQC's website it does say that we can't protect you, you know, from your own Trust [laughs]. And so, we didn't bother with that. That's why we used the person who'd resigned to do the Freedom of Information. So that it didn't come from us within the Trust. We had to be really careful, really careful,' Participant 21.

Therefore, they informed a commissioner of their concerns following their retirement:

[25] The Care Quality Commission (CQC) are the independent regulator for health and social care services in England (CQC, 2022).

'I couldn't do it while I was there because they were not above threatening you with all sorts of things if you whistle-blew. So, you could raise concerns at work, as long as nobody ever knew about it [laughs]. And obviously I'd been raising concerns right, left and centre and therefore everybody was [annoyed],' Participant 21.

When prompted to expand upon the reference to threats, participant 21 stated:

'It was implied. It wasn't overt. It was just things like you know, "you're very lucky to have a job here. And you wouldn't want to you know, lose that, or have problems within that job, would you?"' Participant 21.

Participant 21 articulated a lengthy and passionate account of their experience. They suggested staff worked to the best of their abilities, despite the immense personal and professional pressure, and distress they were subjected to. They reflected upon how the profession was perceived and valued, if at all. They described how the only non-medical and non-nursing profession within the team who were not affected, were psychologists. They related this to their *'special dispensation'* due to their 'attachment' to doctors; and so were deemed 'safe,' at least in the short term. Participant 21 suggested the profession's security was vulnerable and a possible (and implicit) difference in how different healthcare professions are perceived:

'I said, "you wouldn't go to a consultant and go well we've decided we're going to pay you as your basic SHO [Senior House

Officer][26] you know, you'll be fine," [laughs]. Just do what you've been doing on that pay. I said, "you wouldn't dream of doing that to a doctor, why are you doing that to us?" It's just a non-acceptance of how skilled we are… They would never treat doctors the way they treat us… there would be a public outcry… they wouldn't dream of doing it to the medical profession, because the country itself would be up in arms,' Participant 21.

They suggested lacking value and understanding of the profession meant it was often used as a financial exercise to recoup money and was thus vulnerable to cost saving measures.

5.4.3 Perceived future of the physiotherapy profession

Participants provided insight on both their personal futures in the profession, and of the collective profession's future. Physiotherapists felt the profession would continue to expand outside of its traditional scope and into advanced practice roles. Some felt this should be actively encouraged as the profession was underutilised. Some suggested physiotherapists should be encouraged to apply for roles outside of their traditional jurisdiction. Many foresaw a consolidation in the role of assessment and triage, with rehabilitation being delegated to non-qualified members of the profession, such as support workers. For some, this had the potential to deskill the profession and put the profession at risk of displacement altogether:

'I did feel for a long time that we were going down that route where we were deskilling ourselves as a profession, that we were

[26] Senior House Officer is a rank of junior doctor (British Medical Association, 2022b).

losing those skills that made us stand out, because there wasn't a role for those skills within the acute setting or in a high demand NHS setting and we're essentially becoming box tickers and that makes me fear as well the fact that these roles had been going to band threes and band fours, does make me think that maybe our value and our skill set is not being utilised wholly within the NHS and when it's not utilised it's very easy to say well someone else could do something like that,' Participant 12.

Specific roles, such as FCP and 'front-door'[27] roles were named as increasingly relevant for the profession. Physiotherapy's role in public health was highlighted, with a suggestion that the profession should capitalise on this opportunity to contribute to promoting good health and preventative care.

Addressing lacking representation on funding bodies such as CCGs was seen as essential to strengthening the voice of the profession. Improving the profession's evidence base was suggested to be critical in maintaining physiotherapy services:

'If you can't show you're clinically effective, you ain't gonna show you're cost effective and therefore you ain't gonna be commissioned,' Participant 14.

Advancements in technology and pharmacology posed threats to physiotherapy's continuing practice. For example, participants named a recent drug development for Cystic Fibrosis as significantly reducing their need for physiotherapy treatment.

[27] These roles are based in the Emergency Department, whose focus is on assessing patients to prevent admission where appropriate.

Furthermore, developments in artificial intelligence (AI) were foreseen threats to continued professionalism:

'Maybe we will have robots that do our job… there is nothing in our reproducible manual labour that couldn't be outsourced to that kind of technology,' Participant 1.

This participant identified colleagues who were facing this challenge:

'Radiologists are having this crisis, AI is just as accurate if not more accurate at reading and interpreting scans then a human who has trained for 20 years,' Participant 1.

Reducing the profession to tasks was a potential threat, both for usurpation and understanding the profession. Occupational Therapy was suggested to have experienced this, with a perception that their role was solely ordering equipment.

Raising the profile and marketing the profession was commonly cited as action which needed to be taken to prevent the physiotherapy profession from being displaced:

'Until we raise our profile, until we show we should be valued, and we value ourselves, I think it makes us an easy target. Why do we need a physio doing this? Why do we need a physio doing that? Anybody can do that,' Participant 21.

This was deemed both an individual and collective responsibility, for example, both during face-to-face interactions with patients, and through national campaigns from the professional body. Some suggested the success of such campaigns, however, would be dependent on the CSP reflecting the scope of the profession at

leadership level, as it was suggested the CSP's leadership were heavily embedded in MSK.

In terms of their individual futures in the profession, several participants did not foresee a future working clinically or in the NHS, citing the difficulties discussed thus far as reasons for this. Some described wanting to pursue non-clinical, research or service improvement roles, as they felt they would be able to influence change in these roles. The majority of those wishing to leave the NHS or clinical practice had been qualified for less than 10 years.

Those who wished to remain in the profession and the NHS were hugely passionate about doing so. Their retention was anchored in the beliefs surrounding the core values of the NHS:

'I believe in the NHS; I believe it should be free and people have said to me why don't you work privately, and I said because the people who need me most are not the ones who can necessarily afford to pay,' Participant 6.

'My heart is in the NHS. I'm a passionate advocate for the NHS, I suppose that's all I can say. I wouldn't want to work anywhere else,' Participant 10.

Despite challenges, many had huge enjoyment and reward from working in the NHS, which had retained their employment:

'The fact that I'm still here after 25 years is tantamount to the fact that actually overall, I really enjoy it,' Participant 19.

The NHS was associated with opportunities for innovation, secure employment, camaraderie, and support for professional development:

'I absolutely love working in the NHS, I think because I've had such a positive experience and a positive pathway throughout my career, I've loved my opportunities… there's so much going on in the NHS. I find I would be much more restricted in private practice. I would never ever ever consider leaving the NHS,'

Participant 11.

5.5 Other countervailing powers to physiotherapy professional work

Whilst austerity was the focus of the research question, it was integrally embedded within other organisational and structural developments. To subsume all the issues raised by participants under the paradigm of austerity alone, would be to neglect the complexities of austerity in relation to wider social, political, and economic change. Many linked their experiences directly to austerity, and others were embedded within wider social change and alterations in how the health service was structured, managed, and funded. These included political change, the rise of New Public Management, consumerism and technological advances. These concepts are explored in this section.

5.5.1 Changes in government

Changes in the political party in power affected the working lives of physiotherapists. New Labour's election in the mid-late 1990s was associated with fruitful resources and an influx of funding. Several participants described this as a memorable time, due to a proliferation of resources and innovation:

'Some of the biggest changes I've probably seen are mainly I suppose when we had a Labour government, we got quite a lot of

money; I would look back on that as probably the heyday where you could get staff very easily, there was a lot more money around, there was a lot of investment in job roles such as consultant physios, consultant nurses... we were having a lot of new, innovative and different services. And there was just generally a bit more investment in the NHS,' Participant 17.

Some reflected comparatively on their work under the 1990s Labour government and their current experiences under a Conservative government. Whilst there were opportunities to carry out preventative work, inefficiencies under Labour were identified. However, participant 10 reflected upon this time with joy:

'I started work under a Labour government, so I've got a clear perspective on what it was like. I was employed as a locum at a band 8a. When I look back, I was skipping around the borough. [Laughs]. I was given laptops, money for resources, I was in schools doing preventative work just going out looking for referrals… it was great,' Participant 10.

Inefficiencies were present preceding the Labour government; for example, one participant described how staffing levels were abundant during their time as a junior physiotherapist:

'Things have changed dramatically, and from the days of you know me being a baby basic when we were overstaffed and had somebody on holiday cover, I mean one of our rotations was holiday cover… A friend of mine who was working, and I shouldn't say this, but she went to work at [names hospital] and they used to go up on the sunroof if they had nothing to do because they were so overstaffed. Now I accept that was in the days when

firstly, we didn't get paid anything very much but also the health service probably was overstaffed, and it needed better budgeting,' Participant 6.

There were some references to the current Conservative government, though mostly indirect references to how finances and services had become constricted over the past 10-15 years and how this contrasted to the late 1990s:

'So, from having this period, like you had huge amounts of staffing, huge amounts of resources and staff training, time away from your roles to develop yourself, it kind of got contracted again. In the last 10 years there's been a real squeeze,' Participant 14.

For participant 6, austerity was privatisation by stealth, and part of government's political goals to devolve responsibility for publicly funding the NHS:

'This austerity is not austerity. This is "we do not want to fund the health service." So, we will back door privatise it… we can privatise, like the railroads, like the Post Office. Like everything else, we will privatise it and sell it off, you sell it to either the highest bidder so you can get all your backhanders and that's very political. Or you sell it to whoever will take it, whether they're going to chop it or not. Because their interest ultimately is making money,' Participant 6.

Participant 6 was the only participant that spoke in detail about privatisation, with others referring to the entrance of private providers into the NHS; one participant suggested privatisation was ending. Participant 6 was the longest serving member of the

sample, having worked over 30 years in the NHS. They described how:

'I'm very sad by what I see as privatisation only because I've been in it long enough to see the changes,' Participant 6.

They predated privatisation to long before the current government:

'Margaret Thatcher decided she wanted to privatise the health service by the back door, and that's to me where it started. It was political. I believe the Conservatives have been trying to privatise the health service since Margaret Thatcher, and they have done it in a very sly and 'back door' way by introducing private funding, by introducing private companies into the hospitals. Private cleaning, private contractors, even down to private phone companies looking after the phone exchanges,' Participant 6.

5.5.2 Organisational evolution and landscape of employment

Features of NPM and managerialism were observed in contemporary healthcare. For example, business-like behaviour, formal introduction of competition and external providers into the public sector, and performance management (Diefenbach, 2009). Physiotherapists were increasingly expected to adopt business-like and entrepreneurial behaviour. Some saw this as an opportunity for innovation:

'The Trust had what they called a Dragon's Den project. … They actually gave us £60,000 and we were able to employ two therapy support workers to increase our intensity and delivery of

rehab in critical care. And through service evaluation we were then able to demonstrate the need for that and they funded it,' Participant 17.

Physiotherapists were asked to generate income as part of their usual role, through providing training to carers and students at universities, though this was challenging due to time constraints:

'Probably the only difference with the enterprise is because it's an enterprise they would like to make income as well as outcome. But in order to make income they would have to support us more to have more staff and I don't think they've ever really got that understood from the top,' Participant 15.

This was more expected of those who had wider organisational change, for example, participant 15 described their Trust becoming a community enterprise and was thus expected to create income. This participant perceived this change in organisation as a consequence of political goals:

'At the time, the NHS was really struggling and because we were quite a relatively small Trust, we either had to be taken over by somebody else or we had to govern ourselves. I think it was back when the Conservatives were in charge, and I think they were asking people to either do one or the other… it was led by the politics at the time,' Participant 15.

The formalisation of competition and changes to commissioning upon the implementation of the Health and Social Care Act 2012 were experienced first-hand. Of all those who experienced the entrance of external providers into the NHS, none described positive experiences. In fact, some suggested this was associated with a detrimental impact on the service. For example,

participant 2 described how a service they had been delivering was put out for tender and awarded to an external provider. After a short period of 2-3 years, the service was re-awarded to the participant's organisation as they perceived it had not been financially profitable. Furthermore, the service patients received had been subpar:

'It's just frustrating because a lot of the time it just sounds like when these services come back to us, the patients have been getting basically a skeleton service that in no way represents what they need and what they were offered in the past,'

Participant 2.

Additionally, reorganisation to community enterprises or takeovers by external providers were associated with continued or exacerbated cost saving measures:

'A colleague who I respect a lot was working… when Virgin took over their services and they immediately walked in and cut their stuff from four to two. So that is just a classic example of how do you do the same, if not burgeoning caseload, with less staff?'

Participant 6.

Many described tendering services as cost saving mechanism, despite competition being presented as a driver for innovation. One participant experienced being 'TUPE'd' from an acute to a community NHS Trust; something they described as financially driven. They found this difficult to reconcile, as they felt it was not in the best interests of the service:

'I found it particularly difficult when we TUPE'd across. The Trust I work for now is not set up for the service that we have. They didn't realise what they were bidding for. They haven't got the

skills and the knowledge and background to support us…. it wasn't for any other reason that it was just that the costs were cheaper… Since that tender has happened, there's lots of cuts,' Participant 8.

The CCGs' expectations had to considered by clinicians. Some described losing capacity due to the CCG's requirements and thus felt they had to self-govern in terms of resource transparency, so they did not put the service at risk:

'I think the feeling with anything if you're under a tender process is that you've got to prove that your service is the best fit for the job. You don't want to rock the boat and say, actually this isn't working after you've won a tender because you've got to prove that you can do what you said on the tin for that amount of money… Each year we report to Commissioners, but you can't say exactly what you want to say, because what you're going to come up with is we need some more resources, and you know that that's not coming. But there comes a point where that balance is tipped, and you can't continue to operate,' Participant 10.

Others also worked around this balance carefully:

'You've got to pick your battles. Sometimes you've got to try and go a week without saying some things could be done differently or better… if you rock the boat too much, certainly if your service is teetering on the edge of decommissioning, I want to be able to swim out of the boat as opposed to sink if it goes down. You won't be able to be saved by another boat,' Participant 5.

Proving a service's worth was linked to increased use of performance management strategies. Participants had noticed

more use of outcome measurement, auditing, targets, RTTs[28], and 'time and motion' studies, where clinicians had to report their activity for every five minutes in their day. Greater justification for one's time was noticed, and statistics were collected on the number and length of patient contacts. These statistics would be used to evidence service use:

'I want to be able to tell Commissioners what I do in my day because I think there's this assumption that if you're not in front of a child, you're not doing something,' Participant 10.

They were also used to justify why other activities (such as income generation) were not performed, as workload was so high. These practices were imperfect, as the inputting of statistics was time consuming:

'It seems like a lot of it is based on your numbers, your data collection, your service analysis of what you provide and actually where the resources are restricting you. But obviously in order to do that service analysis, you obviously need those resources and the time and the staff members to do that,' Participant 16.

Clinicians had to prioritise patients in relation to RTT targets:

'It's all about figures and it's all about your RTTs. You have to meet the RTTs at the detriment of children that you've already got on your caseload,' Participant 15.

Senior physiotherapists had access to 'dashboards' which presented their team's activity, which was provided monthly and

[28] Referral to Treatment (RTT) is a mandated 18 week wait between a patient being referred to a service and receiving treatment (NHS England, 2016).

discussed with their line manager. This could be dissected to the level of an individual's activity:

'You can actually look at the activity of an individual, which is quite controversial… you could then go into someone's sort of PDR [Personal Development Review] and say well you know, you're not working at the level you should be but of course in physio and rehab it's very hard to quantify that sort of information,' Participant 17.

As mentioned by participant 17, outcome measurement in physiotherapy was an imperfect science, as some physiotherapists had greater teaching/training responsibilities than others:

'I would look on paper like I do very little because a lot of what I do is teaching and I'll go and see patients and problem-solve… my statistics of how many patients I see would be much lower than someone who's working at a Band 6 level, who is purely just you know, a workhorse as such. So, if we want more staff or to put a bid in for a service, it has to be backed-up with the numbers, with the evidence. But the evidence is still difficult to collect. Quantifying it is still a big problem I think in therapies,' Participant 17.

The difficulty in quantifying physiotherapy and rehabilitation created vulnerability to organisational change and cost saving measures:

'Rehab is such a complex, multifaceted, multi-professional, multi-domain beast that we often haven't been able to prove the complete clinical and cost-effectiveness of our profession. So, I think we're kind of being left behind a bit because we haven't

looked at that… We can't expect to have money thrown at us if we can't prove if it's clinically effective. I think we've been quite sloppy about proving the effectiveness of what we do,' Participant 14.

Standardised requirements such as outcome measurement were considered by some as unnecessary bureaucracy, such as equipment procurement. Formalised processes of equipment procurement were prolonged, to the point where it could stifle innovation:

'The process is so protracted that sometimes you just feel like it's not worth it,' Participant 17.

Unnecessary bureaucracy created inefficiency:

'There's this blanket rule in the NHS, that when things are 15 years old, they have to be replaced. And people won't service things after 15 years and that's quite frustrating, so we've got sort of overhead hoists in our gym and our pool and at the moment we can't use them because they're not serviced. And it's so frustrating that sort of sometimes the bureaucracy of the NHS could just be almost a bit petty, and as a clinician that can be very frustrating,' Participant 11.

Although arguably relatively small inconveniences for clinicians, these issues were continued sources of frustration and were time-consuming, which ultimately impacted on patient care.

Changes in the landscape of employment in which physiotherapists were located impacted on their work and career progression. As employees, physiotherapists were not able to dictate remuneration for their services and were subject to

national pay scales. Several participants suggested the implementation of Agenda for Change[29] created nuanced complexities in career progression and role refinement.

Alongside difficulties in receiving adequate remuneration for advanced roles (see 5.4.1.1), discrepancies between professions and their banding were noticed:

'A band 7 physio would maybe be managing a small number of people but if you compared that to a ward manager/nurse role as a band 7, their responsibility and the amount of staff they manage is actually 30 or 40. There's a lot of inequity,' Participant 17.

Agenda for Change created confusion regarding advanced clinical roles, as bandings above 7 were generally considered to be managerial roles. Though band 8 clinical roles do exist, they were notoriously difficult to achieve. Consequently, physiotherapists reached a ceiling for level of specialism should they wish to remain clinical:

'Your career ladder is very short if you want to be a clinician,' Participant 21.

Obscurity in expectations for managerial and clinical band 8s contributed to confusion:

'I think anyone else is the same banding as me, is a manager rather than an extended scope practitioner. It's perhaps that lack of clarity about roles and responsibilities,' Participant 8.

[29] Agenda for Change, introduced in 2004, replaced the preceding clinical grading schemes, aiming to standardise all NHS employees onto the same payment and banding framework (Croner-i, 2019).

'I don't really see a difference in my clinical knowledge between what the Band 8s do and what I'm doing. But I don't have a team to manage, so I think in some respects the banding is probably correct. I suppose it's always a bit woolly isn't it really? You know, when do you suddenly become a Band 6 and not a Band 5?' Participant 18.

Agenda for Change was suggested to have flattened the structure of the profession's roles:

'The whole Agenda for Change thing where there was a lot of flattening in roles and in posts and pay structures and I think that's pretty hard. I see some very experienced people who you know previously I think would have been on a higher scale, but it is how it is,' Participant 13.

Limited career progression initiated the movement of highly experienced clinicians into management roles due to boredom:

'[Progression] it's not good. We see people moving into sort of sideways management roles who are excellent clinicians, they're amazing clinicians but they need something new, they need something different. I think a lot of people do feel stuck. I think they don't know where to go from a Band 7,' Participant 17.

Participant 21 felt Agenda for Change had played a role in the devaluing of the profession's skills:

'Who would want to have a career where you can qualify and then move up a grade and then that's it, if you want to stay a clinician? It doesn't value your service or your skills at all,' Participant 21.

5.5.2.1 Precarious professional work

Some physiotherapists experienced employment precarity. This was from both the threat of decommissioning, and fixed term and temporary contracts. These contracts were more common amongst band 5 and 6 physiotherapists. No participants above band 6 described being on a temporary, or repeating, temporary contract. It was common for those experiencing precarity to roll from one fixed term contract to another; one participant had been on a two-month contract for around two years. Those with precarious employment could only secure permanent employment if a position was advertised, impacting on their personal and financial goals, such as house ownership. Junior physiotherapists would often experience secondment to band 6 level on a temporary basis, to be demoted back to a band 5 contract; something participant 12 found demoralising:

'You just got bumped back to your band 5 and you end up getting you know abused… I've been two years in a temporary band six post,' Participant 12.

This impacted retention:

'… they are thinking of leaving the Trust because they're just not seeing a permanent solution and they're just rocking between temporary contracts,' Participant 12.

Participant 2 related issues with retention and employment to the NHS as an employer:

'We do struggle as a general rule for making the NHS an attractive workplace for its employees, I think we are falling way short of making it an attractive and safe place for people to

work; and I think a lot of people realistically in the NHS just muddle through with what they have and that's sort of an understood ethos of working in the NHS,' Participant 2.

Nonetheless, despite precarity, the NHS provided security due to its perceived longevity and presence as an employer:

'What's kept me in the NHS I think is the stability and knowing that you know your paycheck from month to month is going to be fairly consistent. The NHS was always what I fell back on,' Participant 12.

'I think I'll probably go back to the NHS just because it's a bit of a comfort blanket really,' Participant 4.

5.5.3 Social and technological change

Changes in social behaviour, such as the rise of consumerism and the self-educated patient were linked to contemporary healthcare challenges by participant 9. This participant suggested patients' expectations were higher and they were more prepared to challenge medical knowledge:

'In the past there was just a very different approach to that healthcare practitioner or doctor, and I think they were more respected for the knowledge that they had. Whereas now, there's a lot more knowledge to be gained elsewhere other than you know, that healthcare professional or that doctor, you can use Doctor Google now and people are very well informed before they come to meet with us, so I suppose, those levels of expectations are much higher now,' Participant 9.

Technological advancements, alongside wider social pressures, increased demand for healthcare services. Those who may not

have survived previously were now surviving and living with multiple and complex comorbidities. Participants suggested services had not grown to accommodate this:

'What the health service has failed to appreciate, we are saving 99% of babies and children these days, they're on ventilatory support, they get neonatal support. I am treating 45 Type One SMA[30] children that is unheard of. In all my 30 years until four or five years ago, we never had more than five or six at a time. They died. They're not dying anymore. Neonates, under 26 weeks, they're not dying... we are saving a lot of children, and this is not to me an ethical consideration, whether we do or don't, but a lot of those children have long term needs and they're not being met,' Participant 6.

'We were getting people who had really severe problems, a massive combination of very severe physical problems. We were getting lots of people with trache[ostomie]s. Paediatrics had people on ventilators, permanent ventilators. But we had nothing for them, we had no equipment because we didn't have any money and very few staff,' Participant 21.

Consequently, participants felt that demand and provision were incongruent:

'Then I think over the last 10 years, I've observed and more keenly felt that the pace of need versus the pace of what is actually there is mismatched,' Participant 14.

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[30] Type One SMA occurs in young babies and is associated with weakness, floppiness, difficulties in moving, breathing, eating and swallowing and an inability to lift their head or sit unsupported (NHS, 2020).

5.6 The COVID-19 pandemic and physiotherapy

The interviews were carried out between September 2020 and May 2021, during which the UK continued to be affected by the COVID-19 pandemic. Inevitably, COVID-19 had a significant impact on physiotherapists' working lives. This, alongside the influx of funding into the NHS and unanticipated outcomes for the physiotherapy profession are explored in the following subthemes: 1) the impact on workforce and service provision; 2) ambivalence towards 'the COVID budget'; 3) unanticipated outcomes for the physiotherapy profession.

5.6.1 Impact on workforce and service provision

There were significant changes in service delivery due to COVID-19, such as use of remote consultations instead of face-to-face appointments, closure of 'non-essential' services, and redeployment. Though considered beneficial, remote consultations meant some felt it was difficult to provide adequate and effective care. For those working face-to-face with patients, Personal Protective Equipment (PPE) and social distancing requirements contributed to physical and mental exhaustion:

'We're headachy, we sweat so much more, we need to drink so much more… there's been a few on my team that have had migraines more often… [the] atmosphere has changed, you're not mixing what colleagues like you would have, everything has become a lot more segregated. Generally, the attitude people are just a lot more stressed, a lot more down than we normally have been and it's just a different stress,' Participant 12.

COVID-19 exacerbated already existing issues:

'The problems that were already there, they got worse. Because there was this funny bit where we couldn't just keep on top of it,' Participant 13.

Furthermore, staff were already burnt-out:

'Even before the start of the pandemic we were like running on empty. The service has been really stripped back you know. So, if someone's on holiday and then someone's off sick you know, it's really, really tough,' Participant 17.

Societal restrictions implemented by the government in response to growing infection rates had an impact on NHS staff. Self-isolation guidelines, the stay-at-home order, and closure of schools meant clinicians with children struggled to find childcare, creating exponential staffing issues. Furthermore, clinicians faced a daily exposure to developing COVID-19. Staffing issues and growing patient numbers meant staff struggled to take annual leave, further contributing to a decline in mental and physical wellbeing. Having said this, many spoke to feeling well supported in their teams, facilitating cross-cover, and 'pulling together' to maintain the delivery of healthcare during COVID-19.

When preceding services began to be reinstated as hospital admissions fell and the vaccination programme was introduced, physiotherapists began to address their waiting lists. The suspension and/or closure of some services meant physiotherapists' waiting list grew exponentially. Despite this, pressure to meet targets remained the same:

'Coming back after COVID, there's a really strong pressure to meet RTTs and see children that are being referred, even though we haven't seen children that need therapy all this time. The

emphasis is on meeting RTTs and meeting thresholds than it is on I think patient quality,' Participant 15.

Despite growing waiting lists, requests for additional help to meet patient needs were rejected:

'They just say no [laughs]. It's just a blanket no… [the team lead] has said there is no money, they're not going to give us anyone else, we've just got to prioritise who we see,' Participant 15.

To reconcile mismatching demand and resources, a minimal approach was taken to ensure everyone gets something:

'I mean that whole thing of chucking information… type thing, that pressure of actually doing everything in one session to like limiting things, kind of doing just enough,' Participant 13.

Physiotherapists felt frustrated by this, particularly considering the influx of funding into the NHS as part of the government response to COVID-19; explored in the next sub-theme.

5.6.2 Ambivalence towards 'the COVID budget'

To support the NHS and social care during COVID-19, the government pledged billions of pounds in additional support (Department of Health and Social Care, 2020a) and wrote off historical NHS debt amounting to £13.4billion (Department of Health and Social Care, 2020b, 2020c). This funding injection was most visible to those in acute hospital settings, whilst community physiotherapists described ongoing financial pressure:

'That doesn't seem to have taken the pressure off at all. We're still saving money here and saving money there,' Participant 5.

The increased funding in acute settings meant many opportunistically purchased equipment that been needed for some time, and to accommodate for the greater levels of rehabilitation COVID-19 patients were requiring. Whilst opportunities to purchase equipment were seized, some decisions were inefficient. For example, one participant described how management had purchased equipment which had not been used, due to wider time pressures and ethos of the team to prioritise discharge over rehabilitation. In addition to equipment, more staff were employed through the 'COVID budget,' which created opportunities for innovative working patterns and conditions (discussed in 5.6.3).

Despite many perceived benefits of the funding influx, there were also mixed feelings. Physiotherapists appreciated the funding, but it had a bittersweet reception. For some, having experienced lengthy periods of lacking resources and making yearly budget cuts, the funding injection made them question why funding could not have been provided previously:

'It's just weird, isn't it? The amount of money that got thrown around… we were like, where is this money coming from? Why are we all running round and wearing ourselves out when actually surely two members of staff in all of the Trusts in the country wouldn't have cost that much. … It's made me a bit cross this year that perhaps everyone's struggling and there must be money out there we can use,' Participant 15.

Additional funding during the pandemic created feelings of funding inequity for those who were not admitted with COVID-19 or had been through the service prior to COVID-19:

'When the pandemic started there was a lot of money, quite a lot of money from this invisible COVID budget. So, we were able to get some new equipment… we got a step-down unit, where people who'd been in critical care would go to do their rehab. So, it was a really good multi-professional ward input from everyone. So, it was all new and great because you know, it was COVID, and it's been really hard for us to watch in some ways because we have these critically ill patients all the time and they don't get the service that the sort of first wave of COVID patients got in a way,' Participant 17.

There were several references to the 'COVID budget' and how suddenly, resources were accessible without the lengthy process of procurement and bureaucracy that was usually encountered:

'All of a sudden this COVID budget became a thing whereas before, you'd have to justify it, you'd have to put together a business case, you'd have to do so many things,' Participant 1.

Physiotherapists had complex and conflicting feelings for the COVID-19 funding. They were grateful for extra staff and improved services, but also felt frustrated that these processes could not have been implemented prior to COVID-19. Physiotherapists were sceptical that the level of funding would be sustained and anticipated ongoing and growing pressures as the NHS emerged from the pandemic.

5.6.3 Unanticipated outcomes for the physiotherapy profession

Despite the significant pressure the NHS faced due to COVID-19, it created several unanticipated outcomes and opportunities for innovation. For example, to accommodate for the expected influx of patients and to reduce social contact, many services used innovative means to reach patients. This included virtual consultations over platforms such as Attend Anywhere, and use of Microsoft Teams to facilitate homeworking. These changes were implemented swiftly:

'*The main problem in the NHS is that it's just so sluggish and it takes so long for things. But actually, I think this pandemic has shown it doesn't have to be like that,'* Participant 19.

Many of these services were going to continue, increasing their scope, reach and efficiency:

'It's actually quite an exciting time because I think if COVID hadn't have happened, we would have been very much in the mindset of "well, if you're going to come and see us, you've got to come in person." I think now we're a lot more flexible… We've proved now it's actually easy to link in and be together as a team but not all even be in the same area. Our consultant has been working from home since the start of the pandemic. So, I think there's different models of working, that's hopefully more patient-centred and meeting patients' needs in a way that we didn't think was possible before,' Participant 18.

Discharge out of hospital was expedited and streamlined with participants describing much shorter waits than usual to access

packages of care, community services and/or rehabilitation beds in other settings.

Furthermore, the uplift of staff meant opportunities for teams to catch up on training and service development, have more regular supervision, and trial new ways of working. For participant 17, their service used the uplift in staff to trial seven day working and shift patterns, where staff would work fewer, longer days. This was a success, and their colleagues reported a better work-life balance. However, this was not to be sustained once the redeployed staff returned to their departments, and the team returned to their previous working pattern, describing a sadness in doing so:

'A lot of us are quite sad we're going to revert back … it makes it hard to do a new innovation and to try and work a bit differently. I think COVID has actually given us a bit of an opportunity to do that,' Participant 17.

New roles were created and there was reduced reliance on agency staff:

'We're seeing that already in our Trust [there were] lots more jobs created. I think it works out actually cheaper to have some good staff there… Fingers crossed we're in an upward trend now… They realised that actually there were too many vacancies, before they were maybe using agency. And actually, creating new roles as well. There was a bit of stagnation and just not making any change in those roles, and that definitely needed to happen, and it seems to be happening a lot quicker post-pandemic really, which is great,' Participant 19.

The preparation of hospital settings and increase in staff meant some experienced a short period of time with reduced demand at the very beginning of the pandemic, prior to the peak in admissions. This was used as an opportunity for training and to upskill, including spending time with senior colleagues and receiving formal supervision, something which was often abandoned in the face of time and caseload pressures prior to COVID-19.

Increased media coverage of the physiotherapy profession during COVID-19 was suggested to have improved both public and other healthcare professionals' perception and understanding of the role of physiotherapy. For example, participants cited articles in newspapers and television presenter Kate Garraway describing her husband's experience of physiotherapy whilst on ITU being treated for COVID-19. One participant described how a newspaper article was the catalyst for their friendship groups' understandings of their role on ITU:

'I've had it from some of my friends that are like: "why, what do you do in an ITU? You don't need physio there," and it's like, you just don't get it do you? … There was a really good [article] in The Guardian about respiratory physios and what they do … my friends were like "oh, that's what you do," and it's like yes, see, you actually like got it. So, I think it's been really helpful,'

Participant 3.

Furthermore, the value of physiotherapy and its perception by other healthcare professionals was improved through their presence on ITU and their contribution to wider service pressures. Participants described physiotherapists volunteering to

cover nursing shifts in addition to their normal job to cover vacancies in the nursing rota:

'They've also stepped up to the mark with they were doing lots of nursing shifts because lots of nurses were vacant and nurses weren't stepping up to do those shifts,' Participant 19.

Physiotherapists' presence improved working relationships and created an appreciation and recognition of their role:

'As a physio that went into ITU, I respected [the nurses], but I didn't always feel they respected me back. Whereas from COVID, it was like they completely did a 180 and they were calling us for things and asking questions and I think they finally realised that "oh, actually we do need your specific knowledge," as well as the knowledge they already have… We have created a much better relationship… it's not a hierarchical system anymore, it's more of an equal playing field, because they've realised the need for us. Whereas I think before, they didn't quite see that,' Participant 4.

Employment security and having a meaningful purpose during the pandemic made some reflect upon their role with appreciation:

'It's shown me this last year of the things you don't know that you appreciate. Like I didn't really appreciate being in a job that feels meaningful and if we had to have time out for COVID, we were paid through sickness and you know, we've been given wellbeing. So, I've actually felt it's really supportive. And I think it's got more supportive, it's much better than it used to be,' Participant 19.

Whilst some were sceptical about the continued nurturing of innovation, creativity, and the increased recognition of the role of physiotherapy, others were hopeful that the pandemic had kickstarted the NHS considering its previous challenges:

'Austerity has held the NHS back, definitely. I really hope that we can see that this time on from the pandemic can actually improve that,' Participant 19.

5.7 Summary

Twenty-one participants took part in this study, providing extensive and deeply personal accounts of their experiences of working as physiotherapists in the modern-day NHS. Austerity and wider social, political, organisational, and economic change impacted on physiotherapists ability to fulfil their professional responsibilities. Austerity had profound effects on physiotherapists' clinical reasoning and decision making. Where possible, they attempted to resist changes which they felt would impact negatively on patients. Where this was not possible, physiotherapists would enact methods of personal and professional preservation in an attempt to sustain their health and wellbeing and maintain an acceptable standard of care within the constraints in which they were located. Interprofessional hierarchy had the power to both devalue physiotherapists' input, and to enhance their professional development. The findings uncovered practices of power imbalance and circumstances where this was enacted to the level of harm. Circumstances where cost savings were so insistently pursued to the extent of workplace bullying were uncovered, and mechanisms designed to prevent this were ineffective. The role of physiotherapy had

evolved, and physiotherapists were making active attempts to expand their jurisdiction, often encroaching upon medicine's traditional scope of practice. Physiotherapists recognised vulnerability to their sustained presence in the healthcare professional ecology and suggested there was a need for collective action to ensure the profession's security in the future.

Chapter Six: Discussion and Conclusion

6.0 Introduction

This chapter will synthesise the findings of the study. This study aimed to explore how a smaller, subordinated healthcare profession (non-medicine, non-nursing) reconciled austerity and how this impacted on the nature of their professional work. The key findings of this study are summarised before being discussed in detail. The contributions to the literature are outlined and the limitations of the study presented. A summary and concluding remarks close the thesis.

6.1 Summary of analysis

6.1.1 Critically-informed interpretive discourse analysis

Analysis of NHS discourse identified a range of complex practices used to reconstruct healthcare professionals as agents of change that extend the neoliberal agenda and austerity measures into the publicly-funded health sector. The state used the discourse and ideology of professionalism to appeal to its values and hence, motivate compliance and subsequent action by healthcare professionals. Therefore, healthcare professionals' responsibilities were reconstructed by government and its arm's lengths bodies. There was a discursive attempt by the physiotherapy profession to capitalise on an increased recognition of the profession's ability to deliver cost savings in an era of austerity.

6.1.2 Qualitative data analysis

Though austerity was unspoken, it had a profound impact on physiotherapists' work, including stunted professional development, bedside and service rationing, and

reconceptualised clinical reasoning. Austerity had detrimental effects on health and wellbeing, and perpetuated power imbalances to the level of harm (through bullying and harassment).

Physiotherapists' ability to reconcile challenges to their professional work existed upon a continuum, ranging from powerlessness to (context-contingent) use of power networks. Physiotherapists always had to negotiate power from those situated above them in the interprofessional hierarchy. Physiotherapists commonly experienced moral distress (Jameton, 1984) when attempting to negotiate resource deficits which challenged their professional (and personal) expectations of care.

The physiotherapy profession adopted methods of restratification (Freidson, 1985; Waring, 2014) to adapt to contemporary healthcare. This involved encroachment into medicine's jurisdiction by professional elites, creating a higher level of risk, responsibility, and workload for the rank-and-file members of the profession. There was greater delegation to support workers by all qualified members of the profession, which in turn, meant more delegation to unpaid members of the workforce (such as carers and family members). Flexibility of boundaries between the nursing and allied health professions occurred to cope with workload, rather than as an extension of a professional project.

Dysfunctional employment practices were used to manage the workforce and save money. Failing to backfill maternity leave, recruit to vacant positions, and precarious employment were all common practices, all of which had implications for workforce sustainability.

6.2 Introduction to meta-themes

The qualitative and discourse analysis data demonstrate how the legacy of subordinated professionalism impacted on the nature of professional work in physiotherapy and how subordination affected physiotherapists' ability to reconcile logics that challenges their notions of professionalism. Furthermore, analysis of subordinated professionalism has uncovered dysfunctional employment practices and precarity in a subordinated group; something which has scarcely been identified in the archetypical professions.

This is discussed in greater detail in the meta-themes of the study: 1) subordinated professionalism in reality, 2) physiotherapists' ability to reconcile austerity and challenges to professional work, and 3) the paradox of precarity. Following this, the sociology of professions as a theoretical framework is revisited to articulate how my study contributes to contemporary understandings of the sociology of professions. The implications for the professions and methodological and theoretical limitations of the study are then discussed.

6.3 Subordinated professionalism in reality

Though physiotherapy was traditionally considered subordinate or a 'semi-profession' (Etzioni, 1969), neo-Weberian professionalisation strategies have been exercised by the profession. For example, the profession achieved occupational closure (Freidson, 1970a, 1970b) through credentialist entry and regulatory processes. Thus, entry to the profession is granted only to those who demonstrate specialist knowledge and therefore warrant membership. The profession has undertaken a

clear professional project (Larson, 1977), in which they have (arguably) been successful, as professional status and a position within the NHS market were secured.

Nonetheless, the reality of existing within the healthcare professional ecology (Abbott, 1988) as an allied or traditionally subordinated profession is complex and contains threats to professional sustainability. As Larson (1977) and Nancarrow and Borthwick (2021) suggest, professional projects are an ongoing process, and this was the case for physiotherapy. This consisted of continuous negotiation with others: organisations, the public, the state, neoliberalism and its associated logics. Physiotherapy provides a distinct example of Abbott's (1988) professional ecology and the consequent 'rejostling' that takes place as the profession attempts to compete interprofessionally to protect their jurisdiction whilst simultaneously attempting to expand their own distinctive monopoly. Part of this rejostling (Abbott, 1988) was evident through methods of restratification (Freidson, 1985), where physiotherapists adapted their roles and responsibilities in the face of change (see 5.4.1.1). Despite this, the profession was facing threats to its continued presence, through decommissioning and potential usurpation from other (cheaper) occupations. The profession's autonomy and specialist knowledge were also at risk of being undermined by the growing standardisation of care and focus on discharge to create inpatient capacity.

Whilst a professional project is a collective activity, individual members may have different goals (Larson, 1977; Nancarrow and Borthwick, 2021). Although most participants appeared to have a collective goal of sustaining the profession, the ability to

engage in a professional project varied intraprofessionally. In this, study, professionalising activities (such as jurisdictional extension and restratification) were activities for professional elites. These members were often senior physiotherapists who had worked in the NHS for extended periods, many with networks with senior management, CCGs, and other powerful professionals, such as consultants and matrons. On the other hand, rank-and-file members of the profession (mainly band 5s and 6s) focussed on the day-to-day work on the frontline. Many rank-and-file physiotherapists described 'just getting through,' and had little time or opportunity to engage in professionalising activities. This was also observed in nursing, whose frontline clinicians focussed on *'getting the job done,'* (Field-Richards, 2017, p.276).

The chasm between professional elites and rank-and-file physiotherapists regarding professionalising activities should in some ways be expected considering Freidson's (1985) restratification thesis which posits that professional *elites* are able to reorganise to cope with bureaucratic change (Freidson, 1985; Waring, 2014). This study offers empirical evidence of this and provides insight into power imbalances and the implications this has on professionalising activities. The implications of elites undergoing restratification for the rank-and-file physiotherapists included increased workload and responsibility, greater caseload complexity, less supervision, and they generally felt more powerless to make their voice heard. Adams (2020) identified similar disruption to professional unity in their study examining engineering, with conflicting logics, hybridity and restratification. Adams (2020) examined the implications for intraprofessional

division resulting from hybridity and restratification for professional employees and managers. Although this is contextually different from the intraprofessional division observed in physiotherapy in relation to professionalising activities and restratification, the two studies demonstrate how a chasm between elite and rank-and-file members is reproduced. What is often left unstudied are the implications for the rank-and-file, which this study has identified. Several rank-and-file physiotherapists expressed a desire to leave the profession, their organisation/the NHS or clinical work, due to the stresses of their daily work life. This is not to say restratification was the only influence on attrition from the profession, work-life balance, and job satisfaction, but that the consequences of changing division of labour and delegation were contributing factors.

6.3.1 Professional identity and meaningful professional work

Physiotherapists in this study expressed professionalism in taxonomic forms, via notions of altruism and autonomy (though as discussed, they also engaged in neo-Weberian methods of occupational closure, interprofessional competition, and restratification). Nonetheless, many of the physiotherapists interviewed were experiencing a professional identity crisis. This often pertained to the mismatch between personal and professional expectations, and what they were able to deliver due to organisational/managerial expectations and the austere healthcare setting. It is important to note here that this was distinguishable from the shock newly-qualified healthcare professionals feel as they enter the realities of professional work (extensively researched in nursing- see Duchscher, 2009; Ho *et*

al., 2021), though the newly-qualified physiotherapists interviewed had experienced this to some extent.

The uneasy reconciliation of personal/professional expectations and the realities of contemporary healthcare had catalysed an erosion of meaning in professional work. For the physiotherapists in this study, meaning was integral to their identity. Physiotherapists described how pressures to 'make do' and deliver 'skeleton' services had eroded meaningful professional work, standardised their role and tasks (affecting some departments more than others), and had dehumanised care. For physiotherapists, meaningful professional work involved acting as advocates for their patients, as support networks, *knowing* their patients, and developing long-term, holistic, and meaningful relationships with their patients/clients. All of these were at odds with the resource-restricted environments in which they were situated.

Some physiotherapists described feeling so disconnected from their own notions of physiotherapy professionalism and identity, that they felt they did not understand the profession in its current state, with one physiotherapist stating they wished to see the profession ***'burnt to the ground.'*** These physiotherapists felt the profession had become so 'wayward' (as one described), they questioned whether the profession would be able to sustain a professional project in contemporary society, and for them, it would not be successful. This raises important theoretical, professional, and social questions. For example, have the professions survived contemporary developments, globalisation, and capitalism due to their perceived function in society? Is the degradation and standardisation of professional work becoming

apparent in professions more vulnerable to such processes, such as those less powerful, smaller, and subordinated professions? Could this be an indication of movement towards a post-professional era? (See section 6.6). Socially, do we need professions? Or does this evidence indicate a reconceptualisation and expansion of the concept of a 'profession' in the sociological sense?

Examinations of how professions respond to challenges to their professional work often focus on how these are resisted, reconciled, or negotiated due to the perceived loss of professional power and/or autonomy (e.g., Currie *et al.,* 2012; Numerato *et al.,* 2012; Waring, 2014). Some have referenced adherences to professional norms and values in response to challenges to professionalism, such as managerialism (Exworthy and Halford, 1999; Hoyle and Grant, 2015; Kerasidou *et al.,* 2016). This study provides insight additional to these studies, in that erosion of meaningful professional work in healthcare professions is also a catalyst for professional resistance and circumvention, and for others, reproduced feelings of powerlessness.

There are few studies examining how physiotherapists construct their professional identity, but those that do exist describe physiotherapists' professional identity as fluid, continuously negotiated and co-constructed, and based on *'evolving attributes, beliefs, values and motives'* (Hammond *et al.,* 2016, p.71). Harman *et al.* (2021) examined the development of professional identity in those undergoing a Master's programme in physiotherapy in the first year of their programme. Harman *et al.* (2021) suggested that those interviewed related their career choice to the altruism and meaningfulness associated with the

profession. Furthermore, they suggested the physiotherapy profession *'aligned with their personal beliefs and values; they perceived that physiotherapy would be a rewarding profession based on the opportunity to connect with others, build relationships, and make a difference in peoples' lives,'* (Harman *et al.,* 2021, p.598). Therefore, my study has provided evidence of physiotherapists' responses when an underpinning value of identity is challenged, an area for future research suggested by Hammond *et al.* (2016).

This study has identified the importance of meaning for physiotherapists, both in notions of professionalism and in the construction of their professional identity. This study has shown how if these are threatened or degraded, professional identity must be reconstructed and reconceptualised. As demonstrated in this study, this is possible for some, negotiable for others, and for those remaining, impossible.

6.3.2 The double-edged sword of indeterminacy

Physiotherapy's claims to professional knowledge reflected the complex balance between indeterminate (abstract) and technical (concrete) knowledge, developed by Jamous and Peloille (1970) and expanded by Abbott (1988) (see chapter two). Physiotherapy's reliance on both forms of knowledge to exercise autonomy demonstrated the delicate balance between credibility and protecting professional privilege. Physiotherapists used claims to specialist, esoteric knowledge to exert professional privilege. For example, when defending decisions which went against organisational expectations (e.g., caps on number of treatment sessions), physiotherapists used their possession of

esoteric knowledge to management, whose responsibility it was to monitor compliance to such restraints. Physiotherapists would use their knowledge (both abstract and concrete) to clinically reason and reach a professional judgement, which could not be challenged by those outside of the profession (such as management) or outside of the clinician-patient interaction. Physiotherapists described navigating complex cases based upon their experience and tacit knowledge to problem-solve. This can be considered as both part of traditional notions of professionalism and an example of exercising indeterminacy.

The profession also used technicality to enhance credibility and their professional project. Technicality has strong links to the biomedical model and thus played an important role in the physiotherapy profession establishing themselves professionally. Physiotherapy has a historical affiliation to the biomedical model in their professionalisation, which has been criticised (Nicholls, 2018). Furthermore, physiotherapists considered evidence-based practice and being technically informed was an integral part of professionalism. Nonetheless, there was scepticism towards this in the context of austerity, as one participant questioned whether evidence was conveniently skewed towards the most cost-effective option in contemporary healthcare, rather than the most clinically effective option.

Although physiotherapy offers an example of the indeterminacy-technicality ratio in practice, it also demonstrates how professions dependent on indeterminacy can make them vulnerable to erosion in an increasingly fiscally-oriented health system. A core underpinning for physiotherapy professional work was rehabilitation. Rehabilitation was central to all

physiotherapists' work, including those who worked in triage settings or had short-term contact with patients, such as FCPs. Physiotherapists made decisions about patients' predicted rehabilitation needs, gained through experience, similar presentations throughout the course of their career, and patient presentation. However, rehabilitation itself was an indeterminate concept.

Rehabilitation is defined by the World Health Organisation (WHO) as *'a set of interventions designed to optimise functioning and reduce disability in individuals with health conditions in interaction with their environment,'* (WHO, 2021). Rehabilitation *'helps a child, adult or older person to be as independent as possible in everyday activities and enables participation in education, work, recreation and* ***meaningful*** *life roles such as taking care of family,'* (WHO, 2021, emphasis added). However, physiotherapists described rehabilitation as an immeasurable concept due to its multifaceted, complex, and multi-system makeup, with many aspects difficult to quantify. For example, how would a meaningful life be quantified?

The centring of rehabilitation in physiotherapy professional work posed a vulnerability for the profession and other AHP workforce who work collaboratively to rehabilitate. Physiotherapists noted how the increased reliance on quantification and outcome measurement threatened their continued service, as if effectiveness could not be measured, it could not be evidenced, and therefore, the profession would be at risk of decommissioning. So, whilst indeterminate claims to tacit or 'private' (Nancarrow and Borthwick, 2021) knowledge may have facilitated physiotherapy's professionalisation, it posed a threat to

their continued professional presence in contemporary healthcare.

6.4 Physiotherapists' ability to reconcile austerity and challenges to professional work

The literature review identified how members of non-archetypical professions (i.e., non-medical, in healthcare settings) may not be able to reconcile challenges to contemporary professionalism in the same way as medicine: *'some professions may be better equipped than others to remake themselves and to realign their field of knowledge with the logic of the market'* (Fournier, 2000, pp. 84). This was the case for physiotherapy. Physiotherapists had varying abilities to reconcile challenges to their professional work. Physiotherapists were rarely able to directly resist organisational and economic limitations to their work. Even when they did, they always had to negotiate hierarchy and systems of power and dominance to reconcile austerity and challenges to their professionalism (and sometimes to simply practice their work at a basic level). The main sources of hierarchy, power and dominance came from medicine and managers. There was little evidence of exercised hierarchy and dominance intraprofessionally (apart from participant 5's experiences of bullying and harassment[31]), other than access to professional development opportunities. These were reserved for elite members of the profession and a greater clinical workload was allocated to rank-and-file members. Therefore, physiotherapists had an additional layer of complex relationships and systems to

[31] Participant 5 did not explicitly state whether this was carried out by senior physiotherapists, managers, or both.

overcome to facilitate and negotiate challenges to their professional work.

Some were not entirely powerless and exercised their own power, constructed over extended periods, to negotiate countervailing powers and achieve an end goal, though this was often amended in light of lacking resources. Physiotherapists' ability to respond to constraints to professional work was context and decision-contingent but can be seen as existing upon a continuum. Physiotherapists occupied multiple and simultaneous positions on this continuum, dependent on context:

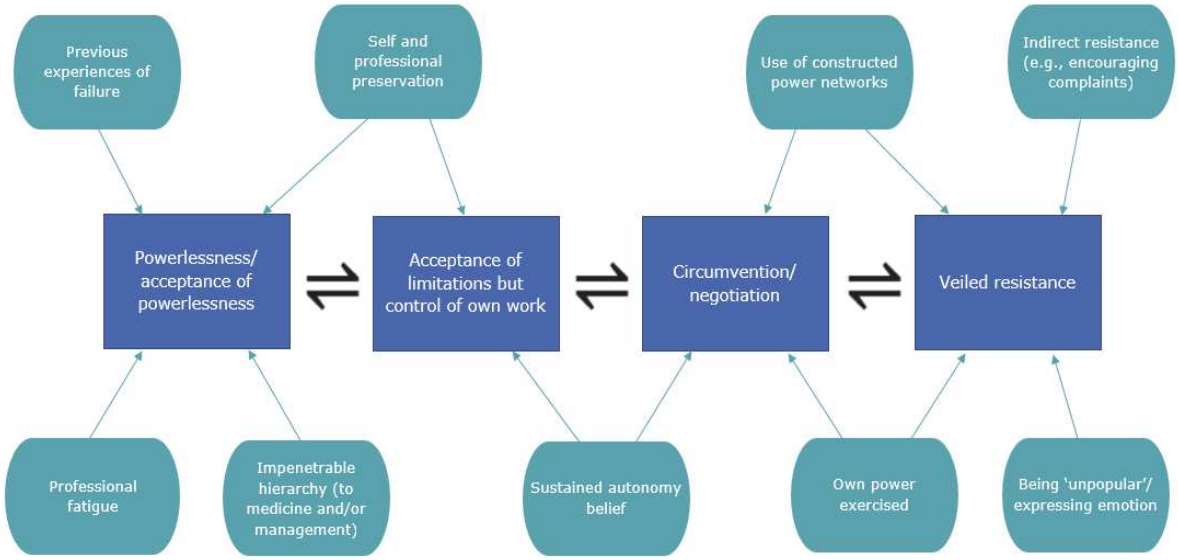


Figure Four: continuum of physiotherapists' ability to reconcile challenges to contemporary professionalism.

Physiotherapists attempted to push back against medical dominance through the rhetoric of autonomy. Some described 'autonomy' as a buzzword in their education; something to explicitly state they possessed as a physiotherapist. When challenges to physiotherapists' decisions were made, they used

claims to specialist knowledge to defend and justify decisions which resisted organisational, managerial, and medical expectations or goals, thus relying on traditional notions of professionalism. For example, physiotherapists would defend working beyond organisational caps in the number of treatment sessions per patient through their professional judgment, i.e., their professional judgment being that the patient needed more treatment. Physiotherapists would be prepared (and expected) to be challenged on working against organisational and managerial constraints. However, not all physiotherapists carried this out, as some were reported to work within the realms of what they felt they were '*allowed'* to do. There was clear disagreement with this statement within the profession by those who felt that autonomous practice meant their patient's treatment plans were up to them, not managers, doctors, or the organisation.

There were some examples of physiotherapists' decisions or clinical judgements being overridden by doctors, who ultimately had the final say. This tended to be in acute, discharge-focused settings. There was a clear pushback against medical dominance in these settings, with physiotherapists attempting to exercise their autonomy. This commonly had wider ramifications as many of these decisions centred on discharge, and physiotherapists would often be assigned responsibility for delaying discharge as they deemed patients not ready to go home.

In these circumstances, safety was often deployed as a rhetorical tool to exert professional privilege. Physiotherapists (and the multidisciplinary team) experienced organisational pressure to discharge patients which was exerted by discharge teams, bed managers and management. Should physiotherapists face

resistance to keeping patients in hospital, they often used safety as a rhetorical tool to reinforce their professional judgment. Physiotherapists felt their area of expertise, recommendations, and justification were not always valued or respected. However, physiotherapists described how deploying the rhetoric of safety (i.e., a patient was not safe to discharge home) would render the patient non-dischargeable, and this was more easily accepted by nurses and doctors.

Waring (2007) explored how changes in the patient safety policy agenda provided managers with the tools to scrutinise medical work. Waring (2007, p.174) suggests medical professionals were able to *'resist, subvert and capture this policy initiative, making it serve their own ends and reinforcing occupational monopoly.'* We can compare the behaviours observed by Waring (2007) to the relationship between medicine and physiotherapy in capturing and deploying safety as a rhetorical tool to reinforce occupational monopoly. Of course, doctors and nurses were also concerned with patient safety, but the outcome of physiotherapists' assessments would often conflict with ward level and multidisciplinary (doctors and nurses) desires, that is the patient needs more time in hospital to improve their mobility vs the patient can be discharged (and thus create capacity). Therefore, in deploying the rhetoric of 'not safe to go home,' physiotherapy's occupational monopoly is reinforced (Waring, 2007) in the face of the potentially conflicting goals (and hierarchical challenge) of other healthcare professionals.

This is not to say physiotherapists would render patients unsafe solely to exercise professional privilege. The patients who were presented this way were judged as not to be safe or fit to go

home at that time. Rather, physiotherapists felt their professional judgement was more respected (and less questioned) if they deployed the rhetoric of 'not safe to go home.' This was reinforced through clear documentation by physiotherapists of their professional judgement and justification, as this provided an extra 'layer' of protection. This was protection from litigation should something go wrong, or if the multidisciplinary team were tempted to override their decision. Documentation was therefore a useful tool in exercising physiotherapists' professional privilege.

It should be reiterated that hierarchy was not always a dichotomous 'us and them' experience, as reflected in physiotherapists' use of power networks with more powerful professions (see 5.4). Junior physiotherapists often developed good relationships with junior doctors, who reportedly experienced hierarchy within their own profession. Junior physiotherapists described a shared understanding with junior doctors and more collaborative working, based on shared experience of hierarchy and generally being of a similar age. This had positive implications for collaborative working and had the potential to promote the role and value of physiotherapy, as junior doctors sought their support for discharge decisions. This coexistence in the healthcare hierarchy was shared by senior physiotherapists who worked closely with consultants, though medicine continued to occupy the apex of the healthcare professional hierarchy.

6.4.1 How does physiotherapy's ability to reconcile austerity compare to other healthcare professions?

Participants in this study referred to other healthcare professionals and how they were also under pressure. However, some did describe how they felt that other healthcare professions, particularly medicine, had more resources to respond. Kerasidou and Kingori (2019) interviewed doctors and nurses working in Accident and Emergency (A&E) in the UK to explore their experiences of austerity measures in healthcare. Whilst their study did not aim to explore their responses to austerity measures, it did provide insight into how they perceived austerity and many aspects resonated with the findings of this study. For example, healthcare professionals described tension between targets and care quality. One doctor described target-focussed work had depersonalised care, turning *'a profession into a mere job,'* (Kerasidou and Kingori, 2019, p.11). Many felt their professions were devalued as CPD was deprioritised and pay did not reflect the complexity or amount of work. Many experienced burnout and emotional distress, with detachment and powerlessness common in the face of austerity (Kerasidou and Kingori, 2019).

Other UK studies have demonstrated the impact of austerity on moral distress in nursing (Morley, Ives, and Bradbury-Jones, 2019) and how austerity affects professionals' ability to deliver safe practice and uphold professional ethics (Owens, Singh, and Cribb, 2019). Globally, austerity and its impact on the professional work of nurses has been carried out in Italy (Palese *et al.,* 2014), Greece (Theofanidis, 2017), Spain (Gea-Sánchez *et al.,* 2021) and Australia and New Zealand (Willis *et al.,* 2017).

These studies have shown changes in professional work, workplace challenges, and responses to austerity. For example, deteriorating working conditions, reduced care quality, high workload, stress (Palese *et al.,* 2014; Willis *et al.,* 2017; Gea-Sánchez *et al.,* 2021), precarious work (Palese *et al.,* 2014; Willis *et al.,* 2017), role substitution (Theofanidis, 2017; Willis *et al.,* 2017) and resistance to austerity measures (Gea-Sánchez *et al.,* 2021).

In studies examining other political, social, and organisational change, doctors, although undoubtedly affected, were generally able to retain power and exert influence on policymakers, government, and managers, and reorganise as needed (Currie *et al.,* 2012; Numerato *et al.,* 2012; Waring, 2014; McGivern *et al.,* 2015; Denis *et al.,* 2022). Comparatively, in addressing similar challenges, physiotherapy attempted to exercise similar methods of restratification and reorganisation. However, this is something that for most physiotherapists is required, rather than desired, as predicted by Nancarrow and Borthwick (2021). Furthermore, physiotherapists' attempts to influence were generally less successful and they were often deprived of access to senior management and organisational meetings. Consequently, they had little opportunity for their voices to be heard and they relied on those with access to speak for them (and these persons may have had their own professional goals). Therefore, although physiotherapists did possess an element of power to exercise reconciliation techniques, their attempts seem less successful than those made by their medical colleagues. The physiotherapy profession was also subject to other limitations on their ability to

reconcile austerity and their professional work due to precarious working conditions, which is explored in the next section.

6.5 The paradox of precarity

This study has identified the concept of precarity in professional work. Before outlining how precarity (and paradoxical precarity) are relevant to the professions, it is important to explain the concept. Rodgers (1989) described precariousness and work insecurity as possessing four dimensions: temporal (degree of uncertainty of continuing work, similar to job insecurity), organisational (how workers control their work time, intensity, and conditions, including autonomy), economic (workers' pay and opportunity for progression), and social (protection from unfair working practices, discrimination, dismissal, access to social security). The main groups who have been researched as precarious workers include those in retail, hospitality, and those working in the 'gig' economy[32]. However, this study has provided empirical evidence of how precarity has infiltrated the professions, as suggested by Malin (2020) and despite, in some countries, physiotherapy jobs being considered secure (Nicholls, 2022).

We can examine physiotherapists' experiences of precarity using these dimensions. Physiotherapists arguably experienced all four dimensions of precarity. They were uncertain of continued work contracts (temporal), they often felt their autonomy challenged and control over their work limited (organisational). Their pay

[32] The gig economy is a mode of employment associated with short term, freelance work which is often based on zero hour and 'on demand' contracts; these are often managed via online applications, for example, Uber (Gross, Musgrave and Janciute, 2018).

was dictated by pay structures but had limited opportunity for progression and they often had to 'fight' to be renumerated for specialist roles (economic). Physiotherapists experienced potentially discriminatory practices such as maternity leave not being backfilled in a female-dominated profession (social).

Standing (2011, p.10) goes further to conceptualise an emerging class, the precariat, who lack seven key forms of labour-security:

- ***Labour market security***: adequate income-earning opportunities at the macro-level; epitomised by government commitment to 'full' employment.
- ***Employment security:*** protection against arbitrary dismissal, regulations on hiring and firing, imposition of costs on employers for failing to adhere to rules and so on.
- ***Job security:*** ability and opportunity to retain a niche in employment, plus barriers to skill dilution, and opportunities for 'upward' mobility in terms of status and income.
- ***Work security:*** protection against accident and illness at work through safety and health regulations, limits on working time, unsociable hours, night work for women, compensation for mishaps.
- ***Skill reproduction security:*** opportunity to gain skills, through apprenticeships, employment training etc, and opportunity to make use of competencies.
- ***Income security:*** assurance of adequate, stable income, protected through e.g., minimum wage machinery, wage indexation, social security, progressive taxation to reduce inequality and to supplement low incomes.

- ***Representation security:*** possessing a collective voice in the labour market through e.g., independent trade unions with a right to strike.

Physiotherapists experienced an absence of at least five out of these seven forms of labour-related security. For example, lacking career progression and opportunity for macro-level influence (labour market and job security), the commodification and codification of physiotherapists' skills (job security), adopting dysfunctional working patterns to cope with workload (work security), lacking CPD and training creating a loss of 'professional confidence' (skill reproduction security), and a limited collective voice at an organisational and beyond level (representation security). Although physiotherapists do have an independent trade union in the form of the CSP, they described having little other collective voice represented at key organisational and regional meetings. Furthermore, some suggested they did not feel the CSP was a collective voice as they felt its leadership was predominantly based in MSK care (which was also reflected in the CSP's discursive focus on MSK and primary care outlined in 4.2.4). There is very little evidence of the effectiveness of professional healthcare unions functioning as trade unions (for example, the CSP and the Royal College of Nursing). However, comparatively, the British Medical Association (BMA), the trade union for doctors in the UK, has historically functioned as a trade union successfully and been involved in negotiations at state level for many years (see Denis *et al.,* 2022).

The absence of some elements of Standing's (2011) characteristics is not to say they are not present. The identification of precarious work was an offshoot of analysis and

not anticipated in the conceptualisation of the study. If this had been the subject of inquiry, different questions may have been asked and thus may have uncovered all seven domains of precarity. Contrastingly, their absence may suggest that physiotherapists have not fully entered the precariat class but are vulnerable to precariatisation. Most of those who experienced precarity were band 6 or below, suggesting that professional elites may be less likely to be precariatised. However, they may also experience precarity differently.

The paradox of precarity comes from its potential to offer flexibility and opportunistic movements in employment, something which could potentially benefit those undertaking professionalisation strategies, such as the professional elites. For example, temporary contracts could facilitate professional elites movement into advanced scope roles, such as FCP. Some participants described gaining valuable experience at a more senior level through secondments or short-term contracts. Professional elites may have more social and cultural capital (Bourdieu, 1992; Noordegraaf and Schinkel, 2011a, 2011b) compared to their rank-and-file colleagues and thus be more capable to respond to precarity in a professionalising manner. Having said this, precarious work, in the form of short-term contracts and bank/zero-hour contracts, were also seen as beneficial for some rank-and-file members; for example, those who were accessing further education worked on bank contracts to bolster their income, and those who wished to relocate, travel, or take a career break anticipated finding (precarious) work would be relatively easy. Paradoxically, precarious work offered security for some members of the profession, as they described

having the NHS to 'fall back on' should alternate career moves be unsuccessful, as short-term contracts and bank work were generally always available.

More and more employees are experiencing precarity, with the era of globalisation and concepts associated with it (such as neoliberalist principles and commodification of professional labour) having catalysed the growth of the precariat (Standing, 2011). However, the relationship between precarity and those who are considered 'professions' is scarcely explored. Standing (2011, p.23) suggests that those in the precariat class cannot be professionalised, as they are unable to specialise and therefore obtain growth in competence and depth of practice. But what about those who have already professionalised? Saks (2021, p.111) refers to Standing (2011) in that employees, professional or otherwise, have been 'plunged into precarity.' However, there is little discussion on whether professional groups are being precariatised. This is relevant as Standing (2011) suggests anyone can enter the precariat class.

In the literature, there are some examinations of precarity in those groups who are usually considered as professionalised; interestingly, there is little examination in the UK. Goździak and Main (2022) examined precarity experienced by Polish nurses working in Norway. They found that although nurses did not have the typical characteristics of precarious work (e.g., low skill), Polish nurses did experience precarity through multiple low wage jobs, poor work-life balance, varying work hours, high mobility, and short-term employment contracts (Goździak and Main, 2022). Hult *et al.* (2022) also examined precarity in nursing, but in Finland. They found that nurses did experience (mostly

temporal) precarity, though did suggest those who worked in temporary positions had better health and wellbeing scores than those on permanent contracts. This highlights how some may choose to enter the precarious workforce for the flexibility it can offer. Grajek *et al.* (2017) explored precarity among employees of the Polish health system, using Standing's (2011) concept of the precariat. They concluded that several social classes in Standing's (2011) classification were observed amongst the workforce and the phenomenon of the precariat was noted. However, no healthcare providers met all the dimensions of the precariat; suggesting that dimensions of precarity were present, but not in its fullest form. This is reflective of the findings in this study, though the professionals experiencing precarity in this study were NHS employees, whereas those in Goździak and Main (2022) (for example) were migrant nurses on temporary contracts.

The concept of the precariat offers greater depths in reflections upon the profession when examining the 'four As' which are experienced by precariats: anomie, anger, anxiety, and alienation (Standing, 2011; Grint and Nixon, 2015). All four could be seen in those physiotherapists on the route of precariatisation. Physiotherapists felt anomic (listlessness and passivity born from despair [Standing, 2011]), or what Grint and Nixon (2015) summarised as a lack of meaningful work (see 6.3.1). Physiotherapists experienced anxiety due to chronic worry about their security in employment. Physiotherapists felt angry that their avenues for progression were blocked (Standing, 2011), as were their aspirations (Grint and Nixon, 2015). Physiotherapists' experiences of the above made them feel alienated from their

work, due to its lack of meaning, purpose, and social approval (Standing, 2011; Grint and Nixon, 2015).

This study offers an important insight into how professionals can be precariatised, albeit partially. It identifies a risk to the continuation of professionalism and shows that they are not immune to capitalist-driven precariatisation. It would be interesting to explore whether this is occurring in other professions and those considered archetypical, such as medicine. Other archetypal professions, such as the legal profession, are experiencing precarity (Moorhead, 2014). It is unclear whether medicine would experience similar precarity.

6.5.1 The importance of considering precarity

Austerity could be argued as a case example of precarity. This is important as other changes in society, such as COVID-19 and global conflict, may impact on how the professions work. Work is becoming increasingly precarious, and the opportunities seized by professional elites may one day be distributed amongst other allied health professions who are potentially also experiencing precarity and competing to exist in the professional ecology. Viewing professional work through the lens of precarity in the context of austerity has facilitated understanding of how a subordinated profession negotiates power, dominance and hierarchy based on their ability to respond to precarity. Thus, the paradox of precarity materialises, as it offers both opportunity (for the professional elites) and detrimental effects on health and wellbeing, job, and employment security, and degrades the meaning of professional work (for rank-and-file members).

6.6 Revisiting the sociology of professions as a theoretical framework

It is important to revisit the sociology of professions as a theoretical framework to articulate what my study contributes to contemporary understandings of the sociology of professions. The neo-Weberian approaches to the professions have been suggested as the most fruitful approach (Saks, 2016) and there are a large number of analyses using this perspective as a theoretical underpinning. In this study, the neo-Weberian approach has offered great utility in facilitating understanding of how the physiotherapy profession negotiate their position within the professional ecology and how they reconcile austerity and the challenges this poses to their professional work.

Nonetheless, some aspects of analysis have identified issues which can be understood both in neo-Weberian terms and bring to light analytical constructs more closely associated with other perspectives, such as Marxist theory. For example, viewing the profession through the lens of precarity and Standing's (2011) conceptualisation of the emerging class of the precariat may be considered to be predominantly Marxist (though Standing's conceptualisation draws on the work of both Weber and Marx). This is not to say Marxist approaches to the professions should be completely revisited, as they are not without critique (see 2.3.3), but rather to bring attention to the potential for these theories to provide additional explanatory power. This is of particular interest when examining professional groups who occupy a position of lesser power and who are less associated with a dominant social position. This is not entirely unproblematic, as this position may assume medicine for example, is a member of the dominant class

and thus own their capitalist methods of production, which is contentious and a view which highlights the fragility of some Marxist analyses of the professions (Saks, 2021).

Another concept that offered utility in this study's analysis was the indeterminacy-technicality ratio, developed by Jamous and Peloille (1970) and used by Abbott (1988) to understand professional knowledge. Jamous and Peloille (1970) are not typically categorised within broader approaches to the sociology of professions; however, this demonstrates how eclectic use of approaches can be complementary and deepen understanding, as encouraged by Saks (2016). This is not to encourage theoretical ambiguity, attempts to merge theory, or amalgamate theories whose philosophical bases may be incompatible. Rather, consideration of less popular theories in contemporary sociology of professions, such as Marxism, may provide insight when examining processes which deconstruct traditional notions of professionalism, much like neo-Weberian approaches. Furthermore, many approaches are relational and informed by others, as seen in Larson's (1977) Marxist and Weberian influences, and Freidson (1970a, 1970b) drawing upon interactionist approaches in his analysis. Development within contemporary sociology of the professions has culminated in some questioning the whether the professions as a sociological category has ended (Kurtz, 2021). Although undoubtedly the concept of 'profession' is under challenge in contemporary society, prolific writers in the field suggest professions will probably continue to be a key idea in society (Saks, 2021). Responding to this debate, some authors have developed the idea of post-professionalism, discussed in the next section.

6.7 Are we entering a post-professional era?

Post-professionalism, perhaps first coined by Illich (1977) and expanded by others (Kritzer, 1999), has received greater attention recently as challenges to traditional notions of professionalism force them to reshape. Despite its perhaps misleading name, post-professionalism does not indicate the end of professions per se, but a complete reconfiguration of the institution of professionalism itself (Kritzer, 1999). As Kritzer (1999) suggests: *'the professions are dead, long live the professions.'* Post-professionalism can have nuanced differences in interpretation, as will be shown, though central to its conceptualisation is the reshaping of professionalism as a consequence to changing global contexts.

For Nicholls (2022) post-professionalism represents the decentralised role professionals now have in the governance of society. Nicholls (2022, p.178) describes post-professionalism as working *'on the basis that professionals will see their power and prestige diminish over the coming years, as social capital becomes more widely distributed amongst a much more diffuse set of social agents.'* Arguably, this has echoes of deprofessionalisation, as this too represents loss of power, prestige, and a narrowed knowledge gap between public and profession (Haug, 1972, 1975; Freidson, 1984); and thus, a redistribution of social capital as described by Nicholls (2022) regarding post-professionalism.

Nicholls (2022) recognises that his conceptualisation of post-professionalism has affinities to deprofessionalisation, and

although their differences are not explicitly outlined by Nicholls, one can interpret the movement beyond deprofessionalisation in Nicholl's explanation of the implications for the physiotherapy profession.

Nicholls (2022) suggests critiques surrounding the professions and late capitalism are drivers for post-professionalism, with neoliberalist tenets of individualism and responsibility, decentralisation and localism, degradation of traditional notions of empathy and care, complexity, and critique of professional claims of altruism and expertise as important considerations. The key difference between deprofessionalisation and post-professionalism here appears to be in how professions respond to this decentralisation of their importance and redistribution of social capital. For example, in Nicholls' (2022) sense, were physiotherapy to truly embody the professional values of goodness (and not to neo-Weberian notions of occupational closure), they may demystify their knowledge and distribute skills to others, if it were for the benefit of public good and despite any subsequent demise of the profession.

Nicholls summarises this succinctly:

'The greatest fear of the professional… is that people will no longer want them… How do we begin to contemplate demystifying our knowledge and sharing our skills with anyone who wants to use them, the professional asks if the end result is our demise? But if it were in the public's interest to close the physiotherapy profession down completely, for instance, then ***of course*** *we should do it because the key phrase is that it would*

*be **in the public's interest**,'* (Nicholls, 2022, p198, emphasis in text).

Nancarrow and Borthwick's (2021) approach to post-professionalism has affinities to Nicholl's interpretation, though it places more emphasis on the disaggregation of tasks which are then redeveloped into new professional roles. For Nancarrow and Borthwick (2021), a post-professional workforce encompasses a range of clinically qualified healthcare professionals who have reorganised to become part of a new profession and identity, sharing common skills and a common title. Nancarrow and Borthwick (2021) delineate post-professionalism from transdisciplinary practice as this embodies role overlap and interdependences, whereas post-professionalism involves disaggregated, codified, and commodified tasks, transferred to a new identity and profession based on population needs (rather than professional boundaries). Examples of post-professional workforces include diabetes educators and rural generalist health practitioners in Australia (Nancarrow and Borthwick, 2021). An example of this in this in the UK would be Advanced Clinical Practice (ACP) roles, which are performed by a range of healthcare professionals, including nurses, paramedics, pharmacists and AHPs (Forthergill *et al.,* 2022).

Both Nicholls (2022) and Nancarrow and Borthwick (2021) identify post-professionalism's ability to undermine key assumptions of professionalism, such as specialist knowledge, the indeterminacy-technicality ratio, and protection of jurisdiction; these have been demonstrably broken down and transferred to new professional roles, delivered by multi-professional groups based on patient and public need. The findings of this study show

some aspects of post-professionalism in practice, such as a growing challenge to physiotherapy's traditional notions of professionalism, and the increasing influence of technology and individual responsibility through the consumerist, informed patient. Furthermore, a small number of physiotherapists appeared to frame their thinking (perhaps unknowingly) in post-professional terms, in that they considered their profession being slowly dismantled and potentially extinct in the future.

Having said this, the profession appears to predominantly function in neo-Weberian forms of occupational closure and boundary protection, arguably represented in a statement by the CSP following a job description professional boundary dispute: *'physios are not, and don't want to be, nurses,'* (CSP, 2021d). Nonetheless, reticence to engage with post-professional debates and professional criticality may pose greater risk for the profession and their service users (Nicholls, 2022). Post-professionalism poses opportunities to create a flexible workforce (Nancarrow and Borthwick, 2021), which is particularly relevant in resource restricted environments as described extensively in this study. However, as Nicholls (2022) and Nancarrow and Borthwick (2021) suggest, post-professionalism does bring into question professions and professionalism as a concept, and to the importance of these to those using their services (Nancarrow and Borthwick, 2021).

6.8 Implications for the professions

6.8.1 For physiotherapy

The study findings describe a potentially bleak picture for the physiotherapy profession. However, it is important to note how

the profession is coping and responding to challenges to the nature of its professional work. Physiotherapists strived to provide excellent care despite their challenges and were committed to enhancing patient-centred efficiency and improving patients' experiences. Physiotherapists showed innovative ways of overcoming challenges in contemporary healthcare practice.

As a result of the COVID-19 pandemic, physiotherapists described rapidly implemented innovation, improvements in their working life due to adapted working patterns, and renewed cohesion across physiotherapy and other professions. Physiotherapists found new roles and extended practice, which was welcomed both by themselves and other professions. Physiotherapists described an organisational realisation that innovation did not have to be time-consuming, and flexibility across the workforce enhanced efficiency. This provided opportunities for continued development and innovation for the profession in the future. Furthermore, physiotherapists felt more valued and respected, because of both media coverage of their work (such as Vogue: De Rosée, 2020) and collaborative working with other professions during the pandemic.

The physiotherapy profession, much like other healthcare professions, is at a crucial point in their professionalisation. The profession is expanding and extending their scope of practice and jurisdiction, with potentially cost-saving and efficiency-enhancing roles. This benefits both the profession's longevity and potentially improves the care patients receive. However, a chasm within the profession is evident. Those who occupy the lower rungs of the physiotherapy ladder are feeling disheartened, frustrated, and alienated with their work, due to repeated experiences of moral

distress and powerlessness. The advancement of the profession[al elites] should not be at the cost of those who are the future workforce. These members are losing their confidence and meaning in the profession and describe seeking alternative, non-clinical careers. This could have catastrophic consequences for retention and future-proofing the profession. The profession (and the NHS) must collectively, work to enhance the working life and technical skills of both the professional elites and rank-and-file members of staff, should they wish to continue to be present within the healthcare professional ecology.

The findings have provided empirical evidence of bedside rationing, and explicit and implicit forms of cost saving which are having a clear impact on patient care, with physiotherapists suggesting that the most vulnerable members of society and disadvantaged and marginalised groups being disproportionately affected. The professions are well placed to campaign and advocate for these people and all participants demonstrated proactive attempts to promote equality. Addressing structural and institutional inequalities is the responsibility of all professionals and their leadership, if professions are to embody and operationalise their claims to altruism and working for public good. There are encouraging signs that this is becoming increasingly considered as a core role of professional work; for example, the CSP's equity, diversity and belonging strategy (CSP, 2021e).

Relatedly, professional leadership, both within organisations and nationally, should reflect the broad spectrum of physiotherapy professional work, as some members of the profession reportedly felt that their specialities were underrepresented at senior

leadership level, due to a dominance of musculoskeletal leadership members. Furthermore, efforts should be made at organisational, national and government level to involve AHPs in decision-making and service planning, as they are underrepresented and often denied access to such activities.

Importantly, this study has provided empirical evidence for much of the theorising surrounding professions and the impact on a subordinated and more vulnerable profession. It has provided evidence of the profession's need to engage and reflect critically on itself, as recommended by Nicholls (2018, 2022), in order to dispel traditional notions of professional boundaries, if needed to improve patient care.

6.8.2 For the allied health professions more generally

The study and its findings provide learning and implications for other allied health professions. Like Nancarrow and Borthwick (2021), this study has demonstrated the ability of an allied health professional to adapt to service changes, respond quickly and flexibly (as during COVID-19), and demonstrate a highly-skilled workforce, working interprofessionally and collaboratively. It does also however identify risks and threats to ongoing professional work, which are likely to affect other AHPs. This could potentially be to a greater extent for some AHPs, as physiotherapy represents the largest AHP in the UK (Dorning and Bardsley, 2014).

This study will provide a basis for analyses of other AHPs, and examples of professional reorganisation that have taken place in physiotherapy, such as FCPs, are being extended to other AHPS; for example, the FCP paramedic (Health Education England

[HEE], 2021). The extension of FCP roles to other AHPs provides similar opportunities to those seized by physiotherapy to capitalise on the need to create cost savings, address the shortage of GPs, and to extend their professional jurisdiction. The ability to broaden their skill set and work flexibly, both whilst providing cost savings are a unique selling point for the AHPs. However, this comes with trade-offs, and as identified in this study, a price. Enhancing level of specialism has meant physiotherapists have fought to be renumerated both in finance and status (e.g., pay and banding). However, as acknowledged in this study, this was a difficult process for AHPs and may significantly contribute to their cost-competitiveness, as they deliver labour at a lower cost. This should be taken into consideration for other AHPs pursuing extended scope roles and may represent another trade-off for the presence of subordinated professions competing for their place in the professional ecology.

Other healthcare and subordinated professions may also benefit from examination to determine whether similar responses and experiences of power, dominance and hierarchy are experienced. Furthermore, the perspectives of support workers should be investigated. It is clear they are increasingly delegated greater levels of responsibility and risk, yet their experiences are neglected, echoing Saks (2020) description of support workers as the 'invisible providers' of healthcare. Support workers offer a huge amount of support to AHPs and arguably sustain (and deliver) a large proportion of their prescribed practice as shown in this study. Future research should explore this and the potential for these workers' labour to be exploited.

6.9 Contribution to the literature

This study contributes to the literature in several ways. It has provided empirical evidence of austerity on the frontline of healthcare, such as bedside rationing, and has identified forms of explicit and implicit cost saving. It has identified the impact of austerity on patient care and how marginalised and disadvantaged members of society are most affected. The study also provides insight into how professional identity is constructed and reconstructed in relation to organisational, social, and economic contexts.

The study offers important contributions to how clinical reasoning is cognised in austere health settings. Traditional reductive logic is challenged by the need to consider resources in the primary stages of clinical reasoning and often above patient need, not through want but requirement. The concept of resource-led clinical reasoning was introduced and offers utility for future analyses of clinical reasoning in different contexts. Furthermore, the analysis of the concept of rehabilitation potential and how this is contextualised in resource-restricted settings provides a basis for critical reflection on the profession's normalised clinical reasoning processes.

The study contributes to the sociology of professions literature in a number of ways. This study has demonstrated how the neo-Weberian interpretations of the professions continue to hold utility in examining professionalism in contemporary society. The study has shown how a non-archetypical profession negotiates challenges to their professional work whilst also working within an interprofessional hierarchy and as a profession traditionally

considered subordinate. This has been lacking in the sociology of professions literature. The study has also demonstrated the utility of revisiting the meaning of professionalism and how, when this is lost, professionalism is undermined, and professional identity is reconstructed. Furthermore, the utility of temporally dated but not conceptually dated theories, for example, the indeterminacy-technicality ratio and Marxist approaches to the professions, has been renewed.

This study has uncovered the concept of professions as precarious workers and/or their vulnerability to becoming precariatised. This study has suggested that widening chasms between professional elites and rank-and-file members may render those considered the 'workhorses' of the profession more vulnerable to processes of precarity. Precarity in the professions has scarcely been researched and this offers new avenues of exploration into how the professions are navigating the challenges that are faced them in an advancing society.

6.10 Methodological and theoretical limitations of the study

The study was subject to methodological and theoretical limitations. Firstly, the study used qualitative methods, underpinned by an interpretive epistemology. As discussed in chapter three, this paradigm comes with critique; for example, qualitative methods are critiqued for their ability to provide valid, reliable data and is often subject to additional ethical considerations due to the researcher's emotional and physical proximity to their participants. Furthermore, the study was carried out by a physiotherapist, with their own preconceptions,

assumptions and experiences which would have inevitably shaped the relationships formed with participants and the interpretation of data analysis.

Although important to recognise, these critiques are rooted in objectivist and positivist desires for an objective and controlled research setting. The subject matter researched is rooted in complex social life and thus, standardising or controlling the research setting is impossible and not an aim of qualitative research. It is not to say therefore that qualitative research should be of poor quality, but attempts can be and have been made to promote transparency and rigour throughout this study. In chapter three, ethical considerations in this study were discussed in depth and transparency throughout has been demonstrated through use of reflective journals and being completely transparent about the researcher's background and assumptions.

An additional limitation to this study, was that it did not follow its planned methodology (ethnography) due to the COVID-19 pandemic. If ethnography had been possible, this would have potentially produced a larger dataset and opportunity to explore phenomena in more depth. Furthermore, participant observations would have enabled an analysis of actions, rather than relying on participants' accounts of their actions. Having said this, the data collected provided an in-depth insight into the research question and was more in-depth and greater in number than anticipated at the onset of the COVID-19 pandemic. Additionally, the amended methods enabled a national approach to data collection rather than a local analysis of one organisation.

The analysis relies on the accounts of physiotherapists who took part in the study. Therefore, this may not represent all physiotherapists' views. Nonetheless, the aim of qualitative research is not to provide generalisable results, but to explore phenomena in depth and articulate and evaluate the experiences of those interviewed, which this study has achieved.

The theoretical framework used in this study is subject to limitations. As discussed in chapter two, the neo-Weberian approaches to the sociology of professions have been criticised for their lacking empirical evidence, unsubstantiated claims, and use of ideal types (Saks, 2010, 2016). This study has addressed the lacking empirical evidence to an extent as it has carried out an empirical study using this approach as its theoretical framework. The study has therefore contributed to the literature and use of this method and demonstrated its utility in analysing empirical data. The study did not focus on ideal typical analysis specifically but recognised their limitations and realistic presence (as discussed in chapter two). Additionally, the neo-Weberian approach has been critiqued for its neglect of subordinated, marginalised, or professionalising groups (Saks, 2010, 2016). This study has contributed to the literature in this respect, as it examined a traditionally subordinated profession. Future research into marginalised and professionalising groups is required.

Alternative theoretical and methodological positions may have offered different perspectives on the data analysis. For example, the study could have adopted a feminist epistemology to explore gender as issues of subordination and hierarchy were explored. This paradigm would have offered an alternate approach to the research question. It is important to acknowledge this limitation

as physiotherapy, much like other AHPs, is highly feminised (Nancarrow and Borthwick, 2021), with 74% of the CSP registered physiotherapists in the UK identifying as female (Beswetherick, 2021). Therefore, there may well be paternalistic control exerted from the traditionally male-dominated profession of medicine. Indeed, this study did demonstrate how gender-based discriminatory practices were taking place, such as the failure to backfill maternity leave to save money; consequently, workload was increased for the remaining, predominantly female, workforce. This study did not collect in depth demographic data such as age, location, and gender identity. This was a limitation of the study in that as gender identity was not collected, it is not possible to ascertain how gender may have influenced physiotherapists' professional work. However, as discussed, gendered discriminatory practices were identified regardless.

There is no entirely unproblematic underpinning epistemology or theoretical framework for research, and it is possible that subject matter can be examined from numerous perspectives. In this study, the neo-Weberian approaches to the sociology of professions, focussing on notions of social closure and professional boundaries in the context of austerity was selected for analysis, and the aims of the study were achieved.

6.11 Concluding remarks

The legacy of physiotherapy's subordination and its consideration as a profession supplementary to medicine remains (Larkin, 1983). This materialised through physiotherapists' ability to respond to austerity, and their reconciliation of austerity and other countervailing powers to their work. Austerity impacted on

the nature of physiotherapists' professional work through practical means: limited resources, growing (in size and complexity) caseloads, and implicit and explicit modes of cost saving on the frontline.

Ultimately, physiotherapists (as a subordinated profession) were more exposed to the harshness of austerity and to negotiate these challenges, they were required to navigate additional layers of power, dominance and hierarchy compared to their archetypical (medical) counterparts. It is not to say that medicine has been unaffected by this, but that the subordinated professions occupy a greater position of vulnerability.

To conclude the chapter, it is useful to revisit the research question: How does a smaller, subordinated healthcare profession (non-medical, non-nursing) reconcile and accommodate austerity and what impact does this have on the nature of their professional work?

Physiotherapists used methods of restratification and circumvention within the nature and structure of their professional work to reconcile austerity. Physiotherapists always had to negotiate hierarchy and power dynamics to accommodate challenges to their professional work. Physiotherapists rarely (if ever) were able to directly resist or influence change without navigating complex layers of hierarchy and power; their attempts were met with both successes and losses. Physiotherapists higher up the intraprofessional hierarchy and who had working relationships with more powerful professions and positions (such as consultants and senior nurses) were more likely to be able to influence change, resist organisational and financial restrictions,

and achieve their professional and service goals. Physiotherapists capitalised on areas to contribute to cost savings through extended practice and encroachment into medicine's jurisdiction; simultaneously extending their professional project. Physiotherapists' professional work was commodified and codified, which eroded the meaning of their work. This had implications for physiotherapists' job satisfaction, moral distress, retention, and attrition from the profession. The difficulty in quantifying rehabilitation and meaning made the profession vulnerable to decommissioning in an increasingly fiscally orientated health system. This may have similar implications for other AHPs as they also work collaboratively, with rehabilitation at their centre, and have little representation on senior management and funding bodies to advocate for their professions.

The allied health professions are at a crucial time in the professionalisation. As predicted by others and discussed in this study, this has implications for AHPs' continuing professional presence and also raises questions for their existence at all. As discussed, the physiotherapy profession and their allied health colleagues must reflect critically and use their position to promote equity for their service users, particularly for those who have a limited voice. It is of course acknowledged that the health professions are under immense pressure, they may feel their ability to do this is limited, and this may pose difficult questions for their ongoing professional presence, however, as Nicholls (2022, p. 256) suggests, this *'does not mean we should not try.'*

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Appendix One: Ethical Approval Letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Professor Stephen Timmons
Nottingham University Business School
Jubilee Campus
Nottingham
NG8 1BB

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

06 July 2020

Dear Professor Timmons

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Professional work in austere healthcare in the UK- the case of physiotherapy.**
IRAS project ID:	**272374**
Protocol number:	**19082**
REC reference:	**19/EM/0321**
Sponsor	**University of Nottingham**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **272374**. Please quote this on all correspondence.

Yours Sincerely
Beverley Mashegede

Email: approvals@hra.nhs.uk

Copy to: *Ms Angela Shone, Sponsor Contact*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed belov

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [2019 To Whom It May Concern Letter for EL PL and PI]	1.0	30 August 2019
HRA Schedule of Events	1	04 October 2019
Interview schedules or topic guides for participants [INTERVIEW TOPIC GUIDE ProfWorkAusPhys V2.0 06 09 19]	2.0	06 September 2019
IRAS Application Form [IRAS_Form_16092019]		16 September 2019
Letter from funder [Proof of funding]	1.0	15 January 2019
Letter from sponsor [19082 Sponsor letter]	1.0	09 September 2019
Organisation Information Document [OID ProfWorkAusPhys V3.0 06 09 19]	3.0	06 September 2019
Other [Fiona Moffatt CV]	1.0	04 November 2019
Other [DTP Letter Proof of Review]	1.0	28 October 2019
Other [Annual Review Feedback on Study- Nottingham University Business School]	1.0	30 May 2019
Other [Ethical Review and HRA Further Information Requests ProfWorkAusPhys V1.0 04 11 19]	1.0	04 November 2019
Other [POSTER ProfWorkAusPhys V3.0 06 09 19]	3.0	06 September 2019
Participant consent form [CONSENT FORM FOR DOC&ART ANALYSIS ProfWorkAusPhys v2.0 06 09 19]	2.0	06 September 2019
Participant consent form [CONSENT FORM FOR INTERVIEWS ProfWorkAusPhys V2.0 06 09 19]	2.0	06 September 2019
Participant information sheet (PIS) [INFO SHEET ProfWorkAusPhys V3.0 06 09 19]	3.0	06 September 2019
Research protocol or project proposal [PROTOCOL ProfWorkAusPhys V4.0 04 11 19]	4.0	04 November 2019
Summary CV for Chief Investigator (CI) [CI Stephen Timmons CV]	1.0	06 September 2019
Summary CV for student [Rachael Tucker CV]	1.0	09 September 2019
Summary CV for supervisor (student research) [CI Stephen Timmons CV]	1.0	06 September 2019

IRAS project ID	272374

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
Single centre study	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No funds will be provided to the participating organisation/s to support this study	A Local Collaborator is expected at the participating organisation	Where arrangements are not already in place, research team members undertaking activities that do not impact on the quality of care of the participant (for example, administering questionnaires), a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix Two: Substantial Amendment Outcome

From: New IRAS Dev <no-reply-iras@hra.nhs.uk>
Sent on: Wednesday, July 15, 2020 5:38:59 PM
To: rachael.tucker@nottingham.ac.uk
Subject: IRAS 272374. Amendment

IRAS Project ID: 272374
Sponsor amendment reference: NSA01 July 2020

Thank you for submitting your study amendment. In accordance with the outcome of your completed amendment tool, this amendment requires no further regulatory review. Please now share this amendment with your UK research sites, in accordance with the instructions in your completed amendment tool.

For studies with more than one UK research site, your amendment will now be automatically shared with the R&D offices of any NHS/HSC research sites in Scotland and Northern Ireland, but you should share the amendment by email directly with those Research team/s.

For all NHS research sites in England and Wales, please now share this amendment by email directly with those sites, including both the R&D offices and research teams.

Do not reply to this email as this is an unmonitored address and replies to this email cannot be responded to or read.

This message may contain confidential information. If you are not the intended recipient please inform the sender that you have received the message in error before deleting it. Please do not disclose, copy or distribute information in this e-mail or take any action in relation to its contents. To do so is strictly prohibited and may be unlawful. Thank you for your co-operation..