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Managing to Practice: Managing to Change?

An Exploration of General Medical Practitioners' Orientations to Work

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Abstract

This study explores the managed change strategies that have affected general practitioners in England, and the NHS as a whole, since the turn of the century. Integral to the exploration is a discussion of the implementation of *Working for Patients* (Secretaries of State for Health, 1989a) and the ways in which general practitioners' experience, understand and make sense of this recent state-initiated managed change. A significant and novel focus of this investigation is the link between the broader historical and structural issues with individual interpretive ones.

There are four main parts to this thesis. In part I the origins, content and context of occupational and organisational change in general medical practice since the 1900s are explored and analysed. This historical and structural analysis develops Klein's (1989) general and influential work on the NHS. Themes and categories are identified, and comparisons and connections are made with wider NHS changes to improve our understanding of the occupational and organisational development of general medical practice. This analysis sets the context and historical foundations that help shape *Working for Patients* - the most recent governmental change to affect primary health care.

Part II presents the conceptual thinking which underlies the empirical investigative element of the study and considers the craft of researching. It is argued that individuals need to be placed at the centre of the inquiry to understand better organisational and occupational processes in which they are involved. The thesis as a whole adopts a reflexive style. It is here, however, that the processes undergone whilst forming and carrying out the investigation are discussed in some detail. The main issues that researchers face when conducting qualitative investigations are explored and addressed.

In part III, an exploration and analysis of how GPs account for the present health care situation is presented. Attention is given to how GPs make sense of their work and *Working for Patients*. GPs' sense-making rationales are guided by their orientations to work: how they derive meaning from their actual or possible attachment to an occupational group and their involvement in organisational activities. Tensions and dilemmas identified in the structural and historical analysis in part 1 are seen to manifest themselves in the talk of general practitioners today.

The thesis is concluded in part IV where the structural and micro analyses are brought together. In particular, tensions between occupational and administrative forms of control identified in the earlier parts are brought more sharply into focus. How individual GPs define and make sense of their work and *Working for Patients,* along with the analysis of conflicting principles of work control, is of great consequence in improving our understanding of these change processes.

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Abbreviations

AHA	Area Health Authority
AMC	Area Medical Committee
BMA	British Medical Association
BMJ	British Medical Journal
CHC	Community Health Council
CMB	Central Medical Board
DGH	District General Hospital
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMT	District Management Team
DMU	Directly Managed Unit
DoH	Department of Health
FHSA	Family Health Services Authority
FMI	Financial Management Initiative
FPC	Family Practitioner Committee
GMP	General Medical Practice
GMSC	General Medical Services Committee
GP	General Practitioner
HA	Health Authority
HEA	Health Education Authority
HMC	Hospital Management Committee
HSSD	Health and Social Services Division
JMC	Joint Medical Committee
LA	Local Authority
LHA	Local Health Authority
LMC	Local Medical Committee
MoH	Ministry of Health
MPC	Medical Planning Committee
NAHA	National Association of Health Authorities
NBS	Nottingham Business School, The Nottingham Trent University
NHS	National Health Service
NHSME	NHS Management Executive
PHC	Primary Health Care
RAWP	Resource Allocation Working Party
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RHA	Regional Health Authority
RHB	Regional Hospital Board
SHA	Special Health Authorities
SMA	Socialist Medical Council
TUC	Trades Union Congress

Introduction

General medical practice plays a key role in the provision of health care in modern Britain. General practitioners (GPs) provide medical care for all from "cradle to grave". Because GPs in the main are the first point of contact that patients have with the National Health Service (NHS), they play a crucial role in providing care and referring patients to other services and thus have the capacity to control public expenditure. Despite having a high public profile, few studies have examined general practitioners closely and analysed their occupational and organisational development. Contemporary investigations that do examine GPs tend to concentrate on specific or specialist areas such as urban practices, women in general medical practice or the relationship between patients and their GPs.

Since the turn of the century the role and function of general practitioners has transformed substantially: "The original general practitioner was, let us be frank, a gentlemen dependent on fees, generally of low status and ambition who touted for clinical custom in direct competition with his fellows" (Livingstone and Widgery, 1990:708). Until the end of the nineteenth century there was no thought of a national general practitioner service or universally available health care. In 1948 this was to change: the NHS was established. GPs were central to the government's plans to implement a "rational and effective" comprehensive health service in Britain (Ministry of Health, 1944). The government has since had a political interest in organising the practice and function of general practitioners.

The occupational development of general practitioners has a history of compromise, negotiation and conflict of interest with the government. Central to the understanding of this development is the tension between the two sociologically defined principles of work structuring and control: the occupational and administrative. *Working for Patients* (Secretaries of State for Health, 1989a) is perceived to be the most controversial or radical change that the government has introduced in the last forty years (Chisholm,

1990; Bryden, 1992). The editor of *The British Journal of General Practice* (1992) commenting on *Working for Patients* stated: "The changes represent a fundamental shift in the relationship between an elected government and an independent profession...". The tension between the two forms of work control will be particularly apparent when the White Paper's implementation and interpretation are analysed.

Working for Patients provides a springboard for this investigation. It will be argued that the historical and recent developments in the NHS organisation help influence how general practitioners view their work. Moreover, it will be suggested that an individual's occupational understanding and self identity, along with their organisational understanding, aid them in shaping and constructing their sense making rationales.

There are three main features of this thesis. The first feature is a structural analysis of the development of general medical practice in England which will be balanced by a more microscopic emphasis on process whereby individual GPs make sense of situations and express in their own personal lives certain tensions and dilemmas. The structural analysis develops Klein's (1989) general and influential work on the NHS and identifies themes and categories to improve our understanding of the implementation of *Working for Patients* in general medical practice.

The second key feature is attention to the ambiguous and paradoxical manner in which informants present their interpretations. Tensions and dilemmas identified throughout the history of the health service will be argued to manifest themselves in the talk of general practitioners today. The form in which these dilemmas manifest themselves is of key concern. It will be argued that how the GPs' interpret *Working For Patients* has to be understood in terms of their orientations to work: how they derive meaning from their actual or possible attachment to an occupational group and their involvement in organisational activities. An examination of how GPs use language to explain their work and their interpretations of *Working for Patients* are of paramount importance to this study. Hence, by focusing in some detail on the "discursive resources" (Watson, 1995a) that GPs

draw upon it will be argued that we can understand better the sense-making processes in which they involve themselves. It will be suggested that the discursive resources used to construct arguments and persuasions are culturally defined and those that are selected or ignored may change according to the individual's argument. It will be argued that ambiguities in the informants' talk mirror the current state of the health care system.

The third main feature, and also an aim, of the investigation is its reflexive style. I will reflexively reveal the processes undergone whilst shaping, manipulating and managing the research project. The purpose of this feature is to portray to some degree the part that I play in the study and also to make explicit the obstacles and constraints that researchers are faced when conducting qualitative investigations (see also the aims of the project presented next).

The field work began in April 1990 and coincided with the changes introduced in *Working for Patients* being implemented. The way in which *Working for Patients* has been implemented in England, Scotland, Wales and Northern Ireland differs because of their varying organisational structures. The empirical "data" has been collected in the Midlands, England. Therefore, only those changes that primarily affect the English health service are examined. The research methods used in this investigation are qualitative. In order to access how GPs' experience, understand and make sense of their working lives, semi-structured interviews, non-participant observation and secondary information have been used.

Aims of the Study

The aims of the investigation fall into three areas. These aims were devised towards the beginning of this investigation and were influenced by my experience in the initial project (see setting up the project below):

i. A general aim to develop the theoretical resources that are available for analysing changes in work contexts which differ from the large corporation or bureaucracies concentrated on in so much of the organisational literature, ie. relatively small "professional" practices functioning within the framework of a large national state owned system.

ii. A more specific aim to investigate how individual general practitioners make sense of what I call the "state-initiated managed change strategies" directed at general medical practice in England during the 1990s.

iii. An aim to reveal some of the processes undergone and to explain the theoretical and practical choices that I have made while conducting this investigation. I endeavour to indicate the role that I have played in this investigation and to highlight some of the pleasures and problems that are faced when carry out qualitative research (see also the third main feature of this investigation presented above).

The discussions on change in the NHS, which tend to concentrate on the hospital sector (see Klein, 1989; Pettigrew, 1992; Mohan, 1995, for example), can be usefully supplemented by a close focus on general practitioners. Whether or not the existing academic ideas on organisational or occupational change are adequate or useful to assist in such an analysis is unclear. Hence, another concern of the project is to assess, and where, necessary develop conceptual thinking to tackle the practical problem of undertaking research in this field.

Setting up the Project

Here I outline briefly how the project was established and describe briefly the initial research design ideas and how I came to studying "professional" change processes in general medical practice. The methodology and methods adopted will be addressed in more detail in chapters 4 and 5.

I was employed at The Nottingham Trent University as a Research Assistant / Demonstrator to look at "niche marketing of a national accounting firm". I followed a case study approach to "data" collection (for example, Blau, 1955; Gouldner, 1954 and Selznick, 1949) and became integrated in the marketing function of the accounting firm. As my research progressed I became intrigued by "professional" practices and how they functioned. In particular, the perceived problems resulting from the marketing department attempting to change the firm to a more "market-led" service were of interest. Problems of access in the accounting firm precluded further study of these issues and attention instead was required to be turned to an alternative context where similar problems were being experienced. The field of general medical practice appealed as I saw a number of similarities to my initial project. Shortly after examining general medical practices, with the experience from the accounting firm in mind, a research "puzzle" emerged which I can express as two questions:

i. what are the tensions, if any, between a small "professional" group of workers working within a large state-run organisation such as the NHS and what role does the concept of "professionalism" play in this?

ii. what are the tensions between a "professional" way of organising and performing and an "administrative" way of organising and performing and how do these tensions manifest themselves?

This puzzle, or puzzles, have motivated me to study change in general practice in the way that I have as expressed in the aims of the investigation presented above.

Outline of the Thesis

The investigation explores the issues mentioned above in four main parts: In part I the origins, content and context of occupational and organisational change in general medical practice are explored and analysed; part II focuses on the conceptual thinking and on the researching and reflecting issues which are relevant to this investigations; part III under the heading "Rhetoric, Rationales and Reasoning" concerns itself with the analysis and presentation of empirical "data". On completion of the three main parts the thesis finishes with "Endings and Beginnings" where concluding inferences, analyses and reflections are suggested. The main components are as follows.

Part I plots and analyses the strategic changes, both occupational and organisational, which have affected GPs and have occurred in the NHS since the turn of the century. It will be argued to be difficult to understand fully the issues currently facing general medical practice in England without first looking at the broader historical issues of which they are a part. In chapter 1 there is an examination of the changes that have affected the National Health Service (NHS) as a whole. To contextualise the changes in general medical practice in the 1990s it will be argued that the history of the NHS, in its entirety, needs to be explored. Certain themes and tensions will be raised which frame the historical and more recent developments. Chapter 2 is similar in nature. An outline and exploration of the significant changes which specifically have affected general practitioners are documented and analysed. Whereas chapter 1 will bring out the basic dilemmas and tensions in the NHS, chapter two will examine how these dilemmas and tensions have manifested themselves in general medical practice. By comparing and contrasting current patterns with past ones, we are enabled to see the distinctive nature of general medical practice today. The final chapter of part I (chapter 3)

will be more contemporary and will be devoted to an examination of *Working for Patients* (Secretaries of State for Health, 1989a). The political climate, the rise of general management and the internal market will be discussed in relation to general medical practice in England. The content of *Working for Patients* will be typified into "imposed" and "invited" changes. Issues and themes raised in the first two chapters shall be examined in relation to the White Paper.

In part II the focus of study will shift to both more conceptual and more pragmatic matters. In the main the next two chapters consider methodology, methods and research design. These chapters seek to present an exposition and redefinition of how organisational and occupational life might be understood. It will be argued that individuals need to be placed at the centre of the inquiry to understand fully the processes in which they are involved. A "micro" analysis approach of how social actors make sense of the world which is linked into a broader sociological discussion is suggested. In these chapters in particular I will attempt to reveal, to some extent, the processes that have led me to examine health care phenomena in the manner that I have. Furthermore, I will discuss and account for the main theoretical and practical research choices which are made. In chapter 4 I will present a conceptually-based understanding of strategic change processes. Ideas on individuals and organisational and occupational thinking will be examined and subsequently a conceptual framework will be developed to shape the empirical analysis. The framework developed will complement and build on the more historically-based analysis in part I and the empirical analyses in part III. Central to this framework will be the notion of orientation to work. Chapter 5 will complement the philosophical and theoretical aspects of an investigation (explored in chapter 4) with more pragmatic considerations. The key aspects of investigating GP orientations are discussed: gaining access to the "field", choosing informants, the use of the researcher's "self", "data" collection and presentation methods. Current thinking on qualitative research techniques will be critically examined along with a commentary of my experiences, thoughts and hopes and fears. Although a reflexive approach is taken throughout, it will be here that I personify and exemplify the problems and pleasures, the highs and lows and the trial and error approach often associated with (but omitted from) research projects. The purpose of

exposure is, first, to guide and inform the reader about the intellectual and practical decision-making processes which preceded and influenced the final presentation, and, second, to demystify the research process which is often portrayed as a linear, logical and methodical path. Resulting from the discussion in part II, I will present a framework for interpreting and analysing rhetoric and discursive resources and for understanding the relationship between what is said, culturally-defined discursive resources and sociological analytical constructions. Whereas the conceptual framework will underpins this investigation, this framework will guide the rhetorical and discursive analyses in the next part.

In Part III attention is given to the analysis of the empirical "data". Whereas the emphasis in part I is structural and contextual, the individual is the prominent focus of study here. The three chapters in this part contain, in many instances, extensions of themes introduced in the earlier parts. The conceptual framework and general framework for analysing and interpreting rhetorical and discursive resources discussed in part II will be shape and guide the exploration. The intention of these chapters is to explore in depth how individual GPs make sense of their everyday lives. Orientations to work will be a key conceptual "tool" to improve our understanding of their priorities, sense-making rationales how they construct an NHS "reality". It will be argued that tensions and dilemmas apparent in the history of the NHS manifest themselves in the talk of general practitioners today. In chapter 6 I will focus on the "prior" and "dynamic" orientations to work (Watson, 1995b). It will be argued that how GPs construct their reasoning for entering general practice change as they perceive their circumstances to change. Therefore, a focus on dynamic orientations to general practice will allow for a closer examination of how the GPs perceive present health care phenomena. Hence, underpinning this analysis will be the (potential) impact that *Working for Patients* is said to have. Additionally, I will examine whether an occupational ideology can be identified. Chapter 7 and chapter 8 will be written in tandem. Chapter 7 will link together the theoretical and historical issues by focusing on the tensions between the occupational and administrative principles of work control in the light of the White Paper. The government's rhetoric in *Working for Patients* will be analysed and there will an evaluation of the usefulness in developing a market principle of work control. The overall aim of this

chapter will be to provide a clear and focused structural foundation for the more ambiguous and complex micro analysis in chapter 8. Chapter 8 is devoted to GPs' interpretations of the White Paper. I will suggest that contradictions or paradoxes can be interpreted in the GPs' accounts which reflect the tensions apparent health care since the early stages of the NHS. Two general discursive resources will be identified. Broadly speaking one discursive resource is drawn upon by GPs to dismiss the changes and the other discursive resource is drawn upon to find agreement and support the government's changes. Not all the GPs fit neatly into one category or the other. It is argued that some GPs draw on competing discourses as a result of the confused and complex nature of general medical practice.

Part IV consists of a short concluding chapter. Its aim will not be simply to reiterate what has gone before. Nor will the reader find sweeping generalisations or prescriptive recommendations. I will endeavour instead to outline and clarify the emergent themes and issues raised in this investigation. In particular, the tensions between conflicting principles of work control will be accentuated and how the general practitioners' organisational and occupational (actual or perceived) involvement (ie. their orientations to work) is seen to influence how they comprehend, construct and reconstruct an NHS "reality". Consequently, how individual GPs define and interpret their work and *Working for Patients* will be argued to be of critical importance to improving our understanding of changes of this nature. Furthermore, a reflexive account of the investigation as a whole will be presented. The perceived limitations of this research project and suggestions for future research also will be discussed.

Part I

Exploring Origins, Content and Context

Yesterday is gone,
but its experiences
will be reflected in those of today

Anon

Chapter One

Change and the National Health Service in England

1.0 Introduction

The overall aim of this opening chapter is to explore and investigate what I term the "state-initiated managed change strategies" that have affected the National Health Service (NHS) in England. It is argued to be difficult to understand the issues currently facing general medical practice in England without first looking closely at the broad historical processes of which these issues are a part. Therefore, this exploration provides a springboard for the next chapter where the changes affecting general medical practice are investigated in detail. In this chapter there are eight sections. First (1.1), the political, social and historical issues relevant to the creation of the NHS are explored. Second (1.2), the 1950s - a time of tranquillity and stability - are examined. In this period the government did not introduce any major health legislation, however, certain concerns for the MoH can be identified. These concerns are argued to be relevant to today's health service situation. The following five sections (1.3 to 1.7) plot the next significant "state-initiated managed change strategies" to affect the NHS from the 1960s to the 1990s. These government actions have been instrumental in shaping the present day system of health care. Last in section 1.8 I round up the main issues raised in this chapter.

1.1 The Creation of the NHS

The changes occurring in general medical practice are part of a broad sweep of changes beginning with the establishment of the NHS and are still continuing as the service is adapted to fit the changing circumstances and changing political ideologies. The later analysis of issues and events at the level of local general practice will depend on a historical and contextual understanding of the NHS as a whole. The rest of the present chapter is devoted to establishing this foundation.

The British National Health Service was launched on 5 July 1948. The essence of the system was to provide "free" comprehensive health service for everyone in the country, where there were no qualifying conditions, such as financial contributions, which British citizens had to fulfil to benefit from the service. The government, in the 1944 White Paper, stated their intentions:

> "... to ensure that in the future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health; that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or any other factor irrelevant to the real need - the real need to bring the country's full resources to bear upon reducing ill-health and promoting good health in all citizens" (Ministry of Health & Department of Health for Scotland, 1944:5).

The introduction of the NHS was part of a broader social reconstruction welfare programme introduced after World War Two. An important part of the emerging consensus on the need of a national health service were "the what might be called rationalist paternalists, both medical and administrative... intolerant of muddle, inefficiency and incompetence..." (Klein, 1989:5).

The overall objective, and specific aim for health care, was to look after the people of Britain from the "cradle to the grave". The Minister of Health's job description in the 1946 National Health Service Bill (preceding the setting up of the NHS in 1948) illustrates this idea:

> "[Your role is] ...to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness, and for that purpose to provide or secure the effective provision of services" (Ministry of Health, 1946:1112).

The result of the Bill was the organisation of the existing irrational health care provisions (McLaughlin, 1990). It is useful here to focus on the 1944 White Paper where the plans for the NHS were negotiated by the coalition government of the time and the medical "profession". The foundation of the NHS was a negotiated compromise of different values, politics and ideologies. Here, it is not appropriate to go into depth about the details of this process on the NHS, there are adequate thorough accounts elsewhere (for example, Honigsbaum, 1989; Willcocks, 1981). However, consideration needs to be given to some of the tensions and dilemmas which arose leading up to the 1946 Bill. I suggest that these tensions have relevance to this study because they help make sense of the NHS changes in the 1990s.

Klein (1989) offers a useful spring board for entering into these matters in his discussion of the issues and dilemmas which occurred in establishing the NHS. He focuses on the 1944 White Paper and identified six concerns: central versus local planning and control; administrating the service; coping with voluntary hospitals; decision-making procedures and public accountability; integrating primary and secondary care; and managing GPs.

First, Klein points to the dilemma of the Minister of Health, Henry Willink, as he attempted to build on the existing health "system" to found the new NHS. The Minister wished to have a national responsibility for health care which involved a centralised control system. Paradoxically, at the same time, he wanted a responsive system to local health demands at the community level.

> "It is proposed that the new responsibility for providing the comprehensive service shall be put upon an organisation in which both central and local authority take part, and which both centrally and locally is answerable to the public in the ordinary democratic manner" (Ministry of Health & Department of Health, 1944:11).

The solution offered in the White Paper was that the Minister would assume responsibility for planning whereas local government officials would have the responsibility of running local hospitals and personal health services.

This decision created a new problem of administration. As the devolution of control from central government was agreed, it was assumed that the "structure" of local government was appropriate to cope with the new function. This transpired not to be the case, the local units could not cope with the demands or the size of the health service. As a result joint authorities were set up to run the hospitals and consultant services. Joint authorities included county and borough administrative authorities which were established to overcome the problem of town and county differences in health care provisions (especially given the lack of hospitals in the rural areas). The joint authorities were required to assess the health needs of the area, plan how these needs could be best met and report back to the Minister of Health.

> "An important task, therefore of the new joint authorities will be to unify and to co-ordinate the service. They will be the instrument through which, with the Minister, a rational and effective plan for all branches of the health service in their respect areas is secured" (Ministry of Health & Department of Health, 1944:19).

Local authorities maintained their control of local clinics and other health care provisions.

It is helpful here, to describe briefly the administrative structure and organisation of the NHS in England (also see appendix A). 14 Regional Hospital Boards (RHBs) were set up to administer hospital and medical specialist services, 380 Hospital Management Committees (HMCs) were organised to manage the day-to-day running of the hospitals and 36 Teaching Hospital Board of Governors were established. The 160 Local Health Authorities (LHAs) had the responsibility for (the promotion of) the prevention of illness in the community and providing non-hospital care. Last, in the new structure of the NHS were the Executive Councils which were responsible for arranging contracts of GPs (and also pharmacists, dentists and ophthalmic practitioners). These bodies were directly answerable to the Secretary of State for Health.

As a result of founding the health authorities, a third dilemma arose; how to put into practice the "rational and effective plan" when there were many organisations outside the NHS such as the voluntary hospitals. The Health Minister's solution was a contractual one. The voluntary sector

would be accountable to the joint authority "for the performance of agreed services" and additionally, government officials would oversee this arrangement and inspect the hospitals.

The fourth dilemma identified by Klein concerns public accountability and the involvement of doctors in the decision-making process. The White Paper stated the need for elected representatives to be responsible for their decisions at the local government level. This meant the medical "profession" was under-represented in policy making and local discussions on health care planning and provision. A Central Health Services Council was established, as expressed in the White Paper, for medical "professionals" to offer suggestions and recommendations at the national policy making level (and an equivalent board at the local level).

The fifth issue, was the predicament of integrating secondary and tertiary hospital health care with primary care in general practice. General practitioners, it was recognised, needed to be included in the system of health care if a "rational and effective plan" was to be achieved. Additionally, there was a requirement to have an appropriate distribution of doctors in the service. The government suggested that general practitioners be employed by the local authority so the geographic allocation could be regulated. This proposition was rejected by the British Medical Association Council as they refused discussions with the Ministry on this point (Honigsbaum, 1989). An extract from the British Medical Association illustrates this feeling:

> "Except for a vocal minority of doctors grouped round a party political flag [the Socialist Medical Association], by far the greater part of the profession is rigidly opposed to a whole-time State salaried medical service, and it is upon this one issue that opposition must be unshakeably offered in the coming months" (BMA, 1944b:113).

A more detailed account of the GPs' response and action is discussed in section 2.1. As a result of the opposition to GPs salaries, a Central Medical Board (CMB) was established to plan and control the distribution of general practitioners in relation to the needs of the community.

The sixth identified dilemma was the problem of managing the individualistic, often single-handed, general practitioners (GPs) in taking on new ideas of medical and administrative practice.

The fees paid to general practitioners (capitation payments) were not conducive to investment in medical technique or to investment in their premises. The BMA resisted attempts to have GPs as salaried employees, although Wilkin *et al.* (1987) question this attitude as being unrepresentative of most GPs but advocated by the leaders of the "profession". A negotiated decision was reached between the government and the British Medical Association. GPs would remain contracted by the Central Medical Board to provide patient care for patients registered with them, although the way to pay GPs was not decided here. Medical autonomy for the patient and the GP was honoured. Further, GPs would be encouraged to group together in joint authority owned Health Centres. The White Paper stressed that "there is a strong case for basing future practice in a Health Centre on a salaried remuneration or some similar alternative which does not involve mutual competition" (Ministry of Health & Department of Health, 1944:30). These are some of the main themes that featured prior to 1948. The end result of the White Paper was a compromise between competing policy aims and considerations of interested parties in the process.

1.2 1950s: Tranquillity and Stability

Before significant legislative changes established in 1974 are examined in the next section, it is useful to look over the 1950s and highlight some concerns which arose for the Minister of Health as the 1946 Bill was put into practice. Documented material on general practitioners' opinions and views on these changes are explored in the next chapter and in chapter 8. In the latter chapter there is a more focused discussion on how the GPs in the Midlands interpret *Working for Patients*. The concerns that are to be described here have importance in aiding our understanding of the context of the changes that have affected the service in the 1990s. Three concerns are discussed below: limited resources and unlimited demand; operationalising the 1946 bill; the rising conflict of ideologies between collectivism and individualism.

The first concern for the government to be discussed applies to a realisation that there were too few funds to finance existing demands for health care; there were not enough resources to match the needs of the nation. Furthermore, the demand for health care was increasing. A contributing factor to the increase in demand was the medical "profession's" interpretation of the new health service. It was understood by the "profession" that there would be no financial barriers which would inhibit the provision of care for patients. Thus, doctors (hospital consultants and GPs) did not take finances into consideration when diagnosing, treating or referring patients, their ultimate concern being to get the patient well. Klein (1989:36) refers to this practice as "professional perfectionism". The medical "profession" agreed to the rationalisation of the national health service on the provision that there would continue to be no financial controls on the practice of medicine. However, hospital doctors found themselves controlled and regulated by state restrictions. These financial controls could not be extended to independently contracted GPs (dentists, ophthalmic practitioners or pharmacists). If treatment and referrals in primary health care increased and thus costs increased, the government could do little to prevent it. A situation which is mirrored in contemporary health care management (see 9.1). This realisation had repercussions for LHAs accountability and medical autonomy as is discussed below (1.2.3).

A second concern for the government was operationalising the NHS Bill. As conflict and compromise was the theme in the run up to the 1946 Bill, consolidation became the theme of the 1950s. When Ian Macleod, the Minister of Health from 1952 to 1955, took up his office he stated his wish for a period of little change and for a time of tranquillity: "It is about time we stopped issuing paper [legislation] and made the instructions work. I want to try and create local interest and above everything to get a complete partnership between voluntary effort and the state" (quoted in Fisher, 1973: 24).

The administration of the 1946 Bill was an enormous task. The NHS is a huge, complex and heterogeneous organisation as described in 1.2.1. Problems arose as new rules and regulations

were set up to deal with the new procedures, for example there were 55 trade unions, representing people who worked in the Service, with which to negotiate.

There was, at this time, a continuing acceptance by the state that there should be some maintenance of "professional" autonomy; "professional" morale was being boosted. The Ministry of Health's policy was to support the "professions" in the health service to react to the needs of the population. Sir George Godber (1975), a key planner in the 1950s, talks of the philosophy and the process of change in the NHS. He said,

> "The NHS is comprised of very many services rendered daily by physicians, nurses, dentists, pharmacists and others. The content of these services is defined, not by planners, but by essential professional knowledge and skills. Change in method and practice is brought about by intra-professional exchanges; it may be abrupt because of a scientific development such as the advent of a new drug, or it may occur gradually with experience" (1975:5).

With the new structure decisions were encouraged to be made at local level. Each of the Boards (HMCs, RHBs and the Governors for Teaching Hospitals) had three "types" of people; lay administrators, medical administrators and finance officers. No national policy or guidelines existed for appointing the administrators, so each authority was unique and had a culture of its own at a very localised level. National policy affected the structure of the HAs but was quite separate from day-to-day operations.

The third concern of the government looked at here relates to a conflict of ideologies. The Bevan philosophy of the NHS was to have a centrally planned organisation to deliver care to match the health needs of Britain whilst still retaining a significant element of local autonomy. To have national accountability, detailed statements of expenditure need to be available. Members of parliament wanted to know the expenditure breakdown of costs incurred. The Public Accounts and Estimates Committees of the House of Commons was set up to examine the way in which public funds were being spent on health services. LHAs were required to provide detailed accounts of expenditure and at the same time manage the provision of health care to their

population (Ministry of Health, 1946). There were complaints from the authorities of over-bureaucratisation and interference from the Department of Health in the way they worked.

There was a conflict between those who were responsible for finding the funds to pay for the service and those who were responsible for spending the public's funds. Sir Cyril Jones, when looking at the finance of the NHS, commented on the "fundamental incompatibility between central control and local autonomy" (Public Records Office, 1950) as revenue raising and public spending are two very different activities. Jones argued for medical administrators to be taken out of the RHBs and NHS administration generally, to separate the conflict of interest between cost and care. He advocated cost control should be a non-medical management decision as medical "professionals" have a self interest in the practice of medicine. Jones' ideas were rejected by Bevan.

However, Bevan did make some changes in the distribution of income to the local hospital authorities. He fixed an allotted amount (a capped budget) for the authorities instead of the previous open-ended payment system. The restriction was not a concrete limit, but more of a guideline of expected expenditure. Local responsibility was encouraged to save and economise on resources. Whilst central control was administered, albeit with very flexible boundaries, local autonomy in expenditure was largely sustained. The conflict was avoided.

The 1950s were an era of making the existing system work rather than a time of legislative change. The dilemmas which occurred in the setting up of the NHS, outlined in the above section, are still apparent (as will be discussed later) and it can be argued that the fundamental conflicts have been avoided leaving an ambiguous and confused health service (cited in McLachlan, 1990). We can see then in the 1950s a time of administrative operationalisation, financial limitation acknowledgement and morale-building in the medical "professions". Tranquillity and stability were encouraged by the Minister of Health. But there was a more turbulent and innovative time to come.

1.3 Significant Changes

The majority of the changes after the 1950s have affected the administrative procedures in the NHS to try to control and manage the limited resources. To offer a chronology of the many statutes, circulars and orders that have affected the NHS would be a superfluous task for our uses here. Instead I will give an account of the major influences that have affected and formed the present system of health care today. Over the last twenty years however there have been few changes in the structure of the division between primary and secondary care in the Health Service.

Major organisational changes were introduced in 1974 (see DHSS, 1972), 1982 (see DHSS, 1979) and following the Griffiths Report in 1984 (see Griffiths Report, 1983). "Management" was introduced into the NHS at a time of general rationalisation of public services by the government (Hunter, 1988). One of the first organisational changes, less fundamental than those which were to follow, was in 1968. Here the Ministry of Health and the Ministry which dealt with national insurance and social security merged to form the Department of Health and Social Security (DHSS). The impact of this merger was slight. It has been suggested that the motives were political to ensure that the Minister of the newly formed DHSS would have a budget the same as the Exchequer or the Foreign Secretary (McLachlan, 1990). This amalgamation continued until 1988. In 1974, however, the first major upheaval in the way the NHS was organised was experienced. The 1974 so-called "Reorganisation Act" is explored next.

1.4 1974: Efficiency and Rationality

In 1974 a four level managerial hierarchy was brought into effect: the DHSS at the top of the tier, then 14 regional health authorities; 90 area health authorities; and then the 200 district management teams (see appendix B). The local authority community health authority was brought

under NHS rule. The aim of this reorganisation was to bring together the existing separate administrations of hospitals, GPs and local authority health services.

It was the responsibility of each new authority (RHA and AHA) to provide a comprehensive health service for their population with the resources available (Royal Society of Health, 1977). It was believed by the government that continuity of care could now be achieved (Raffell, 1984). Each authority needed to assess the health needs of its area, prioritise these needs and plan for the provision of health care. The management of these authorities was provided by a "consensus" team consisting of a medical representative, a nursing representative, a treasurer and an administrator (Cox, 1991).

Additional bodies created in the 1974 changes were the Family Practitioner Committees (FPCs), the Community Health Councils (CHCs), Professional Advisory Committees and a Health Service Commissioner. The FPCs are responsible to the AHA and are discussed in more detail in the next chapter (section 2.5). The CHC represent the views of patients and customers to the AHA and were established in the hope of increasing management efficiency and getting all people's needs heard and met in the community. The Health Service Commissioner investigated mal-administration or complaints of negligence made against a health authority.

The Professional Advisory Committees were established by the RHAs and the AHAs and have medical representatives as their members. It was through this Committee that the "professions" could voice their views and participate in local and regional policy making. Other means for medical representation were built into the official NHS structure, for example, the Central Health Services Council which advises the DHSS. Medical "professionals", including nurses (for the first time) were given political power. The representatives were on decision-making boards, they had a mechanism for vocalising their opinions and could veto policies of the District Management Teams.

The government's motives in bringing the administrative procedures of hospitals, GPs and AHAs together, were to improve the efficiency and effectiveness of financial management and the implementation of national policy. The "unification" of administration, it was believed, would permit an "unbiased" and "constructive" view of patients' needs in primary health care, in the community and in hospitals (DHSS, 1972:2). If the "rational and effective plan", originally desired in the White Paper in 1944, was to be achieved then, it was believed, that it was a matter of getting the organisation's structure "right" - when the right fix was achieved then the operation would run smoothly.

The 1974 reorganisation illustrates a continuing emphasis on management and accountability. However, the introduction of the four level hierarchy led to increased quantities of paper work and more complex administrative arrangements, rather than enhanced efficiency and accountability. As Klein states (1989:98): "If indeed the new model NHS emerged as an extremely complex structure, it was because he [Sir Keith Joseph, the Secretary of State for Social Services] was trying to achieve a variety of policy aims, while seeking to preserve consensus and to avoid conflict".

So, the 1974 restructuring can be seen as a means of satisfying the various interests in the medical "profession" by increasing their power, as well as satisfying members of parliament and civil servants' requirement for management accountability, rationality and efficiency. The result was dissatisfaction (Raffell, 1984). In 1976 a Royal Commission was asked to assess the structure of the NHS and to "consider in the interests both of the patients and of those who work in the National Health Service the best use and management of the financial and manpower resources of the National Health Service" (Royal Commission, 1979:1).The report commended the government's achievement in the integration and the unification of services for the patient in both the hospital and the community. However, the Commission was critical of the other areas. The criticisms they made were as follows: there were too many administrative tiers; too many administrators; slow decision-making processes; too many funds wasted; there was low staff

morale; and too much emphasis on sickness rather than health (eg. disease management rather than health promotion and prevention). As the term "morale" is vague the Royal Commission assimilated morale "with a general state of content or discontent which might relate more to general feelings about the NHS than the feelings of satisfaction with their jobs or working context" (Royal Commission, 1979:34). The result of the report was the next significant change: the 1982 reorganisation. The government acknowledged many of these criticisms in their paper, *Patients First* (DHSS, 1979).

1.5 1982: Localism and Centralism

In 1982 the area health authorities (AHAs) were abandoned in an attempt to decrease some of the growing administration and bureaucracy of central government. After the AHAs were gone the focus was on District Health Authorities where the delegation of decision was moved largely to the hospital and community unit level. Again the theme and dilemma of central control versus local autonomy can be seen. A quote from Patrick Jenkins' paper *Patients First* captures the government's intent to decentralise the NHS:

> "We are determined to see that as many decisions as possible are taken at the local level - in the hospital and the community. We are determined to have more local health authorities, whose members will be encouraged to manage the Service with the minimum of interference by a central authority, whether at region or in central government departments" (DHSS, 1979:2).

Jenkins' paper formed the blueprint for the 1982 reorganisation. The theme in the reorganisation was localism, where power was given to small units (decisions were being made in some 200 DHAs rather than in the 90 AHAs). DHAs were established to combine the functions of the existing areas and districts and came into operation in April 1982 (see appendix C for the national structure). RHAs, FPCs and CHCs remained. The objective of the changes was to simplify the administrative procedures and to encourage decisions to be made nearer to the service users; the patients. Klein calls this the rise of the "public philosophy" (1989:136). The title of the paper

"Patients First" indicated the wave of thought to come; consumerism became a central theme to the health reforms throughout the 1980s to the present day.

An additional effect of the 1982 changes was a reduction in medical expertise as responsibility was delegated to the local level. Consultants needed to have a more general medical knowledge in the local hospitals than was permitted in the large District General Hospitals (DGHs) which were popular in the early 1970s (In 1980 there was a 600 bed limit in the DGHs). Finance was still coming from the Chancellor of the Exchequer and hospital managers were more accountable to the higher tiers in the NHS.

The 1980s saw a continuity of the dilemma which was apparent in the setting up of the NHS in the mid 1940s; increasing local autonomy whilst maintaining central control. The tension between consensus management (involving the medical "profession" and the government) and strategic planning had not been resolved. The NHS that we have looked at so far can be described as a collegial or "professional bureaucracy" system as the control of the tasks tended to rest with "professional" groups rather than management (Mintzberg, 1988). In the way that the NHS was organised, Jenkins believed that it could not respond to changes in the health environment or respond to the strategic planning of management. Both these features were essential properties of the governments' overall strategic plan.

The solution for settling the clash of the two principles, it was believed by the DHSS, lay in the creation of a mechanism which pushed doctors to be responsible and accountable to managers (Holliday, 1992). The consequence of the ongoing conflicts resulted in another appraisal of the health service in 1983, the Griffiths Report.

1.6 1983: A Move Towards General Management

1983 can be seen as the milestone in a change of philosophy for the NHS. Patrick Jenkins was replaced by Norman Fowler. Fowler promoted a sharp contrast in the way that the NHS was to be managed. As we have seen, there has been a general trend since 1948 towards a decentralisation of activity decisions being made at the local level, with financial constraints being implemented by the DHSS. Controls pre-1983 were concerned with inputs. Post 1983 saw the freedom of local decision-making being inhibited by tight objectives, performance-related pay schemes and performance reviews. These were set and monitored by the DHSS. The principle of "consensus management" was threatened (Petchy, 1986). There was an emphasis on ministerial directives, accountability and centralisation in the NHS (Pettigrew, McKee & Ferlie, 1988; Cox, 1984; Hunter, 1984) A central thrust of this shift was the move towards general management in the health service. Controls were concerned not with inputs but with outputs.

Before I explore the increase of management controls in the NHS generally, I will briefly consider some possible reasons for the change in strategy. First, the Thatcherite political policy of the 1980s was one of top-down restructuring which affected the NHS like other nationalised industries (Pettigrew, Ferlie & McKee, 1992). Second, Klein (1989) points to the Financial Management Initiative (FMI) as a contributing factor. If the DHSS was to successfully bid for funds from the treasury then it had to be seen to take seriously the general FMI policy encouraged by the government at that time. (For a thorough examination of the implementation and effects of FMI see Munson, 1990.) Third, there was the continuing consideration of costs and finance of the NHS and fourth, the sustained political power held by the "professional" representatives threatened the implementation of government policy and consequently had to be addressed.

In 1983 Fowler appointed an advisory group led by Sir Roy Griffiths, to evaluate the use of management in the health service. The report identified a poorly defined management function

and an inadequate implementing mechanism of government policy. In the report Griffiths comments,

> "Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans and monitoring actual achievement. It means that the process of devolution of responsibility, including discharging responsibility to the units, is far too low" (Griffiths Report, 1983:12).

It was recommended in the report that a more coherent and explicit management function was to be employed, focusing directly on the importance of cost efficiency and staff appraisals.

> "Our advice on management action is not directly about the nature of the services provided to patients. But the driving force behind our advice is the concern to secure the best deal for patients and the community within available resources; the best value for the tax payer; and the best motivation for the staff. As a caring and quality service, the NHS has to balance the interests of the patient, the community and the tax payer and the employee" (Griffiths Report, 1983:11).

The recommendations of the report were implemented by the DHSS. Consequently the Health Service Supervisory Board (now the NHS Policy Board) and the NHS Management Board (now the NHS Management Executive) were set up to streamline and strengthen the management function. The focus of Health Service Supervisory Board concerned strategic planning and setting of objectives for the entire NHS as opposed to specific details of hospital management (Ham, 1985). The Board was chaired by the Secretary of State. The NHS Management Board, accountable to the Health and Social Services Division (HSSD), was responsible for the implementation of strategies devised by the HSSB and for promoting drive in the leadership in hospitals (Levitt & Wall, 1992).

General managers were introduced into RHAs, DHAs and hospitals in 1983 (all were in place by 1986). To try and combat medical aversion to the introduction, the government encouraged consultants to apply for the managerial positions. Griffiths (1983:18) saw consultants and doctors as "natural managers" who should take the responsibility for the consequence of their clinical decisions. Griffiths comments:

> "Their decisions largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of resources. The nearer that management gets to the patient, the more important it becomes for the doctors to be looked at as 'natural managers'" (1983:18).

The maintenance of the "professional perfectionism" supported in the 1970s had been abandoned. Very few clinicians became managers (Holliday, 1992).

The general managers were employed on short term contracts (usually three years) and were reviewed in the light of their annual appraisal of their performance (Harrison, Hunter & Pollitt, 1990). Another mechanism proposed by the Griffiths Report to manage the conflict between the managers and the clinicians was introduced in the form of management budgets by the NHS Management Board (later referred to as resource management). Doctors had set budgets according to their workload (Perrin, 1989 provides a detailed analysis of this function). The civil service was under examination at the same time as the NHS by Derek Rayner, the Deputy Chairperson of Marks and Spencers. In combination, the Griffiths review and the Rayner examination changed the notion of management from an information-seeking and consensus style to a swift decision-making and implementation style (Dingwall, Rafferty & Webster, 1988). Performance Indicators (PIs) were introduced in 1983 at the recommendation of Rayner. Doctors and managers could subsequently be challenged about their use of resources (Levitt & Wall, 1992). Individual Performance Reviews for general managers were introduced in 1986.

There was strong opposition within the NHS to the Griffiths report. It was seen first to challenge the "unique" identity of the NHS (as it was compared and contrasted to private sector institutions) and second to qualify the traditional services' identity with economic considerations, both were seen to be unacceptable to NHS members (McNulty, 1988). The report was viewed as a threat and a challenge to the traditional values, assumptions and culture of the NHS.

1.7 1989: Working for Patients

To continue setting the context of change in the NHS I will examine two issues arising from the White Paper, *Working for Patients* (Secretaries of State for Health, 1989a). First I examine some possible reasons for a further review of the NHS and, second, I explore broadly the content of *Working for Patients*. As before, I focus on the NHS policy implemented in England where my empirical "data" is based. *Working for Patients* is central to this thesis, hence, hereafter I refer to, expand and add to the ideas explored here. In chapter 3 I explore in detail the "imposed" and "invited" changes of the Act which (potentially) affect GPs. (For a detailed analysis of the political climate at this time and of Margaret Thatcher's influence on the NHS since 1979, see Mohan, 1995.)

In 1988 the government announced that a review was to be conducted on the NHS. After the Griffiths report there was speculation made by doctors, nurses, managers and others, that substantial financial cuts were to be made. In Britain and at the time of the "winter of discontent" there was an influx of media coverage urged and supported by the medical "profession", to inform the public of gross under-funding within the service and with the additional aim of getting more NHS funds (Holliday, 1992). Klein explains the extent of the coverage: "Never before in the history of the NHS had there been such a public demonstration of concern involving all the authoritative figures in health care policy arena" (1989:223).

The crisis of low morale of the "professional" groups in the NHS can be understood as a contributing factor in deciding to review the health service. "professional" autonomy was seen to be attacked and the consultants were pointing to the government for the lack of funds. The DHSS became the Department of Health (DoH) and Kenneth Clarke was appointed as the Secretary of State for Health. The government increased expenditure on the Service from £18.9bn in 1987 to £20.9bn in 1988 (HM Treasury, 1992). This combatted some of the discontentment within the

"profession". After the announcement of the review, there was an array of ideas and opinions suggested for the future direction for the NHS. The recommendations broadly fell into two categories: a financial focus and an efficiency focus (Levitt & Wall, 1992). Supporters of the financial case put forward ideas such as replacing the tax-financed health care system to an insurance-based health care system to reduce the financial burden of the health service. The supporters of the efficiency case stated for example, the need for organisational change in the health service to improve the effectiveness of resource use. There are strong similarities with both these broad recommendations and the American system of health (advocated by Enthoven) (Pettigrew, Ferlie & McKee, 1992). Enthoven's ideas and recommendations for the NHS in England are explored later (see 1.7.2).

Working for Patients was the result of the NHS review. In the foreword of the document, the Prime Minister stated her commitment to building on the existing structure of the NHS. Concern for a move to a system financed by an insurance-based funding as in the American health care system, were confronted. Margaret Thatcher maintained that "The National Health Service will continue to be available to all, regardless of income, and to be financed mainly out of taxation" (Secretaries of State for Health, 1989a: Foreword).

Furthermore, it was made explicit in the paper that there was to be no complete reorganisation of the service, the Bevan philosophy was to be kept (to some degree) where "developments" were to be added to the existing service rather than replacing it: "... [m]ajor tasks now face us: to bring all parts of the National Health Service up to the very high standards of the best, while maintaining the principle on which it was founded; and to prepare for the needs of the future" (Secretaries of State for Health, 1989a:Foreword). In the White Paper it proposes the "very high standards of the best" aim was to be achieved by three mechanisms: tightening up the management structure and accountability to the centre, increasing efficiency through an internal market and allowing for greater patient choice. In the conclusion of *Working for Patients* it is stated that the central aims of the government are: "...to extend patient choice, to delegate responsibility to those who are best

placed to respond to patients' needs and wishes, and to secure the best value for money. The result will be a better deal for the public both as patients and taxpayers" (Secretaries of State for Health, 1989a:102). Similarities can be made here with Henry Willink's wishes for the health service in the 1944 to have a national responsibility which involved a centralised control system and a responsive system to local demand at the community level. However, the local health demands are now allegedly determined by the patient rather than by the medical "professional".

In *Authorities in the NHS*, an examination of the changing role of health authority boards Pettigrew, Ferlie, FitzGerald and Wensley indicate a switch of focus in the service: "Behind these changes lie much wider shifts in language and agenda across the NHS: a new emphasis on 'performance', on securing competitive advantage in the internal market, and more purposive management, including that of professionals" (1991:1). Whereas the issues of "purposive" general management and the internal market are explored in the coming sections, the government's rhetoric is examined in chapter 7.

It is helpful here to summarise the administrative structure of the NHS in England in 1991 (also see appendix D): At the top of the tier is the Secretary of State for Health who is accountable to Parliament. The Department of Health has three divisions: the HSSD accountable to the Secretary of State; the NHS Management Executive (NHSME) and its sections accountable to the HSSD and the Central Resource Management (CRM) and its sections which are drawn upon by the other divisions for analytical support (Ham, 1991). The three divisions work together on various issues. The 14 RHAs, 57 NHS Trusts (in the first wave) and Special Health Authorities (SHAs) are directly accountable to the Secretary of State. The SHAs incorporates bodies such as the NHS Training Authority, London's Post-Graduate teaching hospitals and the Health Education Authority (HEA), these bodies are accountable to the Secretary of State but are outside the formal structure of the health service. The 189 DHAs and the 90 FPCs (known as FHSAs from September, 1990) are accountable to the RHAs to purchase hospital and community health services. GP fundholders receive their budgets from the RHA but the FHSAs monitor their

expenditure against the budget and continue to hold the non-fundholding activities contracts as with the non-fundholding GPs. The Community Health Councils are outside the formal structure of the service but are still funded by the RHA.

1.7.1 General Management Continues

The recommendations that a more coherent and explicit management function suggested in the Griffiths Report, was continued. The newly reformed NHS Policy Board and the NHS Management Executive were briefed to establish clearer leadership and orientation within their structures. The centralisation of objectives and priorities and the delegation of responsibility to and the subsequent accountability of, local management to the centre indicates a top-down style of management. Concerning the health service the government's main function "must be to set a national framework of objectives and priorities. Local management must then be allowed to get on with the task of managing while remaining accountable to the centre for its delivery of the Governments' objectives" (Secretaries of State for Health, 1989a:12).

Rationalisation could be witnessed in the health authorities. The existing sixteen-to-nineteen members were reduced to ten members (five executive members and five non-executive members). The executive members included a general manager and a financial manager. The Secretary of State sought control in the recruitment of HA Board members since 1990 and appoints the chairperson and non-executive members at the RHA level. The other members are appointed on the individual contribution that the person can make (Secretaries of State for Health, 1989a:65). RHAs are responsible for appointing the non-executive members at DHAs with the same criteria. LHAs lost their power to appoint DHA members. The Government sees the RHA as having a key role in the operationalising and implementation of the White Paper. Additionally,

some of the RHA responsibilities have been delegated to DHAs or contracted out of the NHS and some of the responsibilities of DHAs have been delegated to hospitals.

What can be seen in *Working for Patients* is the rhetoric of "small is beautiful" (Schumacher, 1973) as means of achieving cohesion and effectiveness: "If health authorities are to discharge their new responsibilities in a business-like way, they need to be smaller and need to bring together executive and non-executive members to provide a single focus for the effective decision-making" (Secretaries of State for Health, 1989a:65). The government's aim of downward delegation is to ensure that the "day-to-day" decisions are made as close to the users of the service as possible (Secretaries of State for Health, 1989a:14). Furthermore, it is espoused that downward delegation frees health authorities to concentrate on broader decision-making issues, such as the assessment of the health needs of their population. Downward delegation to FHSAs is discussed in chapter 3 (section 3.2).

Downward delegation is also a feature in human resource management. Nurses are given more responsibility in the tasks that they perform; they are now carrying out some tasks which traditionally were junior doctors' responsibilities for example in casualty departments. Additionally, some nurses responsibilities have been delegated to clerical staff, such as staffing reception desks.

The ongoing conflict between "professionals" and management in the NHS was tackled by integrating (or blurring) the tasks of the two functions. This theme was introduced in *Patients First* (DHSS, 1979). *Working for Patients* explains the importance of consultants being brought into the management of resources function by compelling them to be accountable for their clinical decisions. To achieve this aim, the government proposed a procedure known as "medical audit" which is: "a systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome for the patient" (Secretaries of State for Health, 1989a:39).

All consultants have to take part in medical audit and reach an agreement with managers as to an acceptable level and quality of output. The responsibility for the implementation and effectiveness of medical audit rests with the district managers. To ensure local managers have control and influence over consultants, specific job descriptions were issued with defined medical targets encompassed within these. Contractual arrangements can consequently be assessed and monitored.

The government proposed another mechanism to bring managers and clinicians closer together by introducing changes to the appointment and appraisal procedure. The government sought to modify the Appointment of Consultants Regulations in order to include a district general manager in the process. Managers are now part of the appraisal team for clinicians and new appointments of clinicians have a management criteria; they are assessed on their "commitment to the management and development to the service" (Secretaries of State for Health, 1989a:44). It is impossible to reach the highest three distinction awards (introduced in 1948) without this non-clinical contribution. Day & Klein say the outcome of this change "should be to institutionalise greater clinical participation in managerial practice" (1989:14).

1.7.2 The Internal Market

One of the new concepts introduced to the NHS as a result of *Working for Patients* was the development of an internal market where purchasers of health care became distinguished from the providers. The purchasers of secondary care and community health services are the DHAs, GP fundholders, private patients and insurance companies. The providers of secondary care and community health services are DHA hospitals functioning as Directly Managed Units (DMUs), hospital Trusts and private units. Contracts between the units link the internal markets'

constituencies together. There are three types of contracts; block contracts, cost and volume contracts and cost per case contracts. The evidence of contracts signifies a shift in the culture of the NHS to a more business-like ethos. The details of the internal market affecting the general practitioner is discussed in chapter 3.

Robinson sees the development of the internal market evolving over the last decade. He points to "The belief that a competitive environment stimulates efficiency and enhances consumer choice and has been a central component of the government's economic strategy for the past 10 years" (1989:7). It is believed that the foundation of the internal market came from the American health economist Professor Enthoven (Pettigrew, Ferlie & McKee, 1992). Enthoven was requested by the Nuffield Provincial Hospitals Trust in 1985 to review the management and organisation of the NHS in the UK. Enthoven (1985) pointed to the lack of incentives available for the members of the NHS to achieve efficiency. He commented that the changes prompted by Griffiths (employing a less political style of management) was a good idea. However Enthoven saw these changes as "cosmetic" because there was an inadequate reward structure and thus little incentive to change (1985:19). Enthoven criticised the uniformity within the NHS, for example the specific job descriptions for all managers, as a hindrance to achieving efficiency. He also indicated that the DHAs are answerable to too many stakeholders (central government, RHAs, unions, medical professions and so on) and are not focusing their efforts on efficiency at the point of delivery.

The recommendations which Enthoven made included changing certain procedures at the District level, for example, all wages to be negotiated locally; a RAWP-based per capita revenue and capital allowance for Districts; for consultants to be contracted to DHAs on short term contracts which included incentives for increasing productivity; for GPs to be contracted with DHAs; and for Districts to have their own "balance sheet and an income statement" to enable them, amongst other things, to sell capital and borrow at a government interest rate and buy and sell services to other Districts and the private sector. In effect Enthoven proposed a move towards the American

"consumer choice model" where DHAs would resemble Health Maintenance Organisations (HMOs). He describes an HMO as,

> "An organized system (ie. with management controls) that accepts responsibility for providing comprehensive health care services to a voluntarily enrolled population for a fixed periodic payment set in advance (ie. a 'capitation payment' that is independent of the number of services used)" (1985:43).

Enthoven saw that the advantages of the HMO system stemmed from doctors setting their own targets for quality and output. Enthoven believed that doctors are motivated by economic interest and set themselves higher targets than which the government could ever achieve by imposition.

The recommendations offered by Enthoven can be split into two areas: first, he pointed to the lack of incentives for efficiency and suggested performance measures would do the trick and; second, he suggested keeping the present tax-financed system with free access at the point of use for all, and increase competition through trading clinical services. The term "internal market" arose from the combination of these two principles (Robinson, 1989). The advantages of the introduction of an internal market in the UK are summarised by Enthoven:

> "The theory behind such a scheme is that the managers would then be able to use resources most efficiently. They could buy services from producers who offered good value. They could use the possibility of buying outside as bargaining leverage to get better performance from their own providers. They could sell off assets such as valuable land in order to redeploy their capital most effectively. Unlike the normal bureaucratic model, they would not get more money by doing a poor job with what they have... The underbedded areas could buy the services from the overbedded areas, if in their judgement, that was the way to get the best deal for their patients. The flow of services to people could be adjusted smoothly and rapidly without the need to wait for facilities to be built or closed" (1985:40).

There are many similarities in Enthoven's model and the changes proposed in the White Paper, for example we have seen changes in the capital arrangements for NHS property. Since April 1991, HAs have been charged for the use of land, buildings and equipment. This is viewed to provide an incentive for HAs to use its "assets efficiently and to invest wisely" (Secretaries of State for Health, 1989a:18). The government stated that the non-charge on capital could encourage an inefficient use of resources and hinder a realistic costing of services. Furthermore, the internal market provides an incentive for less efficient hospitals and HAs to reach the "very

high standards of the best". As funds are awarded according to output and workloads, it is believed this will encourage the less efficient units to compete (Robinson, 1989).

1.7.3 NHS Trusts

One of the most radical changes proposed in *Working for Patients*, and an essential feature of the internal market, is the NHS Trusts. Trusts are "self governing" units within the NHS structure and are accountable solely to the Secretary of State. Units can opt for Trust status when they are seen by the Secretary of State to have (amongst other things) expertise in management and strong leadership skills. Areas such as finance, personnel, information technology and senior consultants having an important role in the management of the hospital are requirements. Trust status was originally confined to the acute sector of hospitals, however, other units such as ambulance services and mental health care units have become Trusts (Holliday, 1992). It is suggested by the government that Trusts will increase competition, local commitment, enterprise and efficiency. Similarities are found when compared to Enthoven's account:

> "... Self government for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals can flourish, it will encourage local initiative and greater competition. All this in turn will ensure a better deal for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered" (1989:22).

Trusts are free to appoint their own staff and decide on their own management structure to meet their own needs. They are constituted as public corporations and have freedom over the use and the buying or selling of assets. They can borrow funds from the government or from the private sector. Consequently they are free from DHA control. The function of the DHA will arguably diminish as more units become Trusts. The government suggests that RHAs will need to consider the future role of DHAs with a possible view to merging them with FHSAs.

1.8 Rounding Up

In summary, we can see that the aims of the White Paper are to rationalise the health service by increasing the emphasis on management and financial arrangements and by promoting competition and efficiency. The government aims to "... extend patient choice, to delegate responsibility to where the services are provided and to secure the best value for money... The patient's need will always be paramount" (Secretaries of State for Health, 1989a:102).

Change and the National Health Service has been examined in detail. In order to contextualise an understanding of general medical practice today it is essential that the NHS as a whole is looked at in a historical manner. Some of the tensions between the different interested parties in the NHS have been explored in view of the "state-initiated managed change strategies" affecting the service. In the next two chapters I examine specifically the developments of general medical practice. The implications of the changes in the broader health service examined above, are considered in a comparative manner. These first three chapters set the foundations for the empirical analysis in chapters 6 and 8.

Chapter Two

Change and General Medical Practice in England

2.0 Introduction

The overall aim of this second chapter is to introduce and explore the "state-initiated managed change strategies" prior to *Working for Patients* which specifically affect general medical practitioners in England. In the last chapter consideration was given to the history and the broad context of the "state-initiated managed change strategies" for the NHS in England as a whole. The development of the work context of general practice leading up to *Working for Patients* will now be compared and contrasted to the broader NHS experience. Chapter 3 deals with aspects of *Working for Patients* which relate specifically to general medical practice in England.

Developing the sociological imagination includes using material from history. Mills (1970) when advocating the craft of the sociological imagination pointed to the benefits of shifting from one perspective to another in order better to understand the world. He wrote:

> "Whatever the problem with which you are concerned, you will find it helpful to try and get a comparative grip on the materials. The search for comparable cases, either in one civilization and historical period or in several, gives you leads" (1970:237).

By comparing and contrasting current patterns with past ones we are enabled to see the distinctive nature of general medical practice today. So, following this tradition, I continue to set the context

of change in the NHS with particular attention to general medical practitioners and elements in the development of their practice. Chapter 1 brings out the basic dilemmas in the NHS. Chapter 2 looks at the form in which these dilemmas are manifest in general medical practice in historical and general terms. These two chapters and the detailed discussion of *Working for Patients* in chapter 3, provides the basis for my empirical investigation in chapters 6 and 8. It is in these empirical chapters where I examine how general practitioners perceive such dilemmas in general medical practice.

This chapter is divided into nine parts. First (2.1), I explore the origins of primary health cared in a comprehensive state system; second (2.2), the negotiations leading up to the *National Health Service Act* are discussed; third, in section 2.3, the tranquillity and stability of the 1950s is looked at. Fourth (2.4), the *Charter* (implemented in 1966) is examined which resulted in the most significant change affecting GPs until the late 1980s. Fifth, in section 2.5, the 1974 so-called "Reorganisation Act" is addressed and then the localism and centralism of the 1980s is considered in the sixth section (2.6). The next two sections focus on the government's publications which led up to *Working for Patients*: in the seventh section (2.7) the 1986 *Primary Health Care: An Agenda for Discussion* is examined and in section eight (2.8) there is a discussion on *Promoting Better Health.* In the final section (2.9), I give a rounding-up of the main points covered in the chapter.

2.1 The Seeds for a National General Practitioner Service

The first piece of legislation, prior to the 1948 Act, which substantially affected the way general practitioners operated was the *National Health Insurance Act* in 1911. Before 1911 general practitioner services were mainly available through friendship societies which were clubs of working men who offered insurance for their members in circumstances such as illness and death.

The majority of the wage-earning population received their health care through such societies by paying a flat-rate contribution (Levitt & Wall, 1992).

In the early 1900s, Lloyd George viewed ill health as a major contributor to poverty in Britain and hence fought to incorporate non-wage earners into the provision of general practitioners' services (it was the lack of provision in sickness and pensions for the elderly which prompted him to make changes) (Pater, 1981). Lloyd George sought to achieve this aim through legislation and came across opposition when trying to implement the Bill. As we have seen in the development of the NHS discussed in chapter 1, opposition and negotiation were experienced as a result of competing interests and concerns of the doctors, the government and other interest groups. Gilbert sees the progression leading up to the *National Health Insurance Act* as no different; he points to "the story of growth of national health insurance is to a great extent the story of lobby influence and pressure groups" (1966:33).

BMA representatives lobbied Lloyd George to safeguard their interests (Levitt & Wall, 1992:3). GPs were concerned that state intervention in the organisation of their services would threaten their autonomy and their financial position (Ham, 1985). The original 1911 Act was redrafted to incorporate some of the GPs' suggestions. Embodied in the Act, for instance, was: that the administration of the system be run by independent insurance committees (the so-called "panel" system) rather than by the government proposed local authorities; that payment be made by capitation fees rather than by state determined salaries; that doctors choose whether or not to join the scheme and; that patients have a free choice of doctor (if the doctor agreed). There was also to be substantial representation of doctors on administrative boards, such as insurance committees. In addition, the government supported this last suggestion further and established representation on the Central Advisory Committee at the MoH in 1919. Consequently, the government was seen to support clinical autonomy. The *NHI Act* was implemented in 1913.

The government incorporated most of the recommendations made by the BMA but rejected two of the proposals. Neither the £2 per week minimum income limit for patients receiving medical care nor the proposal that doctors' remuneration be fixed at a level which was believed to be appropriate by the medical "profession" were not introduced. The rejection of the income restriction proposal could be viewed as beneficial to doctors as they would be able to treat a wider population than they had envisaged and they would not be financially restricted in their prescriptions or treatments of patients (Honigsbaum, 1989). However, the cost of the treatments of patients in the practice came out of the doctor's own income which meant that there was a strong incentive for the doctor to refer patients to the out-patients departments at the hospitals (Bowling, 1981). The debate on how to pay doctors for their services is still a controversial issue today and will be a theme which is picked-up again later in the chapter.

The 1911 Act allowed a large proportion of the population in Britain to have "free" general medical care and cash-sickness benefits. Hospital services were excluded from the Act and continued to function on a voluntary and municipal basis as described in chapter 1. The provision of general practitioner care was however restricted to wage-earners (initially earning less than £160 per week) and to those over the age of sixteen. The so-called "panel" system only covered the working population and did not cater for non-wage earners such as children and dependants and hospital provisions were kept outside the system.

The 1911 Act is important for four reasons: first, it is the first piece of "state-initiated managed change strategy" significantly to affect general medical practitioners; second, it can be argued that general practitioners used the Act as a catalyst to increase their own self-government as they came together and reached a negotiated compromise with the government; third, it enabled general practitioners to increase the availability of their services; and fourth, it potentially assisted doctors in increasing their incomes.

2.2 Negotiations and the National Health Service Act

The next significant "state-initiated managed change strategy" affecting general medical practice is the 1946 *National Health Service Act*. The Ministry of Health's focus of attention turned away from the hospital service, which had been the central concern of the government over the last century, and towards the general practitioner (Eckstein, 1958). In the 1944 White Paper the government stated their intentions to ensure that in the future every man, woman and child received a comprehensive health service. The government looked to the general practitioner service to fulfil this aim. But, it was felt that the general practitioner service needed reconsideration. The Ministry of Health stated: "Apart from the National Health Insurance scheme and the Poor Law, there is no public provision for general medical attention on any scale" (1944:54).

There were two priorities concerning general medical practice which the government sought to establish. These were stated in the White Paper:

> "The first, which mainly concerns the patient, is that people must be able to choose for themselves the doctor from whom they wish to seek medical advice and treatment, and to change to another doctor if they so wish... The second principle [is that] doctors taking part must remain free to direct their clinical knowledge and personal skill for the benefit of their patients in the way which they feel to be best" (Ministry of Health, 1944:26).

The White Paper was the result of much discussion, especially between Sir John Maude, the Permanent Secretary of the Ministry of Health, William Beveridge and representatives of the medical "profession". In 1937 the BMA and the Trades Union Congress (TUC) came together to review the "panel" system and to attempt to free doctors from the confines of being restricted to the friendly societies (Honigsbaum, 1989). Subsequently, in 1941 Beveridge called for a free universal medical service, financed mainly from taxation. In the course of the debates, stimulated by these suggestions, a number of the dilemmas, reviewed in the last chapter, once again become significant. In summary, the dilemmas were categorised as: central verses local planning and control; administering the service; coping with voluntary hospitals; decision-making procedures

and public accountability; integrating primary and secondary health care; and managing GPs. This time, however, the dilemmas are specific to primary health care. Facets of these tensions can be seen arising in the following interrelated set of issues. These issues are GPs as independent contractors or state employees, the distribution of GPs, the grouping of general practitioners and the administration of the service.

As we have seen, it was perceived by the Ministry of Health to be unfeasible to exclude general practitioner services from the planning process of the NHS if a "rational and effective" service was to be achieved. Maude regarded the general practitioner service as more important than the hospital sector. He stated the "medical services are the foundation of the health service as a whole. Matters of hospital policy are much more limited in scope and, to some extent overlap with medical policy" (MoH 80/26 comments by Maude on BMA papers, 25 May, 1943, quoted in Honigsbaum, 1989:51). However, Honigsbaum (1989) points to other possible motives for the Ministry to begin changes in the health service with GPs. Honigsbaum believes that the fact that there were five times more general practitioners than consultants is a reason for Maude's unusual interest in them. As there was a disproportionate number of general practitioners to consultants, the Ministry was dealing with GPs on the medical representative boards, such as the BMA. So, if general practitioners could be convinced of the proposed changes then it was believed that the consultants would follow suit.

More specifically, William Beveridge supported Maude's idea that GPs needed to be salaried. Beveridge's reason for this was two-fold; to offer a financial incentive for general practitioners to guarantee that the increasing number of cash-sickness certificates would be issued and second, to enable the voluntary and municipal hospitals to have a closer working relationship with general practitioners.

Maude began with a review of the "panel" system. He did not accept the underlying principles of the system. He was against the assumption that competition led to higher standards of care and felt

that the system did not encourage teamwork (Honigsbaum, 1989). He also saw a potential for dual standards of care as there were private fee-paying patients and subscribed "panel" patients. Furthermore, he was opposed to the buying and selling of practices. According to Honigsbaum, Maude's view was that it "forced young doctors to start their career with a load of debt and ... noted that supporters of the 'panel' considered it 'something of a scandal'" (1989:39).

Maude strongly favoured GPs becoming employees of local authorities as opposed to them remaining in the existing "panel" system. Moreover, he believed that there had to be closer ties with the hospital and voluntary sectors so that a "rational and effective" system could operate. This was incorporated into the White Paper where it stated; "general medical practice in the new scheme will be organised, largely as a national and centralised service, but with proper links with the local organisation to relate it to hospitals and other branches of the service as a whole" (Ministry of Health, 1944:12). However, Maude did not wish to impose what I have called a "state-initiated managed change strategy" on the doctors. Instead, he sought their views. There were arguments for and against the proposal that general practitioners should become employees of the Local Authorities. First, the notion of being paid a salary for members of the medical "profession" was seen as a route to excessive administrative control and as threat to their autonomy (Eckstein, 1958). Second, it was accepted by those doctors who saw it as a means to eliminate the incentive of enlisting excessive numbers of patients to increase their income (Willcocks, 1967), and by those wishing to work in a non competitive environment.

In 1942 the BMA set up a Medical Planning Committee (MPC) to advise the Ministry on how the health service should be organised. The recommendations of the MPC included incorporating hospitals and specialist services into the "panel" system; extending GP services to serve 90 per cent of the population (excluding the wealthiest 10 per cent of British citizens to maintain private practice); maintaining clinical independence and experimenting with the reorganisation of general practitioners into health centres (Pater, 1981). The notion of grouping GPs in health centres to share resources and to overcome feelings of isolation was first formally introduced in the 1920

Dawson Report. Dr Charles Hill, the deputy secretary of the BMA, writing unofficially to the secretary of the Beveridge Committee, pointed out the wishes of the BMA and the TUC. Hill argued that

> "the profession did feel strongly about the need to create a medical service for at least 90 per cent of the population... and most members preferred it to be on the basis of NHI... doctors wished to maintain their independent contractor status as enshrined in the panel system but they would not object to the abandonment of insurance finance, particularly of that resulted in the abolition of the friendly societies" (Honigsbaum, 1989:37).

In negotiation, the BMA accepted the need for universal coverage and also supported a move towards group practices and away from the single-handed GP. However, there was a difference of opinion between the Ministry and the doctors as to how the universal coverage and the grouped practice should be administered. The BMA wanted a co-operative style of group practice with no intervention from the Ministry and for payment to continue on a capitation basis rather than a shift to a salaried system within local authority control (Pater, 1981).

Maude posed a compromise between the "panel" system and his local authority controlled system. He retained the optional entry which existed for the National Insurance scheme and made the local authority control system optional for those general practitioners already practising. Maude suggested that a Central Medical Board would be established, with doctors as members, to establish who could join the scheme and also to oversee entry into medical schools.

These ideas manifested themselves in the 1944 White Paper in various forms. It was suggested for example, that general practitioners needed to be accountable to the state to ensure that the general practitioner services met the demands of the people. The Ministry of Health advised that GPs "must therefore, be in some contractual relationship with public authority, which in turn must be able to attach such conditions as will ensure that the services which the people get are the services which they need and that they can get them where and when they need them" (1944:26).

After the White Paper the BMA again resisted the proposal for GPs to be employees of the LAs. There is doubt however, about the extent to which medical practitioners generally were in agreement with the leaders of the BMA in this decision (Wilkin, Hallam, Leavey & Metcalfe, 1987). The reasons for the rejection of the salaried service were believed to be the fear that it would rule out the notion of "free" choice of doctor. It would be more costly than the capitation fee system of payment already in place and the necessity for promotion and posting procedures would eradicate the "family doctor" concept (Pater, 1981).

The White Paper suggested the abolition of the Local Insurance Committees and that the responsibilities of it to be transferred to the Central Medical Board (CMB). It was believed, through the functions of the CMB, that central control could be established whilst maintaining the "professions'" representation (to maintain some of their autonomy): "It is intended to create from the profession itself a special executive body at the centre, which will undertake some of the administrative work of the service requiring a specially intimate link with the profession" (Ministry of Health, 1944:36). The CMB was to be accountable to the Minister of Health and had to adhere to the general direction that he offered. The Board had the responsibility in the planning of the distribution of doctors to meet the local needs. Consequently, it would have the authority to refuse permission to a general practitioner to practice in an area considered to be adequately supplied with general medical care.

Turning to the issue of the distribution of general practitioners under the *National Insurance Act* (as explained in section 2.1), GPs were given the power to practice when and where he or she wished. This autonomy was in conflict with the Ministry's desire to provide a "free" comprehensive health service for all. The freedom of location did not automatically ensure that there was an appropriate distribution of GPs in relation to the population. Specifically, there was concern from the MoH in the White Paper that there was no mechanism to ensure an appropriate distribution of doctors in Britain. It was stated,

> "It is true even now that the need for doctors in one area may be scantily or unsuitably met, while that of another area may be over-supplied. Certainly when

> the much bigger public responsibility is assumed of ensuring a personal doctor service for the whole population there will have to be means of securing, through public organisation, that the resources available are so disposed as to fit the public need" (Ministry of Health, 1944:27).

Again, the argument for salaries was reinforced. In the 1944 White Paper it was stated "there is at present no effective means of ensuring a proper distribution of doctors" (Ministry of Health, 1944:27). Government intervention was viewed as being essential for general practitioners to be available in all geographic locations: "...There will have to be means of securing, through public organisation, that the resources available are so disposed as to fit the public need" (Ministry of Health, 1944:27). It was stated in the White Paper that the existing National Insurance scheme would not be radically changed and the "new service should be achieved not by tearing up all established arrangements and starting afresh but by evolving and adapting the present to suit the future" (Ministry of Health, 1944:27).

The MoH was also keen to group general practitioners together in practices. They wanted a move away from the "all-sufficient" doctor towards a pooling of general practitioner expertise:

> "The tendency will be away from the idea of the all-sufficient doctor working alone and towards a bigger element of grouped practice and teamwork - in which the individual doctor retains his personal link with the patient, but has at his side the pooled ability of a group of colleagues as well as consultants and hospital services behind him" (Ministry of Health, 1944:28).

With an emphasis towards the "grouped" practice, GPs would become employees of local authorities to eliminate the element of competition which is believed to have been Maude's concern. It is interesting to note the policy of the Socialist Medical Association (SMA) here. In 1933 the SMA published their health policy. The main points of this policy can be summarised as follows: the need for a free-of-charge medical service for all; doctors should work as full-time salaried state employees; GPs should be in grouped practices and all medical functions should be rationally co-ordinated by LAs. The SMA did not significantly depart from these principles and later (in 1942) they became incorporated into the Labour Party's health policy (Eckstein, 1958). Bevan's health plan resembled many of these characteristics as we will see later. The BMA, however, did not adopt all of these. The BMA was in support of the move to health centres on the

basis that they would at first be experimental and outside state control. A poll published in the BMJ indicated 68 per cent of doctors were in favour of the move towards health centres (there was a 48 per cent response rate from 26,000 members) (BMA, 1944a). So, it was proposed that two systems would run side-by-side; the essence of the National Insurance committee scheme and the salaried service.

I argue that general practitioners affected the planning process significantly in the run up to the establishment of the NHS in England. In 1945 Willink presented a statement to the Cabinet. The statement indicated modifications to the 1944 White Paper which resulted from negotiations with the medical representatives. Concerning the central organisation of the service, the CMB would be abandoned. The CMB had always been seen by the doctors as an attempt by the central bureaucracy to gain control (Klein, 1989). It was suggested by the MoH that a Central Advisory Body be established with members appointed in agreement with the BMA. The CAB would have direct access to the Minister. Local organisation was also to be changed. The AHAs became planning agencies which had no administrative function (controls over the hospital sector continued to stay with the remaining units of local government). The 30 members would compromise 12 medical "professional" and voluntary hospital representatives and 18 LAs officials. Regional bodies with medical representation would, among other functions, advise the Minister on the needs of the region. Health centres were to be provided, staffed and managed by LAs under close Ministerial control and only on an experimental basis. General practitioners became contracted (in and out of the health centres) by local committees in a similar set-up to the existing NHI scheme and were paid by capitation fees. There was to be no restriction on the number of doctors entering a geographical area but there were financial incentives to attract GPs to under-represented areas. The sale of practices (subject to review in later years) would carry on.

Willinks' modifications are seen as an attempt to maintain the "consensus management" principle in order to protect medical autonomy. This was argued in chapter 1. Pater sees the MoH's concessions as large. He summarises:

> "The price paid included not only the abandonment of important elements, such as controls and the distribution of doctors, the rapid development of health centres, and the cardinal principle of combining planning and execution in the same local hands, but also the creation of a planning and administrative system of almost unworkable complexity" (1981:104).

There was a change of government in 1945 and Aneurin Bevan became the Minister of Health. Bevan changed the philosophy of the department away from Willink's "consensus politics" to "ideology politics" (Klein, 1989). Most of the radical changes affected the hospital sector and he was mostly willing to accept the negotiated compromise with general practitioners. Bevan approved of the maintenance of the NHI system and promoted that the GP services were to be administered by Executive Councils.

There were 138 Executive Councils in England and Wales which covered the same geographical boundaries as the county and county borough councils. There were 25 appointed members on each Council; five by the Minister to represent the interests of the total NHS, seven by local doctors, eight by the local authority and the rest were representatives from the dentist and pharmacist services (Eckstein, 1958). Doctors had won an increase in the direct representation which they had pushed for in the previous years, increasing their representation from 10 per cent on the Insurance Committees to 28 per cent on the Executive Council (Honigsbaum, 1979).

The role of the Executive Councils was administrative; to ensure that "all persons availing themselves... will receive adequate personal care and attendance" (Ministry of Health, 1946:1148). This involved the preparation and publication of lists of practitioners, granting the right of patients to choose their practitioner if accepted by the GP, locating medical services for those who did not choose a general practitioner or for those refused, handling complaints and administering the contracts for the practitioners. The general practitioners worked as "independent contractors" and were paid an annual rate for the number of patients they had on their list (Willcocks, 1967). The ECs came into operation in 1947 (see appendix A for their position in the administrative structure of the NHS at this time).

The development of health centres was a principle that Bevan followed and one that was advocated by the SMA. It was stated in the 1946 Bill that health centres would be provided by local authorities but with GPs working in contract with Executive Councils (Honigsbaum, 1989). This was to function as a bridge between the medical services (for example, home nursing, ambulances and health visitors) and the health services to rationalise the NHS. The sale of practices in the future would thus be inhibited and existing private doctors would be compensated.

Regarding the payment of general practitioners the plan was to have a capitation fee that would decrease as the size of the GPs patient list increased and there would be a fixed part-salary. Reporting on Bevan's comments it was said that he "was look[ing] forward towards the establishment of a full-time salaried medical service in due course, but felt that it would be impractical to make such a major change in established practices at once" (Public Records Office, 1946). Furthermore, on this issue he remarked also that, "there is all the difference in the world to plucking fruit when it is ripe and plucking it when it is green" (quoted in Pater, 1981:129). The BMA was convinced that this would mean all general practitioners would be compelled to be full-time state employees in due course. (Part-salaried legislation introduced in the 1960s, discussed later, showed this not to be the case). Lastly, Bevan introduced a Medical Practices Committee, which consisted mainly medical representatives, would control the distribution of doctors and entry into the medical occupations.

There was a large opposition against Bevan by GPs, to the point that it was not clear that the service would begin to operate on 5 July 1948 (Honigsbaum, 1989). Consequently, Bevan returned to the "consensus management" option as he conceded that only new general practitioner entrants would be part-salaried employees and only for the first three years in practice (Klein, 1989).

Not always was the medical "profession" documented as a united body. We have briefly seen the differences between the policies of the BMA and the SMA. The division of the two occupational-

representative groups grew larger from here on (see below). Honigsbaum (1979), in *The Division in British Medicine*, explores in depth the disagreements and conflicts between doctors and their representative groups. However, the main division was between hospital consultants and general practitioners. Honigsbaum (1989) argues that Bevan exploited the division between the medical "professionals" to achieve his own goals: "When he [Bevan] met the doctors... he was rude, blustering and threatening to the GPs, but smooth and amiable to consultants" (Honigsbaum, 1989:148).

Klein (1989) conceptualises the differences in the doctors' objectives and visions as between the "individualists" and the "technicians". The individualists were those who wished to preserve the individualistic way of life underpinning general medical practice. The BMA was a supporter and initiator of this ideology. The technocrats on the other hand, were those who wished to encourage a technically-efficient, rational and high quality service for all focusing the attention for the NHS on the consultant services. The Royal Colleges, especially the Royal College of Physicians (RCP), were supporters of this ideology. For example, in 1943 the consultants set up their own committees (with some BMA representatives) to promote the views of the hospital consultants and in 1946 the RCP published a report which stressed the need to develop a regionally-based service focused on university medical schools. Consultants wanted their views to be heard as distinct from the BMA as it was generally regarded that the BMA was primarily representing general practitioners (Pater, 1981). Bevan was more willing to negotiate at this time with the consultants as there were fewer of them, thus their co-operation was essential for the service to be effective. Honigsbaum notes that "[c]onsultants thus became the recipients of special favours, but Bevan could not ignore GPs: he had to satisfy both to make the NHS work" (1989:153).

The NHS began to operate on the 5 July 1948, although there was further alterations made. In 1949 Amendment Bill, general practitioners (and opticians, pharmacist and dentists) gained the legislative prevention of a full-time salaried service. Bevan held back this concession until, what has been named, the "psychological moment" (Honigsbaum, 1989:152). Bevan felt that Willink

had surrendered enough to general practitioners' demands prior to his appointment and, hence, there was little left to offer GPs in negotiation.

These are some of the main themes which concerned general practitioners prior to and during the establishment of the National Health Service. The Act is important to note as it illustrates the influence that the GPs had, through the BMA and the SMA, on the final characteristics of the newly formed NHS. The BMA reacted to the Ministry's proposals in a defensive way rather than an attacking or instigating manner. Nonetheless, it can be argued that the general practitioners managed to block some of the fundamental principles of the MoH, for example the move to LA owned health centres and "grouped" practices. Eckstein when writing on the noticeable lack of health centre practice and the role of the MoH commented, "The hope of 1948 that the Health Service would radically alter the condition of general practice has been disappointed; nor has any concerted effort been made to realise it" (1958:168).

Furthermore, GPs successfully resisted being full-time employees of the state. They maintained what Klein (1989) refers to as "medical perfectionism" (see section 1.2.1). Also, turning once more to the administrative structure, GPs blocked the MoH to have only appointed people to administer the service. The ECs included locally appointed representatives from general medical practice. However, Pater argues, "these councils were, in theory, independent but, in practice, they were administering detailed regulations and paying remuneration which had both been determined nationally by negotiation between the minister and the profession" (1981:168). Nonetheless, general practitioners had representative positions and were involved in the decision-making process. That is, general practitioners were active participants in the managerial bodies. Willcocks comments on GPs and the 1946 Bill: "They [the GPs] had not won complete victory, but it could have been much worse - and there were further gains to be recorded later" (1967:85). In summary, the MoH and general practitioners were in conflict and compromise in the run up to the 1946 Bill and in the operationalisation of the Bills.

2.3 The 1950s: Tranquillity and Stability

During the 1950s the general practitioner service did not experience legislative changes; it was a time of consolidation. The GP sector of the NHS was perceived to be successful in the early years. Godber explains, "It was general practice, sustained for 37 years by National Health Insurance and gaining substantial additional support for the new system, which really carried the National Health Service at its inception" (1975:5). However, during the 1950s (as set out in section 1.2.1) there was concern from Sir Cyril Jones on the financing of the service. This concern focused mainly on the hospital service where changes could be made to reduce the national expenditure. However, hospital expenditure only comprised half of the total, the other half was utilised by general practitioners, dentists, opticians and pharmacists (Klein, 1989). There was a perceived cost increase by the Ministry, however the in the Guillebaud Report (Guillebaud *et al.*, 1956) it was indicated that this was due to a general rise in prices and an increase in the population (a 2 per cent rise from 1948-1954). The current net cost of the NHS fell from 3.75 per cent in 1949-50 to 3.25 per cent in 1953-54. Trends in expenditure were different for different sectors and it can be inferred that the government wished to reduce GP expenditure. One of the mechanisms used was the introduction of prescription charges. Klein points to a probable reason for this: "The irony of the NHS as set up in 1948, and perpetuated since, was precisely that it could exercise least control over the gatekeepers to the system as a whole: the general practitioners, through whom all referrals to hospital were channelled" (1989:37). If GPs decided to refer more patients to the hospital sector or increase their prescription amounts there was little the government could do because general practitioners were private contractors. Therefore, in 1951 there was a charge on all prescriptions. Revenue raised was minimal; under one per cent in 1950-51 and reached a peak of 5.3 per cent in the 1950s (Klein, 1989). Although this charge was supported by the Guillebaud Committee in 1956 when reviewing the expenditure of the NHS, the committee disagreed with the introduction of the restricted prescription drug list advocated at the time. In the 1960s the government introduced an exemption category, mainly covering the young and old, resulting in a

low revenue earner as 60 per cent of prescriptions fell into the exemption category (Appleby, 1992).

Returning to payment and the cost of GMP once more, the total expenditure increased by £6.2 million between 1949 - 1954 in actual prices (Guillebaud *et al*, 1956) (see appendix E for more detail). The Guillebaud Committee account for this increase as a result of the rise in costs per patient / year (ie. a rise in capitation fees paid) after the Danckwert's award was introduced in 1952-53. In 1953, Justice Danckwert awarded GPs a substantial rise in income and made the allocation of funds related to the actual number of GPs rather than to the population covered by the NHS. One of the aims of this was to encourage newly trained doctors to go into general medical practice. Some of the raised incomes were safeguarded in a special fund from which GPs could use to improve or build new premises (Levitt & Wall, 1986). Furthermore, the BMA on behalf of general practitioners (and doctors) requested a further increase in income. The Ministry of Health referred the issue to a Royal Commission chaired by Sir Harry Pilkinton who advised that an independent Review Body on Doctors' and Dentists Remuneration was to be set up (see 2.4).

The 1950s saw the establishment of the College of General Practitioners. At the time, the BMA was concerned in the main with medical politics and the terms and conditions of service and tended not to focus on the standard or quality of care (Gould, 1991). The idea of setting up a College of General Practitioners (CGP) was to focus on the latter with an aim of increasing the respectability and lobbying powers of general practitioners (Tudor Hart, 1988). The Royal Colleges of Surgeons, Obstetricians and Physicians were opposed to the CGP. Despite this opposition, and after much negotiation, the College of General Practitioners was established in 1952 (and was awarded a Royal Charter twenty years later).The establishment of a college for general practitioners can be seen as a step to distinguish general practice as a credible medical speciality in its own right. Improving GP teaching and training, the GP-patient relationship as well as improving GPs premises were priorities for the college (Gould, 1991). The first president was

Will Pickles who had a practice in Wensleydale and an international reputation for infectious disease research, epitomised the college's approach to general practice (Tudor Hart, 1988). Initially the College attracted few general practitioners because although it endeavoured to increase the standards of premises and the quality of medical care, the funding for these changes had to come from the GPs themselves (Tudor Hart, 1988). The college, however, did not attempt to recruit all GPs in the first instance. It recruited by invitation and targeted those GPs who practised in market town clubs, had small lists and had what can be called a "moralistic" or "conscientious" outlook. Hence, although the BMA and the CGP performed different functions, they both aimed to improve the status and working conditions of general medical practice.

In summary, what had evolved through the 1950s was a partial and political solution to the problem of coping with the limited resources, the unlimited demand of general medical care and meeting the expectations of general practitioners. Klein indicates this to be a time of a change in direction for the NHS: "It is therefore scarcely surprising that in the 1950s the NHS evolved from being an instrument for meeting needs (as conceived by the founding fathers) to becoming an institutional device for rationing scarce resources" (1989:40). The NHS was getting a reputation for overspending despite the little increase in actual expenditure through the decade.

2.4 1960s: A Charter for the Family Doctor Service

1966 saw the most significant change which affected general practitioners up until this time: the *Seventh Report of the Review Body on Doctors' and Dentists' Remuneration* (1966). This report fuelled the debate on GP remuneration, the "pool" system and premise-improvement funding. GPs were not satisfied with the awards made to them by the MoH and the General Medical Services Committee (a division of the BMA) responded by threatening mass GP resignation and by producing an alternative strategy for primary health care. Prior to the review body report, the

BMA had published *The Charter for the Family Doctor Service* (1965) which set out the Association's demands. The *Charter* was the result of long negotiations within the BMA and between medical representative bodies and the government (Klein, 1989). Many of the BMA's proposals were ignored, however GPs were rewarded by substantial increases in their income. The *Charter* resulted in the most significant change to affect GPs up until the late 1980s and is the blueprint for contemporary general practice (Bryden, 1992) or as McLachlan expresses it: "This particular piece of policy action... has probably been the most important step in the development and improvement of general practice since 1948" (1990:131).

The *Family Doctor Charter* (1965) is important as it illustrates the MoH's ability to bring about strategic changes in the NHS and also illustrates internal politics within the medical "profession". GPs had to fight a long campaign within the BMA to get their views and policies recognised (Wilkin, Hallam, Leavey & Metcalfe, 1987). The *Charter* can be divided into four main areas: remuneration and divisions in the medical profession; allocation of funds and loans for the GP service; the GP contract and education and training. The BMA wanted the "pool" system to be abandoned and remuneration to be awarded by the number of patients in the general practitioner's list. The "pool" system was a capped-budget system of payment. They called for an independent body to be established to give loans for practice building and improvements and lastly, that there should be a choice of payment for the GP; the existing capitation fee, a salaried service or a piece-rate method. As a result of the *Charter* GPs formed their own specific training in addition to the general hospital training they received.

Concerning GP remuneration, the BMA at their annual general meeting in 1963 agreed that GPs' incomes needed to be raised. Central to these discussions was the growing split between hospital consultants and general practitioners. At the AGM it was decided that GPs' pay needed to be brought in line with hospital doctors and the general status of GPs needed improving (Klein, 1989). Tensions between the two occupational groups continued and consultants and general practitioners fought for work task control. The MoH did not intervene in discussions in this area

(Honigsbaum, 1979). General practitioners maintained their access to hospitals to perform minor surgery, had the use of hospital diagnostic facilities and had beds in cottage hospitals. However, little was reconciled between the two groups. Ham (1985) explains the situation in the 1960s: "The gulf between general practice and specialist practice widened, despite recommendations from bodies like the Guillebaud Committee that bridges should be built between the two branches of the NHS" (1985:21). GPs thus had not improved their range of services in the hospital sector. They had only increased the number of patients in their care. As far as GPs were concerned, this split from the hospital sector was essential for them to maintain their "professional" autonomy (Levitt & Wall, 1992). Hence general practitioner attention was turned to the health centre, as promoted by Bevan, to exercise their skills and autonomy. This is discussed in more detail below. GPs received an award of £5.5m to their "pool" system and the Minister of Health (Kenneth Robinson, from 1964) began negotiations on a new contract for GPs loosely based on the BMAs' Paper *The Charter for the Family Doctor Service* (1965).

Concerning the allocation of funds and as a result of the *Charter*, GPs were able to receive reimbursements including rent and rates and 70 per cent of the cost of ancillary staff. In addition to practice expenses (amongst other items), general practitioners received direct reimbursement of income from local authority and hospital work, and a system of seniority payments (Levitt & Wall, 1986). The Cost Rent Scheme and the group practice allowance (for designated areas) encouraged practice improvements and smaller practices to group together. One of the key elements of the 1946 Act was beginning to be realised; the move to health centres and grouped practices. The Gillie Report (Ministry of Health, 1963) encouraged these moves. The report not only encouraged doctors to work in grouped practices but argued that financial help be made available to GPs to recruit ancillary staff. Between 1968 and 1975, 553 new health centres in the UK were opened and over 1,400 loans were granted to build or improve practices (Drury, 1977). Furthermore, the number of practices which housed three or more doctors in England rose from 42 per cent in 1964 to 60 per cent in 1973 (DHSS, 1985). From 1968 to 1973 the number of employed nurses increased by 26 per cent and the number of full-time equivalent clerical staff

increased by ten per cent each year (Reedy, 1977). GPs became employers and the administration of their practices were dealt with "in-house". For many practices the administration responsibilities were often delegated to a senior member of the ancillary staff (Bryden, 1992). This is a theme which prevails in the 1990s with the profusion and development of practice management.

Concerning the choice of payment for general practitioners a basic allowance, or salaried provision was made available. The *National Health Service Act* aims to "... facilitate the financing of premises and equipment used by practitioners providing general medical services; to modify the prohibition of full-time salaries for practitioners providing general medical services; and for services connected therewith" (Ministry of Health, 1966b:731). The multitude of remuneration methods was devised, argues Wilkin, Hallam, Leavey and Metcalfe (1987) to avoid the constraints of just one system but also to increase the MoH's influence on the direction of GMP. Through financial incentives the MoH could have some control of primary care by altering the remuneration derived from each sector. The trend towards larger grouped practices continued through the 1970s.

McLachlan summarises the effects of the *Charter* on the attitude of general medical practitioners; "the effects... on morale was to give general practice a new lease of life, is impossible to discount, yet is often overlooked as an impressive example of what can be achieved by administrative will and fiat to steady morale and boost the quality of services" (1990:131). The *Charter* changed ideas about general medical practice. The individualistic, single-handed practitioner was changing; becoming more receptive to work in groups and take on new ideas of medical and administrative practice. GPs had to manage their time better after the *Charter*. Although GPs did not win their demand of reducing the 24 hour, 365 day patient-care responsibility, it is argued that ideas changed as to how to meet this aspect of their contract. Deferring responsibilities to the deputising service became popular from the 1970s onwards (Starkey, 1992).

Another feature of the *Charter* was the development of continuing post-graduate training and education for family doctors. In 1952, the College of General Practitioners was established to promote and design continuing education programmes. The *Charter* recognised the importance of this education. The Todd Report (Royal Commission on Medical Education, 1968) supported this endeavour and recommended vocational training for all general practitioners. Mandatory education was introduced in England in 1982, thereafter newly-trained GPs have to complete a three year education programme in hospital posts and in training GP practices, additional to their pre-registration hospital appointments. The move into a separate education provision was a significant for GPs as it distinctly separated them from the specialist hospital doctors. This separation of the two occupational groups was increasingly noticeable over the next ten years (Klein, 1989).

To summarise, the *Charter* changed the foundation of primary medical care up to the 1980s. In negotiations with the government and within the medical "profession", changes happened regarding the remuneration system, the allocation of funds and loans for the GP service, the GP contract and GP education and training. The significance of the *Charter* is captured by Klein: "The Family Doctor Charter negotiations thus provide a case study both of the limits on the potential for change, imposed by the prevailing consensus, and the opportunities to influence clinical practice through the use of incentives" (1989:89). Attention is now given to the 1973 *National Health Service Act* which was implemented in 1974 and became known as the "Reorganisation Act".

2.5 1970s: The Reorganisation Act

The next piece of legislative change which affected general practitioners significantly was the *National Health Service Act*, 1973, which came into operation on 1 April 1974. As explored in

section 1.4 the thrust of this "state-initiated managed change strategy" was to bring the administrative procedures of GPs, hospitals and area health authorities together to improve the effectiveness and efficiency of implementing national policy and the financial management. How to administer the NHS was a problem identified by Klein (1989) when discussing the 1940s and the establishment of a "rational and effective plan". Other bodies and advisory groups had suggested also this strategy, such as the Gillie Report (1963) mentioned above. However, the Act more closely resembled the Porritt Report's (1962) suggestion for local unified administration under Area Health Boards. It seems that the government's belief was that if the operation was to run smoothly then the organisational structure needed to be the "right" structure. There was the desire for an organisational fix. In the 1970s there was also a "consensus management" ideology (explained in the last chapter) as Sir Keith Joseph wanted to satisfy the wishes of the various interests in the medical "profession" by maintaining some level of medical autonomy (amongst other matters), as well as fulfilling the demands of rationality, accountability and efficiency from MPs and civil servants.

Concerning general practitioners, the government intended to incorporate executive councils under one unified health authority, along with RHBs, Hospital Management Committees, board of governors and LHAs (Ham, 1985). However, this unification was not achieved as general practitioners stayed being independent contractors. Klein describes "the 1974 unification of the NHS ...[as] a fiction" (1989:97). Furthermore, Kogan (1978) argues that "consensus management" and the planning system resulted in confusion and ambiguity, not unification. He suggested that there were fundamental problems in implementing the DHSS's priorities and inadequate information on which to make decisions at regional and area levels.

The 1974 reorganisation is significant as it symbolised the changing situation of political power within the medical world. The change required AHAs to establish Family Practitioner Committees (FPCs) to replace the former Local Executive Councils responsibilities for general medical practitioner services (as well as the dentists, pharmacists, opticians and ophthalmic medical

practitioners). The role of FPCs was primarily administrative. The four functions of the FPC were to enter into contracts with GPs for services, to have a list of practitioners, to pay practitioners and to deal with complaints of their services (Royal Society of Health, 1977). The FPCs were financed directly by the DHSS and its members were appointed by the AHAs, local "professionals" and local authorities. Out of the 30 members, eight were selected by GPs (seven from the other occupations), 11 by the AHA and four by the LHA. Each FPC appointed their own chairperson. In total there were 15 lay people from the selection procedure. A survey published in 1985 showed that these mainly constituted "professional" middle class representatives from teaching, law and accounting occupations (Levitt & Wall, 1992). The FPCs were frequently criticised for being dominated by "professional interest" which supported GP autonomy (Levitt & Wall, 1992). In general terms, the management aim in 1974 was to maintain the Secretary of State's accountability to Parliament and at the same time delegate more responsibility to AHAs (Leathard, 1990). See appendix B for a diagrammatic representation of FPCs in the reorganised NHS.

Because of the financial arrangements, AHAs had little control over FPCs and thus had no direct control over GPs (Brown, 1979). Furthermore, FPCs challenged the strategic judgement of the AHAs on issues such as resource allocation (Holliday, 1992). The only areas that the AHAs could directly affect GMP were in the health authority owned health centres and through the ancillary staff appointed in the practices. Neither of these influences radically affected the nature of general practice on a national scale. Essentially, FPCs were independent bodies and the desired integration between primary and secondary care did not materialise. In effect, there was little change to the flow of patients from primary to secondary and possibly tertiary care (McLachlan, 1990). General practitioners remained autonomous. The new arrangements for the GP service remained basically unchanged from the 1911 *National Insurance Act* and the *National Health Service Act* in 1946. The desire for the FPCs to remain independent is further exemplified by their unwillingness to join the National Association of Health Authorities (NAHAs), which was established after the reorganisation by the area and regional health authorities. FPCs founded an

independent Society for Family Practitioner Committees which advised the Royal Commission on GP matters (Brown, 1979).

Under the 1974 *Reorganisation Act*, there was a statutory call for Professional Advisory Committees. As seen in section 1.4, these were established by the RHAs and AHAs and gave medical practitioners a platform to express their views, to offer advice and to be consulted on policy issues at these levels. The doctors' and general practitioners' advisory committee was known as the Area Medical Committee (AMC). The BMA negotiated with the MoH and secured equal representation for GPs and hospital doctors, (including trainee GPs, junior doctors and community medicine doctors) (Brown, 1979). Each AMC elects their own chairperson and if the chairperson is a hospital doctor then the deputy needs to be a general practitioner and vice versa. The chairperson and deputy of the AMC are also members of the regional medical committees. The membership requirements for AMCs again illustrates the division between the two occupational groups. As Brown says: "For doctors, therefore, an advisory system was constructed in such a way that it could not be dominated either by hospital interests (which was the main worry) or by general practitioners" (1979:28). Nonetheless, the AMC representation indicates the increase in power of both groups on the administrative procedure and the strategic decision-making at local and regional management levels. Additionally, as GPs resisted local authority control and resisted becoming mandatory state-employees, they could effectively practice where and how they wanted.

The 1974 "state-initiated change strategies" were administrative in nature and did not significantly affect the relationship between primary, secondary and tertiary care. Nor did the changes significantly affect the doctor-patient relationship. The *Reorganisation Act* can be seen as a political vehicle for general practitioners and the DHSS. GPs won equal representation on the AMCs and regional management committees which increased their separation from the hospital doctors and thus advanced their autonomy. The MoH, wished to improve the efficiency and

effectiveness of financial management and the implementation whilst supporting medical autonomy. Hence, the dilemma of integrating primary and hospital sector had not been resolved.

The Royal Commission's Report (the Merrison Report) in 1979, assessed the structure of the NHS and the effects of the 1974 reorganisation. The evaluation of primary care services was, on the whole, favourable: "The development so far of the primary health care team has been encouraging, but there is a continuing need to encourage closer working relationships between the professions who provide care for the community" (Merrison Report, 1979:90). Other improvements were recommended, including the continuing education and training of GPs, further training for clerical staff, increasing the standard of existing practices and the building of more health centres. The drive of the report was again similar to the 1946 Act.

Accountability was another criteria by which Sir Alec Merrison and his team judged the NHS. Prescription costs were again a concern. In the report it is stated: "To a large extent GPs can control their own prescribing costs but they have little incentive to keep them down and are subject to pressures from pharmaceutical companies and patients to prescribe expensively and often ineffectively" (1979:91). To improve effectiveness and economy in the prescribing of drugs, the report recommended that the DHSS should encourage generic prescribing and provide a list of limited drugs available for NHS use. It was also suggested that improvements in the training of GPs on "sensible" prescribing were needed (1979:86).

Concerning the management of the financial and manpower resources, the Commission recommended that the AHAs be abolished and that the FPCs be integrated into the main management structure to enhance primary health care services. The result, it was thought, would bring the many occupational groups in primary care closer together and thus share the responsibility of meeting local medical needs in a more effective manner. The next change which affects general practitioners was in 1982. The consultative document *Patients First* (1979), based on the Commission's report, was the foundation for the Act.

2.6 1982 and 1983: Localism, Centralism and General Management

Essentially, the 1982 reorganisation was intended to simplify the structure of the NHS. The DHSS sought to delegate as many decisions as possible to the community level. In line with this rationale and as we have seen the AHAs were abolished. It was thought that they were too far removed from the patient, the local community and the primary health care workers (Allsop, 1984). There was also a greater concern on expenditure than in the 1960s and the 1970s (see section 1.5 and 1.6 for a more detailed discussion on the political climate and the NHS as a whole at this time). In 1983, following the Griffith's Report, state-initiated changes resulted in the introduction of general rather than functional management in the NHS. This change in the main concerned the hospital sector (see 1.6 for details).

Resulting from the 1982 reorganisation the Secretary of State had increased powers and appointed the chairperson of the DHAs (as with the AHAs). The DHAs members was appointed in the same way as the AHAs and the District Management Teams (DMTs). That is, the chairperson had little say in who was to represent the work occupations (for example the hospital consultant and the GP on the DMT). The DHAs became the basic planning unit. Short-term operational programmes, including a cost-improvement plan, were introduced (Ham, 1985). The DHAs had to report to the RHAs at an annual review meeting. The RHAs were accountable to the DHSS after the recommendation of the House of Commons Public Accounts Committee. As I suggested in 1.6, the maintenance of "professional" perfectionism supported in the 1970s was abandoned in the hospital sector with the introduction of Griffiths' recommendation of a shift towards general management. Although one person, the District General Manager, was responsible for the whole organisation, a DHSS Circular (HC(80)8) stated that there needed to be a GP representative on the Board (amongst other representatives from the other occupational groups). It was maintained that the medical representatives were selected by their peers. It can be argued that the difficult

decisions, concerning priorities or spending for example, were delegated to the local level. Hence, this allowed members of the DHA to locate and participate in important policy issues.

The FPCs became independent bodies in 1985. They were independent financially and functionally from the health authorities (Taylor, 1988). FPCs boundaries remained basically the same as the AHAs but FPCs still did not have a management function as general practitioners remained independent contractors. Consequently, there was no explicit directive towards general management in general medical practice as seen in the hospital sector. However, FPCs were encouraged to modernise their management structures. An example of this was the creation of planning and liaison positions in most of the FPCs. There was some apprehension with FPCs becoming independent bodies would result in a further separation of general practitioner services from other NHS sectors. To combat these fears, a joint working party was established in 1984 comprising members from FPCs and DHAs. The working party recommended that FPCs produce an annual report and a Profile and Strategy Statement every five years (Ham, 1985).

The reorganisations which occurred through the 1970s and early 1980s that mainly affected general practice, affected them in an indirect or roundabout way. The main changes which we have seen above have affected the administrative structure of the NHS. As GPs are outside this structure with independent status, the way they practice medicine and how they organise their practices had not been substantially altered. The only direct form of control established at this time was that newly-trained GPs had a mandatory three years vocational training. Since the 1966 *Charter*, it was not up until the mid-1980s when the government looked directly at the provision of primary medical care again. As Calnan and Gabe explain: "... [I]t is only recently, since the mid-1980s, that the state has become more interested in general practice, frequently intervening between the producers and consumers of medical care to regulate and control aspects of general practice and consumer satisfaction" (1992:151). In the mid 1980s the government embarked on their first comprehensive review of general medical practice.

2.7 1986: Primary Health Care: An Agenda for Discussion

General practitioners, the "gatekeepers" to the NHS, had avoided the significant controls when other areas of the NHS had not. Klein (1989) argues that the DHSS was wary of dealing with the BMA because of the political costs that it had received in the past. Nevertheless, primary health care became a focus for containing public expenditure in the mid 1980s. The financial costs of challenging GPs seemed to outweigh the political costs (Tudor Hart, 1988). Expenditure on Family Practitioner Services increased from about £2 billion in 1979-80 to about £4 billion in 1984-85 (Secretaries of State for Social Services, 1986). The two largest expenditure areas were general medical services and dispensing. I argue that the overall aim of the 1986 Paper was to review the efficiency and effectiveness of primary health care services in order to control costs. In the introduction to the Paper, it states that "Our primary health care services are good but could be better still. The Government believes there is scope for improving the quality, effectiveness, and value for money which patients and the nation get from them" (DHSS, 1986:2). The Paper identified the following objectives:

> "To give patients the widest range of choice in obtaining high quality primary health care services; to encourage the providers of services to aim for the highest standards and to be responsive to the needs of the public; to provide the taxpayer with the best value for money from the NHS expenditure on family practitioner services; to enable clearer priorities to be set for the family practitioner services in relation to the rest of the NHS" (DHSS, 1986:2-3).

As you can see in the development of this chapter, there has been a shift in the ideology of the government concerning primary health care. The shift is away from the paternalistic and consensus management ideology, towards a consumerism ideology. The "value of money" objective is a new criterion on which to judge primary health services. It is also the principle aim of *Promoting Better Health* (1987) and the next significant legislation to affect GPs; *Working for Patients* (Secretaries of State for Health, 1989a) (discussed in chapter 3).

In the Paper, prescribing, referrals and staff costs are attributed as key factors for the increase in spending. There were no control mechanisms from DoH or other health agencies, to check the

prescribing patterns of general practitioners. Expenditure on the pharmaceutical services (for GPs and dentists) rose from £981 million in 1979-80 to £1,913 million in 1984-5 (Secretaries of State for Social Services, 1986); a rise of 28 per cent in real terms. Patients contributed to about seven per cent of this total cost. In 1984 there was a "selected list scheme" introduced to restrict the prescribing of certain drugs, as recommended by the Royal Commission in 1979. The drug companies responded to this "imposed" policy by stating that it would create a "two-tier" health service as there would be those patients which would not be able to afford the non-listed drugs (Wheatley, 1985, cited in Klein, 1989). There was also opposition from the medical "profession" and within Parliament. What resulted was a compromise; the selected-list was increased from 30 to 100 items and a NHS Drug Advisory Committee, consisting of medical representatives, was established to consult with the government on which drugs were to be on the list. The government saved £75 million in the first year of operation (Secretaries of State for Social Services, 1987). Medical autonomy was being threatened. GPs had lost some rights to practice medicine in the way they wanted as there were restrictions on clinical decisions.

The number of general practitioners in practice increased (and thus the cost) by 11 per cent between 1979 to 1984, faster than the rate of population. Thus the average list size of each doctor fell. Costs of ancillary workers also increased. However, despite the increase in expenditure in these areas the government could not measure a rise in the quality of service which was being provided: "Though it is reasonable to hope that smaller lists should result in better standards of service to patients, there is at present little evidence of a direct link between list size and the quality of care, and consequently there is little to indicate the optimum list size" (Secretaries of State for Health, 1986:12).

There were a number of bureaucratic controls introduced to restrict the number of GPs practising. Examples of these controls include changes in the retirement age for general practitioners and changes in the remuneration system. Compulsory retirement was set at 70 years of age and GPs over the age of 65 would need approval for their continuing practice. Concerning the

remuneration, GPs had their percentage of income from the number of patients on their list (capitation fees) increased. This change, it was felt, would encourage GPs to be more responsive to local needs and thus entice more patients to join their practice. Supporting this, the government made it easier for patients to change their general practitioner if they so wished and increased the availability of information available on GPs and their practices. To aid the distribution of GPs and improve the standard of care in the inner cities, financial incentives were given to those practising in these areas.

Furthermore, the "good practice allowance" was again suggested as a way to influence the standard of care in general medical practice and the kind of services offered. The 1986 Paper proposed a financial incentive to encourage practices to offer "quality standard of care". Thus, it can be inferred that there was a presumption, that all GPs are orientated solely by instrumental means (cf. Golthorpe, Lockwood, Bechhofer & Platt, 1968). The government sought to embark in negotiations with the RCGP on these issues. As a result, the following areas were suggested to be financially credited: ensuring certain immunisation and vaccination targets be met; a wide range of services including preventative health care be provided; personal availability to patients and general practitioner attendance on continuing post-graduate education programmes. The proposal of the good practice allowance was met with opposition from most of the representative medical bodies, argued Wilkin, Hallam, Leavey & Metcalfe (1987), as it was perceived as an attempt to challenge medical autonomy. Wilkin *et al.* also point to a number of other problems concerning the implementation of the allowance system which the medical bodies raised. First, that the quantity of activities in a surgery do not automatically correspond with the standard of care. Second, that the measurable activities are not necessarily the most beneficial to the patient. Third, that GPs may be encouraged to concentrate on those activities designated in the allowance to the detriment of other non-specified activities, thus potentially not meeting locally-defined needs. Tudor Hart (1988), when discussing financial incentives, argued that rewarding "better" practice with a higher income, increases the separation between "good" and "bad" practices. Likewise, Bosanquet and Lease (1986) indicate that financial incentives are not an effective way to

encourage improvements in practice performance and standard of care where the patient profile is an ageing population and has social and economic disadvantage. The good practice allowance was again proposed in the White Paper *Promoting Better Health*, but was later abandoned.

Overall, attention was turned to the FPC to influence the practice of medical care. The FPC's role was expanded to include planning and developing the services in their area. This was a first step towards a more systematic approach to identifying and prioritising health care needs. Accountability and resource management principles were introduced into the role of the FPCs. In the Paper it was stated:

> "To assist and encourage FPCs to achieve high standards in the management of the resources for which they are responsible and in the development of positive planning, the DHSS and Welsh Office have introduced a system for reviewing the performance for each FPC, bringing to bear on FPCs the principles of sensible financial management. To help FPCs identify the scope for improvements the Departments have worked with them to produce performance indicators, enabling comparisons to be made between similar FPCs. The progressive computerisation of FPCs will also help to improve their efficiency and performance" (Secretaries of State for Health, 1986:9).

Although FPCs maintained independent status and experienced an increase in their managerial responsibilities they also encountered bureaucratic controls as they became directly accountable to the DHSS and were monitored for their "sensible financial management". Morley, Evans, Higgs and Lock (1991) argue that there was a lack of shared responsibility and co-operation between the FPCs and DHAs and that there are insufficient resources available to FPCs to function competently: "In 1985 the giving to FPCs of greater responsibilities, but little power to direct services, meant that the need for an effective and joint approach to primary care services is increasingly evident" (1991:1). In 1987 there was a Social Services Select Committee Report which recommended the government to find the necessary resources to enable FPCs to function effectively. The same year saw the publication of *Promoting Better Health* (1987).

2.8 1987: Promoting Better Health

Promoting Better Health was partly the result of consultations with the public after *Primary Health Care: An Agenda for Discussion* and a DHSS review of community nursing, called *Neighbourhood Nursing - A Focus for Care* (1986) (otherwise known as the Cumberlege Report). *Promoting Better Health* stressed the importance of health promotion and preventative medicine as well as consumer choice. The focus for the Paper was again, primary health care. The introduction to the Paper states the focus:

> "A major theme... is the need now to shift the emphasis in primary care from the treatment of illness to the promotion of health and the prevention of disease... 'Promoting Better Health' sets out the Government's programme for enabling those professionals to deliver services properly tuned to the present and future needs of all consumers" (Secretaries of State for Health, 1987:Forward).

The objectives of the Paper were:

> "To make services more responsive to the needs of the consumer; to raise the standards of care; to promote health and illness; to give patients the widest range of choice in obtaining high quality primary care services; to improve value for money; to enable clearer priorities to be set for Family Practitioner Services in relation to the rest of the health service" (Secretaries of State for Health, 1987:1-2).

In the Paper it is stated that the need for innovation in primary health care included the need to encourage the responsiveness of GPs to meet their populations' requirements and the need to eradicate the differences between practices in the standard of care. The remuneration system would be adapted to support these needs. There was the presumption that competition for patients would promote better standards of care for patients. It is stated: "To this end a greater degree of competition in providing services to patients is the necessary impetus and the combination of a better informed public and a remuneration system geared to consumer demand provides the mechanism" (Secretaries of State for Health, 1987:12). Patients, it seems, were to be educated though various means: by informing patients on the range of services available to them so they could choose a general practitioner which best suited their needs; for the FPCs and Health Boards to provide more detailed information about GPs and practices in their area, for example listing the

GPs qualifications and year of qualification, in addition to the practice details and by encouraging the production of practice leaflets for GP surgeries (this latter point was supported by the BMA). Also, patients were to be educated on the relationship between "life-style" and "ill-health". The government proposed that advising patients about life-style would be a key role for GPs. General practitioners would be encouraged to have health promotion clinics and routine screening procedures to identify people at risk of disease. It can be argued that the government turned its attention to controlling the demand of health care rather than controlling the supply of health care. Fox, Day and Klein (1989) pointed to the AIDS epidemic as a stimulus for this shift in thinking. A Cabinet Committee was established and found that an effective means to curb the AIDS epidemic was by changing peoples' attitudes on sexual habits. It has been inferred that the government was concerned about the financial cost of AIDS' patients on the health system and responded by committing itself to a public health education campaign (Klein, 1989).

The government was still concerned with the individualistic, single-handed GPs and with the general lack of team work in general practice: "Generally there is still too little team-working in general practice, and there are too many surgery premises whose standards is unacceptable low" (Secretaries of State for Health, 1987:12). Their main focus for these concerns were the single-handed GPs in the inner cities. To encourage an improvement in the standard of premises, especially in deprived areas, the government proposed to increase funds available under the cost rent schemes and the improvement schemes. The government aimed also to review its minimum standards for premises. The allocation of funds and the inspection of premises would remain to be a function of FPCs and Health Boards. The government did intend to encourage the use of private loan institutions and sought to change the constitution of the General Practice Finance Corporation to permit this.

Team work, it was believed, would improve the effectiveness and efficiency of the practice which, in turn, would improve the quality of care and extend the choice for patients. Bevan, the SMA and *Neighbourhood Nursing* (DHSS, 1986), as well as others, have advocated this form of work

organisation. Moreover, in the Cumberlege Report, the need for more clearly defined roles in the health care team was identified: it was recommended that general practitioners and nurses should enter into a form of team-contract that would provide a framework from which to organise who does what on a day-to-day basis. However, for this form of organisation to work effectively, issues of power and responsibility would need to be confronted. Wilkin *et al.* (1987) found that GPs felt more comfortable working with nurses which they had employed themselves through the FPC reimbursement scheme rather than working with nurses who were independent. (The Royal College of Nursing advocates that nurses should have clinical responsibilities (Royal College of Nursing, 1987).) The government saw the promotion of health and life-style as a function for the whole primary health care team.

Also on the issue of the employment of staff in GMP, it was stated in *Promoting Better Health* that the restrictions of reimbursements on the type and number of staff in general practice would be changed. This would allow greater flexibility and is a feature of the "devolution" principle adopted by the government. The funds, in the future would come from FPCs and Health Boards after negotiations with LMCs.

There was considerable attention paid to the remuneration and payment system for GPs in the White Paper. The basic practice allowance was proposed to be tightened. The government intended to increase the minimum list size (from the existing 1,000 patient entitlement) and increase the minimum average number of hours spent in surgery sessions (the existing entitlement was an average of 20 hours per week in surgery sessions and on home visits). Additionally, general practitioners and their health care teams would be required to perform health promotion and preventative medicine to qualify for the full basic practice allowance. I would argue that this is akin to the performance-related pay initiative which affected the hospital sector since the early 1980s. In the White Paper it is stated; "... the Government intends to pay a special fee to encourage doctors to provide an initial clinical assessment (ie. a health check and any necessary follow-up) for patients registering for the first time with an NHS doctor" (Secretaries of State for

Health, 1987:14). General practitioners would also continue to be responsible for 24-hour patient care so they can be responsive to their patients needs. The government intended to discuss with GP representatives as to how this objective could successfully be met.

In effect, as the basic practice allowance was being modified, the proposals meant that GPs potentially had to change the way they practised to maintain the same level of income. In the White Paper, it is stated that the actual amounts GPs earn will vary according to the service that they provide and the expenses that they incur. The example given looks at a single-handed junior general practitioner with 500 patients who could earn £10,000 net, whereas a GP with 3,000 patients, who is a trainer and practices in a group practice could earn more than £30,000 net. Other means of increasing pay could be achieved by meeting the criteria of the "good practice allowance" as mentioned in *Primary Health Care: An Agenda for Discussion* (Secretaries of State for Health, 1986). Although some entitlement factors had changed, the intention was the same. The government wished to encourage, through financial incentives, the following elements: personal availability to patients; a wide range of services including health prevention; certain health targets be met; and attendance on recognised continuing education programmes. It was suggested that assessment would be done by other doctors; that is by "peer review". Some of these elements have already been discussed. Concerning the education of GPs, it was proposed that a new post-graduate education allowance would be introduced, to encourage the continuing education of GPs throughout their years in practice. This allowance replaced the existing allowance which was only available to newly qualified doctors and was made mandatory in 1982. Additionally, GPs would also be financially rewarded for performing minor surgery. This, it was believed, would reduce waiting-lists for treatment in out-patient departments and would promote a faster service for patients.

Regarding FPCs, the government intended to increase their managerial responsibilities. The responsibilities, which were suggested, included the assessment of practices and the allocation funds for their improvement; the monitoring the quality of primary health care provisions aided by

the submission of practice annual reports and the allocation of funds for practice team development. In addition, FPCs were to ensure, in collaboration with DHAs, that hospital services be used to guarantee maximum benefit for the patient (in an effective and efficient manner); agree appropriate disease prevention targets for primary health care teams and ensure that the views of the public be taken into consideration (through occasional consumer surveys). The government intended for the FPCs and DHAs to have a closer working relationship and intended to increase the funds available to FPCs to perform their new responsibilities.

The essence of the 1982 reorganisation was to delegate as many decisions as possible to the community level and it was intended that the devolution of responsibilities would continue. The government states:

> "As a further aid to the efficiency of FPCs and to their taking on additional tasks, the Government will seek to devolve as many powers of decision as are consistent with the Government's responsibility to Parliament and its overall responsibility for managing the NHS. A joint working party has already begun to identify the scope for such devolution" (Secretaries of State for Health, 1987:56).

The nature of the White Paper *Promoting Better Health*, was to offer a wider choice for patients; give more information to patients and to raise standards of health and health care. It was to give a higher priority on health promotion and prevention. General practitioner accountability, competition and consumerism were all features of the White Paper which affected general medical practice. The majority of the reforms were introduced through the GP contracts for services as set out in the White Paper, *Working for Patients*. The new GP contract came into effect on 1 April 1990. *Working for Patients* and general medical practice is discussed in the next chapter.

2.9 Rounding Up

In this chapter there has been a focus on general practitioners and the developments in the comprehensive national health service in England. The significant changes which have affected GPs and GMP in England between 1911 and 1987 have been examined. The root, or drive, of these changes have resulted from various pressures - from GP representative bodies and from the "state-initiated managed change strategies". There are changes and continuities in these policies.

Concerning the changes, the most notable is the variation over time in the government's ideologies regarding general practitioners. In the negotiations prior to the establishment of the NHS, we saw a consensus-management ideology where medical autonomy was protected and compromises were reached between the government and the representative bodies such as the BMA and SMA. As a result, two systems of primary health care organisation ran side-by-side: the "panel" system and the LA controlled health centres. This can be contrasted to the fundholding and non-fundholding schemes in *Working for Patients* (which are examined in the next chapter).

There was then the ideology of politics, although this mainly affected the hospital sector, general practitioners were under attack and were threatened with losing their independent status. As a result of Bevan's ministering at this time, GPs and hospital consultants became increasingly divided. In the actual establishment of the NHS there were conflicts and compromises in the establishment of the NHS between the GP representative bodies and the government. The ideology of politics continued until the cost of the NHS became a high priority for the governments. We have seen the various rationalisation programmes which took place during the 1950s, 1960s and 1970s.

The concern for the cost of the NHS in the 1980s can be interpreted as encouraging the government to shift towards a consumerist ideology and to use this as a means to control

expenditure. The government since, has increasingly focused on primary health care. Previously, in general terms, GPs were managed by the government not as an end in themselves, but as a means to alter the hospital sector. General practitioners had not been viewed by the government as having a pivotal role in the NHS. Later, GPs became recognised as the gatekeepers to the NHS and thus controllers of expenditure. Certain bureaucratic controls arose for general practitioners, for example, with the increase FPC responsibilities. These controls took various forms, such as the restrictions to the numbers of GPs practising as we shall see in the next chapter. Furthermore, the "value for money" principle emerged and medical autonomy for general practitioners increasingly became endangered.

There have been different governmental mechanisms and strategies in play with regard to general practitioners. There has however, been a consistent aim of achieving a rational and effective plan for the NHS as a whole. Although general practitioners have maintained their independent status, which has been under threat in the period examined, they have increasingly become a focus for the government as a way to control expenditure at the same time as a means to claim an improved quality of care to the patient. These are themes which are discussed in the next chapter where particular attention is given to *Working for Patients* and general medical practice in England.

Chapter Three

Working for Patients and General Medical Practice in England

3.0 Introduction

Working for Patients (Secretaries of State for Health, 1989a) is a central focus of this thesis. In chapter 1 there was a general discussion of the broad context and content of *Working for Patients* for the NHS. In chapter 2 I discussed the policies which affected GMP leading up to *Working for Patients*. Here, I discuss in detail the content of *Working for Patients* which (potentially) affect general medical practice. The themes and issues raised in the first and second chapters are explored in relation to the White Paper. By correlating and comparing these themes and issues a launch-pad is provided for the empirical analysis in chapters 6 and 8. In these later chapters I discuss how general practitioners in the Midlands are making sense of the changes introduced in *Working for Patients.* Furthermore, how these changes are perceived to affect the nature of and orientation to their work is examined. This chapter will take the following form. There are six parts: first (3.1), I introduce the political context of *Working for Patients* and GMP; second, in section 3.2, I examine the changing role of the FPCs and the rise of general management in primary health care; third (section 3.3), I examine in more detail the "imposed" changes of *Working for Patients* which affect general practitioners; fourth (3.4), I examine the "invited" changes such as the fundholding scheme; fifth, in section 3.5, I discuss the relationship between

the internal market system and general practitioners and sixth, there is a rounding-up of the main issues and themes raised in this chapter (section 3.6).

3.1 The State, Control and General Medical Practice

Working for Patients can be understood to directly challenge general practitioner autonomy. It is the first government strategy to target GPs and attempt to interfere substantially with how they organise and practice medicine. Mohan (1995) explains: "It was not until the proposed new contract for GPs, and subsequently the NHS reforms themselves, that what began to look like decisive efforts to challenge clinical autonomy began to be pursued" (1995:138). In chapter 1, I argued that there was a change in the philosophy of the NHS during the 1980s. The change was away from the established paternalistic approach of health care apparent since the launch of the NHS, towards a more "business-like" ethos. Professor Enthoven was seen as an influential figure in this process, especially in the development of the internal market system. To recapitulate, Enthoven suggested (among other proposals) that DHAs would act as the commissioners of health care and receive an annual allocation of funds to meet the local population needs. That is, DHAs would purchase services from the public and private hospitals on behalf of GPs. Following this approach, general practitioners would have little part in the negotiation process. There was, however, an alternative and competing model offered for the NHS. It was proposed that general practitioners be the commissioners of health services. General practitioners, following this model, would receive a capped-allocation of funds for the purchase of services required by their patients. In effect, GMPs would act as small scale HMOs. The role of the DHA here would be to provide health services and compete with other public and private providers for GPs' custom. DHAs would be responsible for the management and the provision of hospital services in their area. This latter model was suggested by the Office of Health Economics in 1974 (Maynard, 1986; Teeling-Smith, 1985) and was also advanced by Willetts and Goldsmith (1988) at the Centre for Policy

Studies. Both models do have a common ground: the recommendation to split explicitly the purchaser and provider roles in health care. This distinction is discussed in more detail in section 3.5.

In 1988, there was a review of the NHS led by Margaret Thatcher. *Working for Patients* was the result of the review and included aspects from both of the models mentioned above. To summarise the discussion of this review in chapter 1, I stated that it was a private affair which was not open to public debate and the aims included the intent to pacify the medical workers' concern for the level of funding on the service, whilst continuing and furthering the general policies of the government (eg. increasing the emphasis on efficiency and accountability). The review pinpointed GPs as being inefficient, especially in their referral rates to hospitals. It can be inferred that the government felt that GPs were referring in varying amounts which could not be explained by the clinical characteristics of patients (Butler, 1992). The Public Finance Foundation's 1988 report on the financing of the health service stated, "there can be little doubt that further increases in efficiency are possible, and they will need to be realised to make the best use of expenditure" (1988:49). Therefore, primary health care was targeted for change.

Kenneth Clarke (Secretary of State for Health from 1988), who was particularly influenced by Maynard (Holliday, 1992), envisaged an increased emphasis on the GP model over time. In the White Paper it is stated that "General practice will play an even greater role in assisting patient choice and directing resources to match patients' needs throughout the whole Health Service as a result of the Government's new policies" (Secretaries of State for Health, 1989a:54). To aid this process, an intent to relax the qualifying criteria for GP practices to apply for budget-holding status was stated (the term "budget-holding" was later changed to "fundholding"). This would then enable more and more general practitioners to become budget-holders and thus commission health services from DHAs and the public and private hospitals. It was thought by David Mellor (predecessor to Kenneth Clarke) that one reason for the increased policy emphasis on GPs was to restrict or curb the clinical practice of some GPs through financial controls and limitations

(Brown, 1988). It has been suggested that the review body wished for all GPs to be the sole commissioners from 1990. However, the members of the review body saw it inconceivable to immediately implement such a vast change (Butler, 1992).

To capture the essence of the policy changes introduced in *Working for Patients,* Mohan (1995) typifies three strings to the government's bow: anti-corporatism, anti-professionalism and pro-entrepreneurialism. Indeed, throughout the history of the NHS, general practitioners have played a part in and been consulted about any "state-initiated managed change strategies" that concern their work. The deliberate exclusion of the medical "profession" deviated markedly from this previous privileged position. This was a probable reason for the BMA to oppose the "reforms" (Mohan, 1995). Moreover, the government's exclusion of "professional" bodies was not restricted to the medical groups; teachers, the police and the legal "professions" were treated in a similar manner in the 1980s. This stance is reflective of the government's belief that "professional" groups prioritise their own interests rather than those that they serve (BMA, 1990), thus contravenes the government's rhetoric of "patients first". Furthermore, Mohan (1995) typifies the government's actions as supporting those general practitioners who display an entrepreneurial approach to health care. The fundholding scheme encouraged a sector of GPs to benefit from the advancement of their "reforms". Taylor claims that the privileges that GP fundholders gained in hospital admissions were incongruous with the "corporate sense of continuity which distinguishes a professional from an entrepreneurial career" (1990:1304). The boundaries of "professional" and commercial activities can be understood to be blurred (a theme returned to in later chapters). In the next section the rise of commercialism and general management in GMP is addressed further.

3.2 FPCs and the Rise of General Management

In chapter 1, I stated that there has been a general trend since 1948 towards a decentralisation of activity decisions being made at the local level, where financial constraints are implemented by the DoH. I argued that pre-1983 governmental controls for the NHS were concerned with inputs, and post-1983 the controls were concerned with outputs. From 1983, we saw the freedom of local decision-making being inhibited by tight government objectives, performance-related pay schemes and performance reviews. In *Working for Patients*, the government endeavoured to continue the process of resource rationalisation in the NHS by increasing the emphasis on financial and managerial arrangements for GPs and general medical practice. In an attempt to control the costs accumulated by general practitioners, the White Paper stated the government's intent to increase their accountability. One means to achieve this, was by increasing the managerial and financial powers of the FPCs in order to control the outputs of general practitioners. (The FPCs became known as Family Health Service Authorities (FHSAs) from September, 1990.)

Before I highlight the details of the ways in which FPCs can administer, monitor and control GPs as a result of *Working for Patients*, I first focus on the changing nature of the FPCs. In 1985, the FPC's roles were extended to include accountability and resource management powers as they became involved in the developing and planning of services in their area. This was deemed a success and in 1989 the government stated their intent to further increase their role to include: the overseeing of GP indicative prescribing budgets; medical audit; practice budgets and the implementation of computer systems to aid the monitoring of referral rates and; general practitioner prescribing. In order for FPCs to be effective in these additional roles, the government sought to increase the financial resources available to them and change the internal structure and management arrangements.

Concerning the internal structure of the FPCs (referred to as FHSAs hereafter), the general management and rationalisation principles can be seen to be coming into play. There was a "slimming down" operation of the membership of the FHSAs. As with the hospital sector, the "small is beautiful" ideology can be seen. The original fifteen member composition was reduced to eleven. The chairperson, who is appointed by the Secretary of State for Health, leads the committee; there are four "professional" members (one from each family health service) acting, not as a representative for their occupation, as in the past, but serving in a personal capacity. The other members are four lay members who are appointed by the RHA, these again, are chosen for their personal contribution and experience and last, there is a chief executive who is appointed by the chairperson and the lay representatives. The chairperson is also a member of the RHA board. This latter membership was devised to increase the flow of communication between the two authorities and to gain continuity in the implementation of the White Paper. As a result of this reorganisation, general practitioners' involvement in the decision-making process in FHSAs decreased in two ways; first, the appointed GP is not acting as a representative of their occupational group and, second, they have no control over who gets appointed as the leaders of the FHSAs. In a similar manner, the sub-committees were also subjected to a slimming-down operation.

The general management principle which affected the hospital sector since the early 1980s is now integrated into the management of GMP. The new post of chief executive was devised to ensure the successful implementation of the changes stated in *Promoting Better Health* and *Working for Patients*. The key functions of the chief executive includes controlling, targeting, monitoring and instituting aspects of GMP. The person is to be known as the "General Manager" signifying this continuing general management principle. In the White Paper it is stated that "the salaries for these new posts will be set significantly above those of the present FPC administrators, so as to be attractive to good quality managers from both inside and outside the NHS" (Secretaries of State for Health, 1989a:61).

Performance-related pay and individual performance reviews are features of the General Manager post. (Similarly, these became aspects of the hospital managers contracts after the Griffiths Report, see section 1.6). The general manager is accountable to the RHA general manager. There was established in *Working for Patients* a two-year rolling operational plan for the FHSAs to manage their transition. Each FHSA is reviewed annually by the RHA. In addition, FHSAs have a full-scale review every four years by the Minister of Health or a senior official (a RHA official is present as an observer). For the reviews, FHSAs are required to provide details of their operational plans, report back on their achievements of previous plans, provide a health profile and give details of their performance indicators. FHSAs, through later legislation, are accountable to the RHA for their activities, instead of, as they were, to the DoH. The RHAs are responsible for allocating funds to FHSAs, appointing FHSA members, reviewing their performance and monitoring and co-ordinating plans in accordance with DHAs strategies. RHAs are referred to as the "grandparent" of the NHS and FHSAs and DHAs as the "parent". (See appendix D for a diagrammatic outline of these new lines of authority in the NHS in England and Wales.) In order for FHSAs to change their organisations and implement the changes set out in *Working for Patients* the financial resources available to them were increased. In real terms, this increase was just under ten per cent for 1989-1990 (excluding the sums for the development of premises and practice teams) in addition to the six per cent increase from 1988-1989. The management principle is not just restricted to the chief executive position, the government stated their plan to extend and strengthen management at all levels in the newly structured FHSAs.

In the establishment of the NHS during the 1940s we saw Willinks' concern for central versus local planning and control. Willink wanted a national responsibility for health care which involved a centralised control system and, at the same time he wanted a responsive system which reacted to local health demands at the community level. In the late 1980s a similar dilemma arises in the FHSAs' functions. There is a rise in the delegation of responsibilities to the FHSAs (which I come back to later) and an increase in the centralised planning for FHSAs. The NHS Management Executive, responsible for all operational affairs (who are accountable to the NHS

Policy Board) is responsible for the management of the FHSAs. The NHSME is now responsible for fundamental operational guidance, advising on the implementation of national policy and establishing an information strategy. Furthermore, they are responsible for the central development of information technology and allocating funds to RHAs which are then redirected to FHSAs. The NHSME liaison functions between the FHSAs and the health authorities was merged. It is hoped that this integration will decrease the divide between the hospital sector and primary health care and thus enable a rational and effective plan to be operationalised. Consequently, there is a much clearer line of authority for the FHSAs. As I argued in chapter 1, the centralisation of priorities and objectives and the delegation of responsibility to and the consequent accountability of, local management to the centre shows the top-down style of management evident in the NHS. (For a more detailed account of these changes refer to the NHS Review Paper (8)). So on the one hand, there is an increase in centralised planning and on the other, impositions on GPs to encourage local responsiveness to health care demands in the community. Aspects of these impositions are now explored.

3.3 "Imposed" Changes

GPs were subjected to certain state-initiated "imposed" changes. In order for general practitioners to play an increasing role in directing resources to local health care demands and assisting patient choice, the government sought to change aspects of the GP contract. Central to the government's plan is

> "making the terms of service more specific to reflect clearly the requirements of good general practice that better practices already meet in serving their patients... [and] amending the Statement of Fees and Allowances (SFA) so that the remuneration system becomes more performance related, enabling GPs who provide high quality services to get better paid" (Departments of Health of Great Britain, 1989:5).

In *Working for Patients* four areas thought to need strengthening were identified. These areas concern prescribing costs, the remuneration of GPs, medical audit and patient choice. I explore each one in turn.

With regard to prescribing costs, "indicative drug budgets" were implemented in 1991. The aim of this scheme is to control expenditure, promote the "value for money" principle and increase local responsibility. In the working paper, *Indicative Prescribing Budgets for General Medical Practitioners*, it is stated that "The objective of the new arrangements is to place downward pressure on expenditure on drugs in order to eliminate this waste and to release resources for other parts of the Health Service" (Secretaries of State for Health, 1989b:3). The Secretaries of State for Health attributed the need of this control as financial. It is stated that since 1984 expenditure on medicine had increased on average four per cent each year above inflation. In the White Paper it is asserted that there were large variations in the prescribing behaviour of general practitioners. The government believed that this was, to some degree, due to differences in the populations which GPs were serving, but more significantly as a result of general practitioners needing little interest or concern in the costs of their actions (see also David Mellor's statement above). The government aimed to increase GPs' awareness of the cost of prescribing. One of the ways that this was achieved was with the introduction of PACT (Prescribing Analyses and Costs), a recommendation expressed in *Promoting Better Health.* This scheme was piloted in 1989/90 in six FHSAs. The workings of PACT were integrated in *Working for Patients* to "provide a further incentive for doctors to adopt rational prescribing policies" (Secretaries of State for Health, 1989b:5).

The imposed indicative drug budget which affected GPs was not a radical change as such. Throughout the history of the NHS, there has always been concerns with the price of prescribing and general practitioners have inevitably found themselves rationing health care. Butler expresses this practice: "Resources in the NHS have always fallen short of the level that could beneficially be used, and doctors have always in consequence been obliged to constrain their clinical freedoms

within the resources made available to them" (1992:96). What was not apparent before *Working for Patients*, was the overtness of this rationing process. Butler (1992) suggests that, in making the rationing process more explicit, GPs (and their patients) are more likely to understand the financial consequences of clinical actions.

As we have seen, the responsibilities of the FHSAs have increased. One area which the FHSAs have increased their powers is in their control of the prescribing behaviour of GPs. In effect, the FHSA administers a cash-limit on the GP for prescribing. The FHSA allocates the funds they receive from the RHA. The Treasury was concerned at the increasing cost of PHC and cash-limits were introduced as a means to curb expenditure (Glennerster, Matsaganis & Owens, 1992). Until now, PHC was the only sector of the NHS which did not have such a limit.

The NHSME advises FHSAs on how to establish a policy for allocating indicative budgets to practices. FHSAs are required to discuss their particular approach with local medical committees (LMCs). Factors which influence the indicative amounts allocated to practices include the referral rates of patients to hospitals, special interests of practices and those serving patients who require unusually expensive treatment. Social and epidemiological factors are also taken into account. A practice's prescribing is compared to the average of all general practitioner prescribing rates in the FHSAs' area. Where the prescribing level is higher than average and there is an adequate reason for the higher rate, the amount will be set between the average and the actual amount. However, if there is no adequate explanation then the practice needs to adjust their pattern to a lower level. If the rate is below the average then the indicative amount is set at the average. Generic drugs are encouraged to be prescribed by the government as a method to curb costs.

Although general practitioners have always been rationing health care, they are now more dependent on their FHSA for funds than ever before. Hence, clinical decision-making is being interfered with by non-medical criteria. The set indicative prescribing amounts for GPs are monitored by their FHSAs. The GP practice is required to have an estimated monthly profile, in

accord with their FHSA's policy to enable the "effective and economic prescribing within budget" (Secretaries of State for Health, 1989b:9). Budget control is stated as a main function of FHSAs, thus deviations from their profile will encounter "corrective" action. The FHSA has the power to impose financial penalties on those who refuse to curb excessive prescribing. The assessment of questionable expenditure is conducted either by peer review (see the later discussion on medical audit) and/or by a request from the general practitioner to the FHSA for their advice and guidance. The FHSA uses the information from the GPs monthly profile and compares it with the actual rate of prescribing. Also, the FHSA collects dispensing and prescribing information and compares it with the indicative prescribing budget. As GPs are accountable to FHSAs regarding prescribing amounts, FHSAs are similarly accountable to and monitored by their RHA for their expenditure. FHSAs will receive a similar disciplinary procedure if they overspend.

Concerning the remuneration of GPs, changes were imposed which affected the way in which GPs were paid from April 1990. The dilemma experienced in the 1940s (see 1.1) of managing the individualistic general practitioners to take on new ideas of medical and administrative practice was, forty-five years later, directly confronted. We have seen that this dilemma has been approached in the past by the proposition of making all general practitioners salaried or part-salaried employees. This approach however, is not a feature of the 1989 White Paper. GPs, since *Working for Patients*, are accountable through certain bureaucratic controls if they are to maintain their level of income. The most significant change concerns the capitation fees for general practitioners. The government stated that its intention

> "in placing a greater emphasis on capitation in the remuneration system is to reward GPs who give a high priority to attracting and keeping patients by providing a high quality, comprehensive service. More money will follow the patient than has been the case in the past" (Secretaries of State for Health, 1989b:8).

There was a move away from the fee per item-of-service payments towards more emphasis being placed on capitation rates. The government changed the percentage of income which GPs received as a result of the number of patients on their list, from 46 per cent to over 60 per cent. GPs also gained a higher capitation payment for those patients over the age of 75 and there was a new

capitation rate for patients under the age of five years to whom child health surveillance services are made available. The new contract abolished a considerable number of GP payments, including fees and allowances concerning: group practice; vocational training; cervical cytology and childhood immunisation. These fees and allowances were replaced and the income generated would be channelled into other payments, principally capitation payments. Concerning childhood immunisations, pre-school boosters for the under five's and cervical smears, the existing item of service payment was replaced by target payments. Regarding childhood immunisations for example, there are two target levels: a higher level of payment is made to general practitioners which achieve 90 per cent coverage (the WHO target); and a lower level (a ratio of 3:1) for those reaching 70 per cent of their targeted population. The rationale for the increase in capitation was explained as follows: "The Government remains of the view that GPs have a stronger incentive to satisfy their patients if a greater proportion of their income is attributed to the number of patients on their list" (Secretaries of State for Health, 1989a:54).

It can be inferred that the government adopts the view that financial incentives encourage health promotion and screening and immunisation target achievement. The performance-related pay and target payment principle have been introduced to GMP, as with the other areas of the NHS. Both are new concepts for GPs. According to NHS Management Executive (1991), the changes in the GP contract proved to result in the desired strategic change. NHSME state that, after six months of the introduction of the new contract, over 80 per cent of general practitioners were achieving cervical screening, vaccination and immunisation targets. If a practice achieves certain levels then they receive a cash-payment for their work. Other ways in which GPs can "make-up" their income is discussed in more detail below.

The individualistic general practitioners are encouraged implicitly to work with others in their practice (or even in conjunction with other practices) in order to reach the required targets. GPs are being enticed by financial incentives, to take on new ideas of medical and administrative

practice. Control of outputs can be achieved it seems, whilst general practitioners maintain their independent contract status.

Other changes to the remuneration system include the reduction of the basic practice allowance. The amount received is dependent on the location of the practice and can be a zero amount. Also the imposed changes affect where GPs can live. They are now required to live within a "reasonable distance" from their practice to fulfil the requirements of their contract. The reasonable distance is defined by the FHSA. GPs also have to inform their FHSA of any other "professional" commitments.

Consequently, there are variations in general practitioners' incomes depending on the characteristics of their population, the geographic location of the practice and the types of services that they offer. A comparison of earning capacity of an urban GP before and after the changes to the remuneration procedure introduced in *Working for Patients* is given in appendix F. For a more detailed and thorough account of how GPs' pay is determined, see either the Departments of Health of Great Britain (1989) or Chisholm (1990).

The government seemingly intended medical audit to be part of every-day "professional" practice to enhance the overall quality of care given to patients. The audit takes two forms: an internal audit and audit by peer review. The government argues that medical audit can only be fully effective if it is led by members of the "profession" who are knowledgeable about current clinical developments. The Standard Medical Advisory Committee was asked to report on how the quality of medicine care could be enhanced by means of medical practice and on the development of indicators of clinical outcome. The report guided the medical audit scheme. The scheme is also a development from the "Quality Initiatives" produced by the Royal College of General Practitioners, such as *Quality of General Practice* (1985a) and *What Sort of Doctor?* (1985b). The government's definition of medical audit is presented on p.23.

Upon the scheme becoming fully operational, the government intended that all general practitioners, as part of their contract, participate in medical audit. It is stated in the working paper that the General Medical Services Committee (GMSC) sees medical audit as beneficial and recognises it as part of the "professions'" responsibilities. In order for the audit to be systematic, the government established an organisational framework for FHSAs (and Local Health Authorities) to work from. Within this framework, FHSAs need to establish a medical audit advisory group which includes doctors (community and hospital) and other medical workers. The formalisation of medical audit can be understood as another vehicle to integrate primary and secondary health care. LMCs are also consulted in the process. The advisory group is accountable to the general manager. Members of the group are expected to have regular contact with local practices. Although medical audit is an imposed change, members of medical bodies are consulted and an agreed system of audit has to be reached. The findings are not, however, exclusive to the GPs and the medical audit group. FHSAs do have access to the general audit results and they will take remedial action where they deem appropriate. FHSAs also have the authority to undertake independent audits in the form of a combined "professional" and managerial appraisal or as an external peer review.

Whereas the process of medical audit is ostensibly in a consensus-management spirit, where the government and medical practitioners work together towards an agreed result, it is an imposed change as it is a contractual condition where there are managerial inputs. Traditionally, financial controls could not be imposed on GPs as they are independently contracted, thus if treatment and referrals in primary health care increased then costs increased. The government had few means to prevent it. However, in a like manner to hospital doctors after 1948, general practitioners are now somewhat controlled and regulated by state restrictions due to changes in their contract. In the assessment of clinical practice, "professional" autonomy is being challenged and to use Klein's (1989) term "professional perfectionism" has been abandoned in primary health care. The following excerpt illustrates this:

> "While the practice of medical audit is essentially a professional matter, management too has responsibility for seeing that resources are used in the most

> effective way, and will therefore need to ensure that an effective system of medical audit is in place" (Secretaries of State for Health, 1989c:6).

Medical audit has an additional unique function. In the internal market, quality of care has to be maintained in conjunction with the promotion of the competitive pricing for services. Medical audit preserves the "value" of clinical care "for money".

Regarding patient choice, the government maintains that it underlies most of the changes in *Working for Patients*. The government put an unprecedented emphasis on the patients' role in the planning and operation of the NHS. Putting patients first is the rhetoric of the government. Margaret Thatcher states that "The patients' needs will always be paramount" (*Working for Patients*, 1989a:Forward). Through informing the public; making it easier for patients to change GP; making the remuneration system more responsive to the needs of the patient; and striving for "better value for money", are all ways in which the government aims to achieve this end. The patient-influence aims are also supported by the restrictive procedures which restrained patients from changing their doctor were removed. Additionally, the aims are supported by the imposition on GPs to produce a practice leaflet. This was believed to enable patients in making an informed choice when registering with a doctor.

The government espoused that general practitioners could be more responsive to the needs of their patients and increase their role in the steering of resources in the health service as a result of these state-initiated "imposed" changes. These imposed changes mainly comprised modifications to the GPs contractual arrangements where GPs have become more accountable to FHSAs. Four areas have been examined: prescribing costs; GP remuneration, medical audit and patient choice. How these are said to affect the day-to-day practice of GPs in the Midlands are explored in the empirical chapters.

We have seen that there are two competing theories on how to achieve a rational and effective health care system. On the one hand, we have seen in the imposed changes that accountability and

financial controls have increased and the funding arrangements are top-down. On the other hand, there are "invited" changes, such as the fundholding scheme, where there are fewer bureaucratic controls. The aim here is to encourage general practitioners themselves, to be more responsive to their patients' needs. To allow this arrangement, the funding provision here is bottom-up. What I have called the "invited" changes are now examined.

3.4 "Invited" Changes

The imposed changes described above affect all GPs. There are a number of additional choices and options available to general practitioners - these are termed "invited" changes. The invited changes explored here are the practice budget scheme, the computerisation of practices, minor surgery and other "in-house" clinical work and post-graduate education. The bulk of this section is devoted to examining the budget-holding programme (now known as fundholding).

The budget-holding invited change was initially seen as a marginal aspect of the NHS reforms (Judge, 1992). Since 1990, there has been a growing interest in budget-holding (referred to as fundholding here on) and it has become an increasingly important element of the government's reform programme. Glennerster, Matsaganis & Owens explain: "At the start of the reforms many commentators and managers saw fundholding as an experimental side-show. However, it provoked a lot more interest than most health managers expected" (1992:5). In the first wave (April, 1991) 306 practices in Britain became fundholding practices. In the second wave (April, 1992) there were an additional 280 practices and more than seven hundred joined the scheme in the third wave (April, 1993). In 1993, about 25 per cent of the population are registered with a fundholding practice (Holliday, 1992) and in 1995 this percentage rose to 40 per cent of the population being cared for by a fundholding practitioner (Kuper & Adonis, 1995). The principle here is that GPs act as commissioners of health services. This was originally a feature of the draft

Green Paper *Primary Health Care: An Agenda for Discussion* in 1985 (Glennerster, Matsaganis & Owens, 1992). However, it did not feature in the final publication. Nor was it a feature of the White Paper *Promoting Better Health.* Both these documents urged solely for tighter managerial and financial controls over general practitioners to perform their traditional duties, seemingly the antithesis of the fundholding philosophy.

Fundholders manage and control their own regionally-set budgets from which they are responsible to secure a defined range of primary health care services and hospital services on behalf of their patients. It is this self-management and control which distinguishes them from non-fundholding practices. Instead of GPs relying on the DHA to purchase services on their behalf, fundholding GPs can "shop-around", as advocates of their patients, for services in the internal market. The government viewed the fundholding scheme as an "opportunity [for GPs] to improve the quality of services on offer to the patient, to stimulate hospitals to be more responsive to the needs of GPs and their patients and to develop their own practices for the benefit of their patients"(Secretaries of State for Health, 1989d:3). In this way, fundholding can be seen as a means to bridge the gap between hospital consultants and general practitioners and hence integrate primary and secondary care sectors. In the White Paper, this is implicitly recognised: "Hospitals and their consultants need a stronger incentive to look on GPs as people whose confidence they must gain if patients are to be referred to them" (Secretaries of State for Health, 1989a:48). The two branches of medicine have a long history of disagreement (see section 2.2). Two-way communication between GPs and consultants is essential in the internal market and is a way for each occupational group to learn of the others activities (Hughes & Gordon, 1993). Glennerster, Matsaganis and Owens (1992) point to the redressing of the balance of power between the two groups as a motive for the fundholding scheme: "Giving a budget to a GP with power to buy hospital services might help begin to redress the loss of professional status and power, relative to the hospital consultant, that family doctors had suffered for the best part of this century..." (1992:9). The government's principle of increasing the financial incentive for general practitioners will result, they claim, in an increased quality of care for the patient: "...The Government will introduce a new scheme for

enabling money to flow with the patient from the GP practice itself... Both GPs and hospitals will have a real incentive to put patients first" (Secretaries of State for Health, 1989a:48).

There are number of criteria which general practitioners have to fulfil in order to apply for fundholding status. For the first wave, practices had to have 11,000 or more patients on their lists. This number was reduced to 9,000 in 1992 and 7,000 in 1993. Consortia of smaller GP practices can also apply. Practices have to show a capability of managing their own budget, through, for example, possessing IT systems and having adequate administrative staff. Applications for the scheme are made to and approved by RHAs. If a practice is declined fundholding status, they can appeal to the Secretary of State for Health. Practices do have the option of opting-out of the scheme if they give reasonable notice. The GP's FHSA will continue to hold their contracts and will be responsible for monitoring expenditure against the budget.

Once a practice, or group of practices are accepted to the scheme they can then manage their budget in three areas; hospital services, practice services and prescribing. Each area will be discussed in turn. Additionally, from April 1992 fundholding practices were permitted to buy services from community nurses and district health authority health visitors (Wood & Sherman, 1992). Concerning hospital services, there is a limited range of hospital services which fall into the scheme and generally concern those where there is a choice over the time and place of the treatment. In *Working for Patients* these were referred to as "a defined group of in-patient and day case treatment covering most elective procedures. Emergency admissions and medical admissions are excluded; out-patient services; diagnostic investigations of patients and their specimens" (Secretaries of State for Health, 1989d:5). A general list appeared in the later document *Practice Budgets for General Medical Practitioners* (Secretaries of State for Health, 1989d) and a more specific list can be found in a later Act - the *National Health Service and Community Care Act* (Departments of Health, 1990). It is in this latter Act that the government gained it's legal powers to implement *Working for Patients* (and *Caring for People*, Secretaries of State for Health, 1989e). All the services listed concern the treatment of easily diagnosable disorders which are

relatively inexpensive and do not require prolonged after-care treatment. In order for GPs to avoid becoming "bankrupt" by expensive patients, a financial ceiling of "say, £5,000" was put in place for the cost of treatment for any one patient within a year (Secretaries of State for Health, 1989d:8). Excess of this amount would be charged to the patient's DHA. The GPs' budget amount for hospital services is deducted from the DHA budgets. The amount given to GP practices for these services was initially calculated on past referral rates, however as the system matured the amount is determined by the number and characteristics of the patient population that the general practitioner is serving (ie. on the basis of the preferred capitation fee).

The budget also includes the cost of approved practice services, such as staff costs. Staff costs are cash-limited for non-fundholders since April 1990 under the *Health and Medicines Act* (Department of Health, 1988). Fundholders are exempt from this imposition and have the freedom to decide if they wish to spend more funds on staff and less on say, hospital referrals (I come back to this point later). As 70 per cent of the staff costs were directly reimbursed by the FHSA under the existing system, the amount allocated directly to the fundholding practices is deducted from the FHSA's budget. Other payments, such as the "Cost Rent Scheme" and improvement grants, which are also cash-limited since April 1990 under the *Health and Medicines Act* (Department of Health, 1988), are accounted for in the GP's budget. Concerning GPs managing their own prescribing drugs budget, the scheme operates in a similar way to the indicative prescribing scheme as the amount is be set by the FHSA, but the amount will be an actual amount not an indicative one.

The advantages for the general practitioners opting for fundholding scheme include the freedom to "shop-around" for services (as described above), a start-up fee and some degree of flexibility in how they spend their budget. The start-up fee in 1991 was set at £16,000, in addition to an annual management fee of £33,000. As more GPs opt for fundholding status these fees however are decreasing (Holliday, 1992). Concerning the budget, which is paid monthly in advance by the RHA, it can be spent in any proportion in the three areas at the practice's discretion. Non-

fundholding practices do not possess this flexibility. There are some bureaucratic controls built into the scheme though, which can affect the way in which GPs behave. Budgets are reviewed periodically by the RHA and practices are expected to remain within their limit. However, there is a degree of flexibility here - fundholding practices are allowed to overspend by up to five per cent of the budget in any one year on the understanding that it will be deducted from the following year's actual funds. If overspending persists for more than a year the FHSA will carry out a thorough audit. "Savings" are carried on to the following year providing they are spent on patient care.

The fundholding scheme was described in *Working for Patients* in a skeleton-form. The government depicted a general picture and intended for the finer details to be worked out as they arose in the first years of its operation. This design gave GPs, especially first wavers, the opportunity to influence the details of the scheme as they became involved and as the problems evolved. The other invited changes concern financial rewards for actions which the government view in-line with their policy aims. The areas briefly discussed here concern: the use of IT in GMP; post-graduate education allowance; child health surveillance; minor surgery and health targets.

The government actively encourages the computerisation of practices and the development of communication and information technology. The computers and software packages, such as G-PASS, are intended to assist general practitioners in the administration of their practices and especially in health prevention and prevention of ill-health matters. The computers are also expected to aid FHSAs in their monitoring of referral rates and GP prescribing. GPs are invited to participate in this scheme and those practices which install appropriate systems receive a 50 per cent direct reimbursement for the running costs. This scheme was stated to run until 1993.

As proposed in *Promoting Better Health*, the Vocational Training Allowance and the Post-graduate Training Allowance was abolished. The Post-Graduate Education Allowance (PGEA)

replaced these two schemes. Under the new system, Principals and Associates are invited to partake in the scheme. As an enticement, GPs receive a financial incentive in addition to the payment of course fees, travel and subsistence costs. The courses focus on three areas: disease management; service management and health promotion and prevention of illness. To qualify for the payment, at least 25 days need to have been attended in the five year plan and at least two courses in the three areas need to have been covered. Payments are made yearly and are substantial; for example, if the requiring yearly five full-day sessions are attended, the general practitioner will receive a fee of a little over £2,000.

Childhood Health Surveillance (CHS) allows suitably trained GPs to receive a capitation payment for each child registered with them. The parent of the child can choose to have their child examined by the DHA, the existing arrangement, or by their GP (if trained). The principles of patient choice and competition are seen here. In 1991, after six months of the new contract, 53 per cent of practices were taking part in the CHS arrangements (NHSME, 1991).

Minor surgery is an area which the government intends to promote in general practice. A new payment was formed to reward those GPs performing minor surgery. Providing the general practitioner has the relevant training, he or she can perform up to 15 operations in a quarter. If a GP performs one session every month, he/she will receive a payment of £480 (see appendix F) and if the maximum number of operations are performed the GP could receive up to £2400 per year. This scheme blurs the separateness between hospital consultants and GPs and is also congruent with the "value for money" principle. The task of surgery has historically been based in the hospital sector, so if minor surgery can be performed in GMP the work-task distinctions between the two occupational groups will diminish. Six months into the new contract, 68 per cent of GPs had been approved to perform minor surgery and nearly a quarter of a million minor surgery treatments took place (NHSME, 1991). These might have been otherwise referred to the secondary sector. Also, the status of the GP, it can be is enhanced. Furthermore, the training of doctors (both community and hospital doctors) is a general training, until the final years and

involves a large capital outlay. As newly trained GPs can perform surgery and more established GPs can be retrained, it is cost-effective to encourage the practice of minor surgery. In 1996 the Minister of Health, Stephen Dorrell aims to continue this trend. In a meeting with the BMA to discuss "what amounts to a new vision of general practice" (Timmins, 1996:2), Dorrell proposed that GPs become more involved in minor accident and emergency services outside hospital care, among other services traditionally provided by the secondary sector. This, he said, would provide a "huge opportunity to improve the quality of service to patients and make work more rewarding for staff in the medical profession" (cited in Timmins, 1996).

The other invited changes concern target payments, previously mentioned in relation to remuneration, and payments for health promotion clinics (which are performed in addition to those required to fulfil the new contract). Clinics which are financially honoured include well-person, anti-smoking and stress management sessions. In the first six months, 250,000 sessions took place (NHSME, 1991).

It is not clear why there are two competing models for PHC. The bureaucratic controls have increased for non-fundholding GPs and seem to have been reduced for fundholding GPs. The dilemma of local versus central planning seemingly has not been resolved. As "ideal types" there is a top-down decision-making structure for the nonfundholders and bottom-up decision-making structure for the fundholders. Possible reasons for the two purchasing agents, the DHAs and the GP fundholders, could be that there is a need for a purchasing agent for the GP practices which cannot fulfil the fundholding criteria, or, as Glennerster, Matsaganis and Owens (1992) believe, that the fundholding scheme is a means to control expenditure. They state: "There was a suggestion [from the Office of Health Economics] that if GPs were offered more freedom in the use of a larger budget they might be prepared to accept a cash limit on their whole allocation of funds, including prescription costs" (1992:8). If this latter argument is accepted then there are two philosophies incorporated into the "state-initiated change strategies" on how to manage GPs. The first philosophy concerns the imposed changes which predominately concern cash-limits. These

can be understood to be a means to control and restrict expenditure in PHC, ie. control costs externally from the PHC practice. Whereas the second philosophy concerns the invited changes which encourage GPs to take more control over and responsibility for their finances and thus perform cost-saving activities, ie. an internal control of expenditure in PHC. Could it be that there are two different sorts of GP which respond to different forms of management? I explore these issues further in the later empirical chapters.

3.5 General Practitioners and the Internal Market

In section 1.7.3 a general introduction was given to the workings of the internal market. Here, this is expanded on in relation to GPs and with a little more depth. In this section I build on the previous ideas and explore some of the origins of the internal market in England. The separation of the purchaser and provider roles in health is known as the internal market. It can be said that markets in England existed before the set up of the NHS. People have always changed their GP as their circumstances changed or because they were dissatisfied with the service that they received (Holliday, 1992). What is different in the "internal market", is that budgets have been given to purchasers (GP fundholders and DHAs) to secure health provision from the providers. There are other purchasers too; private patients and insurance firms and there are three providers of health care; DMUs, hospital Trusts and private units.

"Provider competition" and other rhetorical terms of the market place has become integrated into the NHS since the 1980s. Ancillary services went to "tender" in 1983 and by 1986, 21 per cent of the NHS contracts were held by private companies (Key, 1988). The seeds of the internal market began after the implementation of the *Health and Medicines Act* (Department of Health, 1988) and became law after the *National Health Service Community Act* (Departments of Health, 1990). In 1988, Health Authorities (HAs) were permitted, in addition to their other responsibilities, to

buy and sell services, land and so on, in order to generate income. The cost of the health service has long been a concern to the government and although income generation was not as lucrative as the health ministers envisaged (£10 million less than expected in 1988-89) (Butler, 1992), commercial enterprise became part of the HA activities. The distinction between the private sector and the public sector behaviour was becoming less distinct and this trend has continued. Butler (1992) points to the experience of the HAs as a significant catalyst for this change. HAs needed to become increasingly aware of their financial arrangements and patients being treated from other areas became a problem. HAs were often reimbursed two years after the referral. By 1987, some London hospitals, such as Guys hospital, would only accept a patient referral if a price was agreed prior to the treatment (Glennerster, Matsaganis & Owens, 1992). Cross-HA charging had initiated the internal market into practice. The internal market is a form of devolution of decision-making. There is the assumption that "money will flow with the patient... The practices and hospitals which attract the most custom will receive the most money. Both GPs and hospitals will have a real incentive to put patients first" (Secretaries of State for Health, 1989a:48). It seems to be believed that economic incentives will improve the quality of care.

In 1991, the change towards dividing the purchasers and providers roles in the NHS was a gradual one. The government intended for patients to be referred from PHC in a "steady state". That is, in a similar fashion to before the changes but for the referrals to be made in a "contract mode" (Glennerster, Matsaganis and Owens, 1992). There could be a number of reasons for this including: first, there was a limited number which opted for fundholding and Trust status (in comparison to the size of the NHS), so an internal market could not effectively operate on a large scale; second, the hospital sector did not have an established pricing policy in place in order to realistically charge purchasers for their services.

The workings of the internal market are advocated by the government to advance the efficiency and patient choice principles. In *Contracts for Health Services* (1990) it is stated that:

> "The proposals for contractual funding for hospital and community care will promote efficiency and enhance consumer choice. Contracts will have a critical

> role as the vehicle through which Health Authorities secure the services required for their population and meet their obligation to improve the efficiency of service delivery with the allocation of resources" (Departments of Health, 1990:4).

As mentioned earlier there are two competing models of health care operating side-by-side. One is where DHAs acts as commissioners on behalf of non-fundholding GPs patients (also for the services outside of the fundholding scheme). The other model is where fundholding GPs act as commissioners on behalf of their patients. Fundholding GPs, acting as advocates for their patients, arrange contracts with the providers. Although the contract can take three forms, they are not quite so distinct in practice: cost per case contracts are where a price is agreed for a single referral. Cost and volume contracts are where the number of cases are defined and the cost of an extra case is specified. Block contracts are where a set price is agreed and the GP can refer as many patients as needed. In practice, the contract may begin with as a block contract and change to a cost and volume through time. Most of the contracts are specific, indicating a time framework for when the referral can take place, a notification to the GP on treatment and tertiary referrals only being made after consultation with the GP (Glennerster, Matsaganis and Owens, 1992). Although DHAs act in a similar manner in the negotiation with the secondary sector, Glennerster, Matsaganis and Owens, argue that GPs feel that the DHA has sided with the provider units which has caused some confusion. Examples of contracts can be found in the appendix of *Contracts for Health Services* (NHSME, 1990). GPs' views and opinions on the internal market will be explored in chapter 6 and 8.

3.6 Rounding Up

Working for Patients is the most radical change to affect GMP since 1948. The aims of the White Paper is argued to rationalise GMP by increasing the significance of financial and managerial arrangements in order to further efficiency and competition principles. The "business" ethos is explicitly stated by the government as a way forward for GPs and GMP. We have seen provisions

to support this shift away from traditional forms of practice, such as the streamlining of the structure of the NHS. In general terms, this allows for accountability and efficiency. In specific terms, there are financial incentives to encourage GPs to "commercialise" their practices. These include provisions such as the management allowance and computer reimbursement.

GMP is now seen as the focus of the NHS with GPs functioning as health advisors and "gatekeepers" to secondary and tertiary care. The NHSME state that, "General practice will therefore have a more pivotal role to play in the development of a more integrated service" (1991:2). We have seen that there is an increase in general management in PHC where the individualistic GPs are being increasingly managed through contractual controls. There is the underlying presumption by the government, that economic incentives result in an increase in the quality of care for patients. Thus rewards are given to an "instrumental" orientation to work, as opposed to say an "intrinsic" orientation (Goldthorpe, Lockwood, Bechhofer & Platt, 1968).

A number of the dilemmas which Klein (1989) raised, as discussed in the first chapter have been returned to in *Working for Patients*. The central verses local planning dilemma has been confronted with the further decentralisation of responsibilities in the management of day-to-day issues, to the FHSAs and to GMP itself. There is also the maintenance, if not an increase in, the centralised controls of these two bodies. Indicators of this are the prevalence of performance-related pay and the tight government objectives. The administration dilemma concerning GMP has been readdressed by the slimming-down operation in the FHSAs and the development of a more localised management provision. Concerning the dilemma of decision-making and accountability, there is a clearer line of accountability throughout the NHS and GMP has lost its peripheral status as it has become more integrated into the planning and organisation of the NHS. Decision-making is being encouraged at a local level; this is especially seen in the fundholding practices. Lastly, concerning the integration of primary and secondary care, we have seen a development in the closer working relationship between GPs and consultants. This closer link has principally arisen, in theory, as a result of the power shift between the two occupational groups.

Seemingly consultants are dependent now on GPs for their custom through contractual arrangements (be it a fundholding or non-fundholding practice). These dilemmas have been tackled by the imposed and invited changes introduced in *Working for Patients*. Bryden succinctly summarises the changes which have affected GPs in the last decade:

> "The GP has metamorphosed from a professionally and managerially isolated healer of the sick, through to a member of the primary health care team during the decade or so when consensus-management was fashionable and on the slick, efficient, competitive and highly audited provider of health care envisaged by the present Government" (1992:66).

In the previous chapter we saw the changes which led up to the "state-initiated managed change strategy" examined here. In this chapter, I have accounted in some detail the government's ideas and policies which have (potentially) affected GMP in the last few years. In the next chapter the existing conceptual tools for understanding change of this sort are assessed. Consequently, a conceptual framework for analysing the empirical "data" will be presented along with a discussion on research methodology. The research methods, used in this investigation, are examined in chapter 5.

Part II

Conceptualising, Reflecting and Researching

How can we know
the dancer from the dance?

W.B. Yeats

Chapter Four

Conceptualising General Practitioner Orientations

4.0 Introduction

In this thesis so far a detailed analysis of the development of the NHS has been undertaken and a more focused analysis of the occupational development of general practitioners. From these examinations we can see a number of patterns emerging which underlie the changes that have occurred in both the NHS generally and general medical practice more specifically. The purpose of this chapter is to achieve a better and more conceptually-based understanding of these processes of change. By examining and critically analysing available ideas in organisational thinking, a conceptual framework will be developed to shape an empirical and closely focused study which will complement and develop the more historically-based analysis.

Conceptual models are used to isolate particular aspects of the world for analysis: they are simplified representations which aid the understanding of social phenomena. The model which I develop to understand the management of "professional" change, suggests three areas of analysis - the individual, the occupation and the organisation. These sections are not rigid dividers but useful divisions intended to aid understanding of complicated phenomena. In this way, through exploring the interviewees' sense-making rationales, I can study the components of change processes past

and recent. In particular, actors' sense-making rationales are viewed in relation to their orientations to work - the nature of practising general medicine is categorised as an occupational-grouping as well as an organisational activity. Studying both the occupational and the organisational dimension of general practice permits a broader understanding of how participants interpret and put meaning to their actions.

This chapter is divided into five parts. First (4.1), I explore the importance of investigating individuals' accounts of their experience, perceptions and understandings. Second, (4.2) there is a discussion of the orientations to work in general terms. Third, in section 4.3, I focus on the nature of being a general practitioner in the sense of an occupational-grouping as a dimension of orientations to work. Fourth (4.4), there is an examination of the organisational dimension of orientations to work. Tensions between the "professional" and "administrative" principles of work control are examined and organisational change is briefly analysed in terms of understanding better the state-initiated managed change strategies" in primary health care. There is a rounding up of these analyses in section 4.5, where a conceptual framework is presented. This framework gives shape to the empirical "findings" in the forthcoming chapters as well as to the historical analysis already given. The practical method steps which were taken in this investigation are discussed in chapter 5.

4.1 A Phenomenological Perspective: The Individual, Identity and Meaning

The methodological assumptions of this investigation follow from the adoption of a phenomenological perspective. There is not a clearly defined "tradition" or "school" of phenomenology. I use the term as an umbrella to include ideas from the following perspectives: symbolic interactionism (Blumer, 1969b), interpretative sociology (Mills, 1959), social

constructionism (Berger and Luckmann, 1971) and naturalistic inquiry (Lincoln and Guba, 1985). Each of these perspectives hold or highlight different aspects of inquiry. However, all stress the importance of studying the individual in an investigation. There is an emphasis on the actors' interpretations, perceptions, priorities and opinions of their social world. This is essentially the aim of a phenomenological investigation. Van Maanen explains that it "...is a philosophy of the unique, the personal, the individual which we pursue, against a background of an understanding of the *logos* of Other, the Whole or the Communal" (1984:ii).

In a phenomenological inquiry, there is an emphasis on the qualitative which is distinctive from the more traditional quantitative sociological investigation. Bryman (1989:24) explains the two approaches as follows:

> "The most central characteristic of qualitative, in contrast to quantitative research, is its emphasis in the perspective of the individual being studied. Whereas the quantitative research is propelled by a prior set of concerns, whether deriving from theoretical issues... qualitative research tends to eschew the notion that the investigator should be the source of what is relevant and important in relation to that domain".

When conducting qualitative investigations the researcher elicits what is deemed important to individuals using various "tools" (which I come back to later) as well as documenting the actors' interpretations of the social world in which they work. This is done through in-depth interviews with individuals to elicit how they interpret their lives and "environment". The research methods used are explained in the next chapter.

It was Schütz whom initially provided an interpretation of phenomenology and its usefulness for the social sciences from its origins in the philosophical writings of Husserl (Lester, 1984). Schütz was interested in how people experience the social world and held the view that people see the world as if it were "out there". There are a number of unquestioned assumptions used by people to interpret and to construct paths of action within it. Schütz refers to the recipes employed to act and to interpret the everyday world (the unquestioned assumptions) as "stocks of knowledge" (Schütz, 1962). The stock of knowledge provides the base for typifying and categorising ourselves, others,

situations and the world generally, to enable sense-making. Schütz stresses that these stocks of knowledge are not static, but change according to what we deem as relevant and of interest. The sense of "our self" changes as we gather new information and construct different categories to understand our everyday lives. Schütz explains; "It is our interest at hand that motivates all our thinking, projecting, acting and therewith establishes the problems to be solved by our thought and the goals to be attained by our action" (1970:111).

The aim of an inquirer is actively to enter the worlds of the actors and to interpret those worlds from a theoretical framework which is grounded in the behaviours, definitions, languages, beliefs and feelings of those studied. To achieve this aim it is necessary to take ethnographically rich accounts and to acknowledge that, as humans, we have different perceptions of the world. The way we act depends on how we see it and our place within it. As Denzin points out, "humans have social selves and as such act in ways that reflect their unfolding definitions of the situation" (1971:38).

4.1.1 Accounting

The use of accounts is important in this process. How individuals construct their world and account for their actions influences what they do: the typifications and categories employed by individuals influence how they choose to act and behave. According to Scott and Lyman (1968:46) an account is

> "...a linguistic device employed whenever an action is subjected to valuative inquiry... a statement made by a social actor to explain unanticipated or untoward behaviour - whether that behaviour is his [or her] own or that of others, and whether the proximate cause for the statement arises from the actor himself [or herself] or from someone else".

It must be remembered that what people say is not necessarily what they do. How individuals behave is dependent on a combination of factors such as their interpretations, priorities, values

and the situation at hand. It must also be noted that retrospection allows meanings to be formed (Lester, 1984). As we "step out" of a situation, it is easier to typify our actions. Hearing an individual's account of themselves and their social world gives us an indication of the processes of self-perception, the values that they draw upon and the meanings that they ascribe to their lives.

In relation to the individuals investigated in this study, it is believed that general practitioners and other actors in health provision draw upon their experience and understanding of general practice, the NHS and of the world in general (otherwise called their stock of knowledge). This stock of knowledge is used by the GP to interpret the nature of and how to take action on, say, the implementation of *Working for Patients*. They then, depending on how they perceive the "state-initiated managed change strategies" along with the resources which are available to them, are likely to behave or respond in line with their constructed "theoretical" model. Questions such as "what attracted you to be a GP?" and "what does it mean to you to be a GP now?" were asked in order to hear their account of their decision-making and interpretative processes. In this way an understanding of how the general practitioner constructs their identity, in relation to their work, can be achieved. Furthermore, I argue that the historical analysis conducted in the first three chapters is, in itself a set of "accounts". Writers (including myself) have attempted to make sense of the developments in general medical practice and in the NHS, based on the information available to us. Equally, the stories or accounts given by the actors interviewed and studied, are of the same nature: attempts to make sense of complicated phenomena.

4.1.2 Social Actors

My referral to the individual as an "actor" requires some explanation. The term does not directly relate to the theatrical meaning of the word. Instead, the usage of describing individuals as social "actors" signifies an understanding that people consciously make choices concerning their lives.

Social actors act intentionally in the world and guide their actions from the typifications which are held and by retroflecting on past actions. The social actor is perceived as a conscious, living, feeling person. This is to take an "existential view" of a person (Anderson, 1991). Fontana usefully describes the relationship between "self" and society:

> "The 'self is existential' because it is an incarnate self, filled with rational thoughts, sudden emotions, deeply felt anxieties, biological urges, and cultural elements. The self is 'in society' because it is a self embodied in the world; because it is studied in its natural settings, and in its interacting stance, and in its experiential confrontation with society" (1984:11).

To describe an individual as an actor is to emphasise the subjective intentions of his or her actions. Weber (1968) considers action to be subjectively meaningful behaviour. Correspondingly, action is derived out of meaning: it is the patterns of meaning, supported by the use of the actor's stock of knowledge, which constitutes their social "reality". Action is a continuum of occurrences which are bracketed, interpreted and added to the existing stock of knowledge that an actor possesses. Weber (1968) considered action as subjective. This is not to say that we are solipsistic or live in isolation of others. The behaviour of "others" is taken into account and affects the way in which we see the world. GPs do not work in isolation: they interact with peers, other members of staff, patients and so on. As the stock of knowledge provides the grounds for typifying others, this categorisation becomes the "in order to" motives for the actors own self-typification and action. Schütz describes this process in the following manner:

> "The world of everyday life is from the outset a social and cultural world in which I am interrelated in manifold ways of interaction with fellow-men known to me in varying degrees of intimacy and anonymity... I can however, experience them in their typicality. In order to do so, I construct typical patterns of the actors' motives and ends, even of their attitudes and personalities, of which their actual conduct is just an example. These typified patterns of Others' behaviour become in turn motives for my own action, and this leads to the phenomenon of self-typification" (1962:60).

4.1.3 Assumptions

In taking this naturalist or phenomenological approach, there are a number of assumptions which need clarifying (cf. Lincoln and Guba, 1985). First, there are multiple realities that exist for each person and between people when describing things or events. Second, the phenomenon, action or occurrence needs to be situated in a social context. Some argue that a much broader cultural context needs exploring to look at wider environmental influences. However, in this study the boundaries are defined by the participants and restricted to the NHS organisation. The third assumption is that the researcher and the participant are interconnected. I have had an active input into the nature of the study and have influenced the "findings" as I interacted with the participants in "data" gathering process. Each of these is now discussed in turn.

i. Multiple Meanings

It is accepted that there are many meanings which people can draw on to explain a social situation. It is acknowledged that the reality is not a "given" but is interpreted and constructed. As mentioned earlier, there is an emphasis on the unravelling of social processes and actions in terms of the actors' own terms of reference. By adopting this approach, we can often access the "inaccessible" views, such as the "informal" interpretation of social "reality". What people say and what they actually do can be different, so we must look further than the "formal", or the perceived acceptable, viewpoint. A tendency in social science research is for the researcher to find *the* interpretation of what something is. Accounts of participants are often compared to the accounts given by the people "in charge". Researchers are often inclined to compare and contrast the "correctness" of others' interpretation to that of the managers, for example, or others in authority (Bryman, 1989). This approach is often, in my view, mistakenly taken to be the "right way" to proceed when understanding the nature of what is being studied. Within the approach that

I am taking this "correctness" is not sought. Rather, the interpretations and meanings given by the actors involved in primary health care have been pursued, where each account is as important and influential to the study as the next. In this sense, the interpretations offered are neither "right" nor "wrong". The use of primary (and secondary) constructs in the later empirical analysis emphasises this importance and its necessity in the understanding of how the "state-initiated managed change strategies" are perceived. The different views that we hold are linked to the sense of being human. We as humans, constantly strive to derive meaning from our lives. Watson provides a delightful comparison between humans and hedgehogs to highlight what it is to be. Watson writes:

> "The hedgehog does not worry about whether or not its mother loved it or in what kind of esteem its held in by other hedgehogs. Neither does it worry about the eventuality of its demise: it has no words for death, no concept of mortality... Humans do not have guidelines for behaviour and interaction with others 'wired into' their brains. Humans have continually to 'work on' their humanness... They have to achieve humanness. *We have an awful lot we need to make sense of to survive mentally*" (1994a:19).

The point of this comparison is to illustrate the difficulties that we, as humans have, unlike hedgehogs. We have a consciousness and hence an ability to moralise, to think about our place in the word and in relation to others. In this way, phenomenology is about "self", as the originator of experience within a biographically-determined situation (cf. Giddens, 1991). People judge situations on what they know (their experiences) and the limits of their mental capacity.

ii. Social Context

The second assumption concerns situating the phenomenon, act or occurrence in its natural setting. To consider the actors' domain, an understanding of their social and cultural context, is essential when conducting research of this nature. The social processes in a social setting (as opposed to an emphasis on structure) are the focus of phenomenological research. Hammersley and Atkinson (1983) urge the use of this approach and state what a person says and does depends, to some degree, on their social context. Hammersley (1992), however, later questions the ecological validity of ethnographic research.

By interviewing and observing the actors in their social worlds (their surgery, for example), insights can be gained. Talking and interviewing people in their place of work allows us to be "culture-hunting tourists": other snippets of information can be gathered such as what objects GPs have in their surgery and how they converse with others. Inferences can be drawn from this. Goffman, in his study of *Asylums*, stated the advantages of investigating patients in their natural setting as allowing the perceptions of the asylum-dwellers to be heard, instead of confining them to the "medical categories": "It is my belief that any group of persons, primitives, pilots or patients, develop a life of their own that becomes meaningful, reasonable and normal once you get close to it..." (1961:7). As time was spent with general practitioners in their "environments", idiosyncrasies, issues and values could be explored which otherwise would not have been touched upon if a "distant" method of collection was used.

A criticism of phenomenological studies is their failure to recognise the historical and macro social structures which shape human experience (Anderson, 1991). The use of organisational, historical and socio-political contexts in this study overcomes this criticism, and are employed to enhance the understanding of the change processes being examined. The first three chapters set the context for and examine the developments leading up to *Working for Patients.* The use of these comparative materials also helps to cast light on the recent developments. Referring once more to Mills and his quest for a sociological imagination, he stresses the potential for using historical analysis: "...To get a comparative grip on it [what you are examining], you have to place it inside a historical frame... This sometimes results in points useful for a trend analysis, or it leads to a typology of phases" (1970:237). The individual responses to the implementation of the White Paper are explored in chapter 8.

iii. Individuals in the World

The third assumption concerns the interrelation between the individual and the world. People do not live in isolation from outside influences. The cliché "no man is an island" summarises this. The stock of knowledge which people develop is derived from notions of self and their relation to the wider environment. As Meltzer *et al.* explain: "The behaviour of men and women is "caused" not so much by the forces within themselves (instincts, drives, needs etc.) or by external forces impinging upon them (social forces etc.) but by what lies in between, a reflective and socially derived interpretation of the internal stimuli that are present" (1978:23). The ideas we have concerning "self" are not biologically determined. The way that we see ourselves, our identity, is constantly changing: it is processual. As Watson says: "It [identity] is always *emergent*; it is part of the continuous process through which we come to terms with our changing world through a process of shaping 'ourselves'" (1994a:59).

Meaning is viewed in phenomenology as inter-subjectively constructed and the role of the researcher is to elicit what is deemed important whilst "data" collecting. The accounts of peoples' thoughts, processes and actions (the inter-subjective construction of meaning) are viewed only to take place when the informant and researcher are involved in documenting the event. Whilst describing the interview process, Fielding points out this relationship: "For ethnomethodologists, interview data do not report on an external reality displayed in the respondents' utterances but on the internal reality constructed as both parties contrive to produce the appearance of a recognisable interview. In short... the interview data [is viewed as] a topic not as a resource" (1993:151). Instead of treating the actors' accounts of rationality as a basis for interpreting an actor's activities, it is possibly to explore how such activities *"provide for"* a sense of their rationality (Silverman, his italics, 1975:279).

Questions arise then, concerning the ecological validity of the study, such as what meanings can be derived from this analysis to understand GPs generally? The application of an

ethnographic-style study is not to predict or relate what *all* general practitioners do, but to understand better the processes that general practitioners involve themselves in. The close examination of GPs here enables, what Yin (1994) calls, "theoretical generalisations" rather than "empirical generalisations".

4.1.4 Theoretical "Tools"

In making sense of the lived, everyday experience of actors, we need to impose some structure in order to present the accounts. Criticisms of past phenomenological research is that impositions of this kind are not made clear (Anderson, 1991). I argue that an imposed structure is an inevitability in all types of research (quantitative and qualitative) even when it is not made explicit. The world that we live in is chaotic and ambiguous. The amount of information that we can "extract" from our "environments" and in relations with others, is minimal. We make choices to filter what is relevant to us. Simon (1957) refers to this process as "bounded rationality": individuals are limited in their reasoning and meaning-making by their perceptual and information-processing abilities. This limiting characteristic also affects the researcher. During the "data" collection and analysis the accounts of experience may be distorted by bracketing, fragmenting and interpreting.

In accordance with the ideas of such phenomenologically orientated writers as Weber and Schütz, the research involves the deriving of analytical concepts (secondary order constructs) from those of "everyday" actors (first order constructs). Schütz (1964:6) notes that:

> "The thought objects constructed by the social scientists refer to and are founded upon the thought objects constructed by the common sense thought of man living his [or her] everyday life among his [or her] fellow[s]... Thus, the constructs used by the social scientist are, so to speak, constructs of the second degree, namely constructs of the constructs made by the actors on the social science, whose behaviour the scientist observes and tries to explain in accordance with the procedural rules of his science".

"Secondary constructs" are used on "primary constructs" to elicit patterns and emerging themes so theoretical generalisations can be made. This is not to say that the actors investigated in the study do not have theories of the world: they do. The theories that they hold serve a different function to that required of sociological theories. GPs' theoretical frameworks relate to the understanding of day-to-day activities so that they can hold meaning to their everyday actions. The function of sociological theories is somewhat different. Although general practitioners' accounts and theories ground and shape the theories used here, the emphasis is to understand more generally, the processes that are happening.

The secondary constructs developed here are typifications, like any other, but take a form that is more useful to social scientific analysis. The idea is akin to Weber's notion of the ideal type. As Weber explains: "In order that... the terms should have a clear meaning, the sociologist must for his [or her] part formulate 'pure' or 'ideal' types of systems for the relevant kind which exhibit the internal coherence and unity which belongs to the most complete possible adequacy on the level of meaning" (quoted in Runciman, 1978:23). It is unrealistic to expect to find these constructs in "reality" because of the nature of their internal coherence. It is only by constructing ideal types that subtle differences can be identified. So, ideal types are not ends in themselves but ways of understanding the world by simplifying the infinite complexities of social life (Watson, 1986). The more clearly constructed they are the better they perform their function as a classifier or as a bench-mark. Thus to distinguish between say, a "business" orientated general practitioner and a "professional" orientated general practitioner, I could typify the first as having characteristics such as an interest in the income of the practice, clear job specialisation and differentiation in the partners' and staffs' activities and exhibiting a planning of services offered to the public. Whereas the "professional" general practitioner could be typified as focusing on the doctor-patient relationship (doing home visits and care on a first-come-first-serve basis, for example) and as having no task differentiation between themselves and their partners.

In order to understand the everyday lives of the actors in this study, the conceptual framework was built (presented in section 4.5). This framework is a result of the inter-subjective relationship between myself (my stock of knowledge, interests, ideas and so on) and those in the field and the theoretical resources that guide my approach. If I was taking a strict "grounded theory" approach (Glaser and Strauss, 1967) then I would solely take the emerging themes and patterns from the accounts of the actors to erect a conceptual framework. I follow Glaser and Strauss's idea loosely: the conceptual framework which I have developed to understand the complicated phenomenon of change processes is a combination of the themes and patterns obtained from the interviews and my "imposed" structure. I aim to make this imposition clear, as I state how and why the conceptual framework was devised and how the research was conducted (including for example, my perceived influences in the "data" gathering process). It is accepted that I will influence my findings (as in any research), as I make choices, tint, interpret and so on in the process. What is essential though, is that this process is made explicit by using a "reflexive" style of research writing (Manning, 1973). By putting "enough of myself in the story so that people can recognise that I am an actor in the play myself" (Watson, 1995a:303) and by using excerpts of conversations in the empirical chapters, the reader can determine to some extent for themselves the role that I played in the exploration. Being explicit in this way therefore allows for some degree of "objectivity".

4.1.5 Internal Realism

This discussion now leads us to the question, "Is there a 'reality' which can be studied?". So far we have viewed the world as perceived to be "out there" as we draw upon unquestioned assumptions to make sense of it in relation to what we consider of relevance and interest. The "reality", it is argued, cannot be objectively understood as the researcher is, and always will be, involved in these choices that are made. Watson (1994b), following Putman (1983), makes this

point clear. "Reality" is viewed beyond the individual however, it exists through ourselves "in the social and cultural processes whereby human beings make sense of the world" (1994b:6). This is not to say that there are not social "structures" that shape our lives. Although actors act intentionally, they can be unaware of the "totality" of the consequences of their actions (Bhaskar, 1979:55). GPs, for example, may be knowledgeable about the processes of patient-referrals, but they may not be conscious of the political and economic processes in play. As Bhaskar states, "What an agent does not make (what it must take to make) it can have no privilege understanding of" (1986:62). Watson (1994b) (and others) refer to this philosophical position, as "internal realism". It differs from the positivist belief, where "reality" is perceived to be external, independent of people and can be objectively studied. It also differs from the post-modern belief that "reality" is regarded to be internal, subjective and only known to the individual. In line with Archer (1988), Watson argues that the pitfalls of these positions can be avoided if the world is seen in terms of "internal realism". Internal realism is the methodological perspective taken in this study as it lends itself to theoretical tools such as social constructionism, bounded rationality and multiple individual perspectives.

We now have explored the starting point for the conceptual framework: the importance in understanding the individual. It is the belief that the way we make sense of the world and create "meaning" for ourselves is socially constructed. This sense-making rationale can only be understood with typifying schemes which are inextricably linked with the social context: that is, what we deem to be relevant together with the biographical context that we bring to a situation. These constructs which we hold for ourselves and the world, are "emergent" as we interact with others and reflect. The ideas developed in this section are used as a foundation for the next, where there is a discussion concerning individuals' orientations to work. By using the "orientations to work" construct we can come to understand better the individual's perceptions of their occupational-grouping and organisational activities.

4.2 Orientations to Work

As suggested in the introduction to this chapter, the model which I develop to understand the management of "professional" change recommends three areas of analysis: the individual, the occupational and the organisational. These three categories are accepted as theoretical and practical concepts (ie. secondary constructs) which are understood to affect the actors' orientation to work. The concept "orientation to work" is argued to be essential to the understanding of change processes. The concept of orientation to work is defined as *those constructs used by actors to derive meaning from their (actual or possible) attachment to an occupational group and their (actual or perceived) involvement in organisational activities.* This understanding, as well as the biographical experiences, inform the actor on how to interpret and act in relation to their work.

A construction of the individual's perception was examined in the last section. Here, attention is first given to a general discussion on orientations to work, second, there is an exploration of the occupational features and, third, there is an examination of the organisational elements. My intention is to consider the progress which has previously been made in understanding orientations to work. This is used as a basis for comprehending past and recent dynamic change processes in health provisions.

People have different perceptions and expectations of "work". It is suggested that these differences can be understood in terms of various orientations to work. "Orientation to work", as a concept, was introduced in the 1960s by Goldthorpe, Lockwood, Bechhofer and Platt in *The Affluent Worker* (1968). Goldthorpe *et al.* were exploring changes in attitudes to class and party-political leaning. Whilst investigating 229 manual workers in Luton, they determined that there were different types of involvement in work. Goldthorpe *et al.* maintain that the way workers define and give meaning to their work largely accounts for their attitudes and behaviour. They collected "data" on the individual and their relationship with their work situation,

organisational participation, interactions with other workers and their non-working lives. To account for the different levels of worker involvement, they identified three main types of worker involvement: "bureaucratic", "instrumental" and "solidaristic" orientations (Goldthorpe *et al.*, 1968:38). Workers with a bureaucratic orientation accounted for their high degree of work attachment as they pointed to their work as a central feature of their lives. Career progression was indicated to be a key concern. Those who were typified as having an instrumental orientation to work were categorised by the perceived separation between work and non-work activities. Work activities were not a central feature of their lives. Work was accounted for as an means to an economically-rewarding end. Individuals who were depicted as having a solidaristic orientation to work were typified by having a high level of attachment to the other workers as they accounted for work in terms of group activity.

Wedderburn and Crompton (1972) in their study of "Seagrass" support the typifications of orientations to work identified by Goldthorpe *et al.*. Wedderburn and Crompton carried out a similar research project in the North East of England and produced comparable "findings". However, they also noted, as Blauner had (1964), that the orientations to work for an individual are influenced also by the technology in use. Goldthorpe and his colleagues, originally questioned Blauner and the significance that he gave to technology in shaping workers beliefs and behaviour. Wedderburn and Crompton concluded that, "Different attitudes and behaviour *within the work situation* could be manifested by different groups of workers largely in response to the differences in the prevailing technologies and control systems" (1972:5).

Goldthorpe *et al.* recognised that there were other typifications of orientations to work, such as a "professional orientation to work". However, they did not expand on these. I intend to develop the understanding of the "professional" orientation to work as the accounts of the actors in this study are examined. The conceptualisation of the term "professional" will be expanded upon in the next section (4.3). Below (Figure 4.1) is a summary of the types of orientation to work, based on Goldthorpe, Lockwood, Bechhofer and Platt's (1968) categorisations.

Orientations to work	Primary meaning of work	Involvement in employing organisation	Ego involvement	Work and non-work relationships
Instrumental	Means to an end. A way of earning income.	Calculative.	Weak. Work not a central life interest or source of self -realisation.	Spheres sharply dichotomised. Work relationships not carried over into non-work activities.
Bureaucratic	Service to an organisation in return for career progress.	"Moral" elements: some sense of obligation.	Individual's position and prospects are sources of social identity.	Not sharply dichotomised. Work identity and organisational status carried over.
Solidaristic	Economic but with this limited by group loyalties to either other workers or the firm.	"Moral" when identification is with the firm. "Alienative" when this is more with workmates than with employer.	Strong social relationships at work are rewarding.	Intimately related. High participation in work linked formal or informal associations.
Professional	No details given.	No details given.	No details given.	No details given.

Figure 4.1 Four possible orientations to work (Watson, 1995b:122).

The categories of orientations to work are secondary constructs or ideal types. Goldthorpe *et al.* used these typifications to account for the various levels of individual involvement in organisations. It is stressed that an individual will account for their situation in many ways and will probably not "fit into" one typification. It was accepted by Goldthorpe *et al.* that all work in industrialised societies had an instrumental element, however, theoretical generalisations can be drawn from such a scheme.

A criticism of Goldthorpe and his colleagues was that they took the orientation of the worker as unchanging. Daniel (1973), indicates that workers have different priorities at different times in their lives. Additionally, Daniel (citing Cotgrave *et al.*(1971) and their research conducted in a nylon spinning plant) noted that an individual may exhibit an instrumental orientation to work when away from the work place, however when at their bench other expectations and definitions

are used. Individuals also potentially hold different orientations to work before they enter an organisation to orientations which they find relevant after they have joined. Watson (1995b) recommends that the concept is usefully separated by differentiating between "prior orientations" to the working situation and "dynamic orientations" which prevail once the organisation has been entered by the actor. It was stated in the last section that our identity is "emergent": it changes according to our sense of self and our interaction with the perceived "environment". Thus, it is argued that the constructs which are used to account for an individual's orientation to work may alter in time, in different work situations and in relation to non-work experiences. Orientations to work are not static, but dynamic processes.

Goldthorpe *et al.* were novel in their approach as they suggested that peoples' expectations and definitions of work organisations varied. In the "classic" organisational studies, such as the Hawthorne Studies, the individual was not acknowledged in this way. For instance, Roethlisberger & Dickson (1939) carried out research based on the Hawthorne experiments, and presumed that individuals did not bring their non-work experience to their work organisation. They attempted to understand the variations in the "responses" to their experiments only in terms of the changes which *they* had introduced to the physical and social conditions (Morgan, 1990a). Other considerations, such as gender and the potential of job-loss if they did not participate in the experiment, were not recognised as having an impact on the "findings" (Rose, 1988; Carey, 1967). The individual's non-working lives or their biographical situation were not considered.

Other researchers, working at about the same time as Goldthorpe and his colleagues, took a similar approach, for example Dubin (1956), Turner and Lawrence (1965) and Hulin and Blood (1968). Dalton (1948) however, twenty years prior to *The Affluent Worker*, studied individuals' reactions to reward incentives. This approach was parallel in nature to Goldthorpe's *(et al.)* study. Dalton conceptualised individual responses to incentive schemes by considering the individuals' biographical and social experience. Their personal situation was seen to influence their reaction.

Albeit, this approach was not widely acknowledged until Goldthorpe and Lockwood published their research in the late 1960s.

What the above writers had in common was the recognition of the importance in understanding the "external", non-work influences which affect an individual's perceived satisfaction and orientation to work. However, it must be remembered that an individual's perception of "self" changes as we interact with others and experience different social contexts, including the working "environment". An actor's orientation to work may change as they interact with others in the organisation. Consequently, there is scope for strategic change processes in organisations. As individual's perception of "self" changes as does the organisation to some degree. I come back to this point when discussing organisational understandings in section 4.4.

4.3 Occupational Understanding

The conceptual framework will now be developed to consider, in more detail, the actors' interpretations of their experiences both prior to entry and within their occupation (ie. their orientation to work). The term "profession" is seen here as a "resource" which is used by some workers to derive meaning from or attach meaning to their work. Commonly, a "profession" is seen as a type of employment or occupation. Occupational categories, like any other form of typifications, are used to provide us with an order so we can make sense of our ambiguous social world. The use of the term "occupation" is a means by which certain social actions can be connected and co-ordinated. It is useful to define an occupation. An appropriate definition is provided by Hughes: "...[A]n occupation is a more-or-less standardized one-man's [or woman's] part in some operating system [which] cannot be described apart from the whole. A study of occupations, then, becomes in part a study of the allocation of functions and the consequent composition of any given occupation" (1971:292).

So-called "professions" are said to be different from other occupations. The connotations and social meanings attached to a "profession" are distinctive as it is awarded with some prestige. Additionally, "professional" organisations or associations are established which control entry and the practising of their members, provide ethical codes and maintain "professional" knowledge. Other occupational groups have attempted to undergo a similar process, known as professionalisation, to reap similar rewards. Becker, interested in the accounts of individuals (the "symbols" that people use), argued that individuals derive meaning by defining what a "profession" *ought* to be like. Becker says: "Professions as commonly conceived, are occupations which possess a monopoly of some esoteric and different body of knowledge. Further, this knowledge is considered to be necessary for the continuing functioning of society" (1970:94). In this manner, "professionals" are constructed as highly valued and morally praiseworthy. Hence, they are perceived to gain a high degree of trust from others.

It is necessary to impose some structure to this discussion on "professionalism" and "professionalisation". I suggest, following Abbott (1991), that the analysis takes three forms: the individual, the "professional" organisation and the state. These secondary constructs are used for the purpose of providing a framework to understand complex dynamic processes. However, it must be remembered that all GPs are not the same and an individual's perception of "being a professional" may change in time, place and context. The professionalisation process, attempting to achieve some degree of autonomy, is a result of negotiation and politicking with other occupational groups and the state. This was seen in the historical analysis where the "profession" of general medical practice was argued to be changing.

Sociologists have categorised the control of occupations, so to make sense of the world of work, into two principles: the occupational and the administrative (cf. Riggs, 1992). The occupational principle concerns the division of labour being fragmented so certain tasks are controlled by the members of the occupational group. Medicine is traditionally seen in this light. The second principle is the administrative or employment principle where the control of tasks is held by the

state or corporate owners. Managers act as the "agents" to maintain this latter control. These principles can be seen as opposing or in tension as we have seen in the discussion of "professional" versus "management" priorities in British medicine. Medicine especially as it is organised within the NHS, and is increasingly seen in these terms, alongside a recognition of its occupational traditions. However, I argue that we need to understand better the perceived forms of task control. These perceptions are influenced by what is viewed as relevant for the actor, their individual situation and at a particular point in time (ie. in the interview interaction). General practitioners, or even medical practitioners generally, are not a united group who form a consensus of approach. We need to research how various individual medical actors make sense of the tension between occupational and administrative principles of task control.

The traditional approach in the understanding of "professions" in its academic version is associated with structuralist-functionalism (Parsons, 1951) I argue that this approach is misleading. It is assumed that a "profession" is a static "object" which exhibits certain common characteristics or "traits". These characteristics it is claimed, distinguish "professional" occupations from other "non-professional" groups. For instance, Carr-Saunders and Wilson (1933) gave a systematic account of the historical development of occupations known as "professions". They highlighted certain features such as providing an altruistic service, a professional culture sustained by the formal associations and the tasks performed require a "skill" or competency which is based in a systematic body of theory and esoteric knowledge. Since Carr-Saunders and Wilson, numerous sociologists have attempted to define this set of traits in terms of distinguishing them from "non-professional" groups (Parsons, 1951; Goode, 1957; Millerson, 1964). This approach suggests that "professions" can be objectively defined but all that is achieved is a label which is not useful of what is more or less a "profession". The point is missed.

Hughes (1958) rejected this notion that a "profession" can be an objectively-defined occupational group. He argues that the question should not be "what is a profession?" but "what are the

circumstances in which people in an occupation attempt to turn it into a profession, and themselves into professional people?" (cited in Atkinson, Reid & Shieldrake, 1977:248). This does not, however, present us with a sufficient solution as this creates further problems. Johnson (1972) indicates the inadequacy to claim that an occupational group can just adopt "professional" status. I come back to this.

Hughes did, however, recognise that there is a need for a processual way of understanding this occupational grouping. Hughes (1960a) introduced the concept of "professionalisation". By this he indicated the need to understand the "professional" occupation as a process in relation to the social, economic and political market and by analysing the notion of power. This view was shared by Vollmer & Mills (1966). It is useful to comprehend a named "professional" grouping as a process where the level of their success is determined by the perceived degree of market closure experienced. Some believe that more and more occupational groupings are becoming "professional" groups as the industrialisation process advances (Goode, 1961, for example). In this way, Berlant (1975) views "professionalisation" as a process of monopolisation, while Larson (1977) accounts for the process in terms of market control and constitution where upward mobility is promoted. It is said, by those adopting this approach that the leaders and representatives of the so-called medical "professions" have sought to regulate and structure the market through limiting and controlling the number of its members (Collins, 1990). Advocates of this approach believe that members of the group or "status group" share a felt identity, ideas and standards within the division of labour (Weber, in Runciman, 1978). It is rightly acknowledged that groups have to change and adapt in order to survive or competition will drive them out. Parkin (1972) suggests that the most important determinant of the rewards received by an occupational group is their "marketable expertise".

It has been argued by others, such as Oppenheimer (1973), Navarro (1977) and McKinlay and Stoekle (1988), that there is a trend whereby "professional" work is becoming devalued and subordinated as the labour process is being continually being fragmented. These writers believe

that the state employers control the work of "professionals". This thesis is known sociologically, as the "proletarianisation thesis". This process is defined by McKinlay and Stoekle as "the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentially of its task activities, thereby subordinating it to the broader requirements of production under capitalism" (1988:11). This process is otherwise known as "deprofessionalization" (cf. Rothman, 1987). Rothman (1987) states that this process is typified by the erosion of autonomy and monopolistic privileges. When this approach is adopted, it is argued that with the greater specialisation and deskilling in health care, resulting from the recent state management policies, other health workers are now performing some of the "once-professional" functions.

There is a danger with both these approaches to presume that the "professional organisation" (the BMA) is a united body. The account given in the earlier historical analysis denotes the tensions within the BMA especially between the hospital consultants and general practitioners. What is explored in this analysis is the accounts, or "occurrences", which have been documented. These occurrences are, as Abbott explains, "the visible, organisational outcomes of the hidden forces and drives in professional life. It is the larger encounters between these forces and drives which are the 'events' of interest, not the particular outcomes" (1991:359). In the analysis of the development of GMP and NHS, it was indicated that there were conflicts and compromises between the state and the GP representative bodies. Although Hughes, and the others, recognised the importance of the market, they failed to acknowledge the exchange processes which occur between the individual and their peers and place of work, representative medical organisations, the state and the wider context. Occupational members do not exist in a social vacuum (Dingwall & Lewis, 1983). It was stressed in section 4.1.3 that individuals are inextricably linked with the social world. Dingwall (1976) argues that much of the confusion concerning the concept of a "profession" arises from the attempts to formalise its meaning rather than examining the way people use and ascribe meaning to the term. Dingwall explains: "All we can do is to elaborate on what it appears to mean to use the term ["profession"] and to list the occasions on which the various elaborations are used"

(1976:335). I stress that the use of the term "profession" is not static, an object or a "reality". It is a process and different people account for it in terms of what they deem as of interest and relevant to their worlds. The empirical analysis indicates this. The approaches adopted by Freidson (1970), Johnson (1972) and Larson (1977) emphasise this importance and are seen to view the "professions" in relation to an assortment of circumstances. This perspective is known in sociology as the "radical-structuralist" approach (Morgan, 1990b). Here the state, the "professional" organisation and the individual are examined.

Central to Friedson's work (1970) is the notion of legitimate power which is "given" to the "professions" by the government. Freidson identifies power, politics and influence as being essential to the understanding of the (changing) nature of an occupational grouping. Recognising that "professions" are not static, he argues that the professionalisation process is dynamic. The way "professions" are conceptualised is constantly under negotiation. To Freidson, power and influence are more important than education, knowledge and task performance in achieving "professional" prestige.

Continuing on a similar theme, Johnson (1972) points to the need to understand the institutional forms of control of occupations in terms of power of specific groups to control the occupational activity. To identify and account for the forms of control, he focuses on the practitioner-client relationship. It is essential, Johnson stresses, to look at the changes in the destination of power in society as a major factor in the changing nature of the clientele and therefore the institution of control. To Johnson a "profession" is not an occupation in itself, but rather a means of controlling one.

Johnson (1972) typifies the forms of control by focusing on the relationship between the "professional" or "producer" and the "patient" or "customer". His second order constructs are: collegiate (the producer defines the needs of the customer and the method by which these are met); patronage or communal control (the customer defines the needs and the method by which

they are met); mediative control (a third party mediates defining both the needs and the manner by which they are met); and state mediation (where the state decides on needs and method). Johnson categorised the medical relationships as a form of collegiate control. This however has come under threat, as was argued in chapter 3, because of the increased involvement of the state in defining the needs of the nation.

It is accepted that the use of words change over time. Any attempt to find the definition alienates the use of the word from its everyday use. Hence, we need to focus on the way and the context in which a word is used in everyday settings and what role it plays. In this vein, it is suggested by Becker (1970) (following Turner, 1956) that we look at the word "profession" as a "folk-concept". The concept "profession" is seen as a "symbol". Becker defines this in the following way: "symbols 'help people' and groups organise their lives and embody the conception of what is good and worthwhile. They enhance the possibility of purposeful collective action. They make more real the realization of ideas held by large segments of society" (1970:102). The use of "profession" has symbolic meaning for actors. Becker explains this further: "The name carries a great deal of symbolic meaning, which tends to be incorporated into the identity... these meanings are often systemized into elaborate ideologies which itemize the qualities, interests, and capabilities of those identified" (1970:178).

As pointed out at the beginning of this section, Becker (1970) was concerned with the accounts of individuals and the relationship of those to "reality". Becker indicates that the use of a symbol denotes an "ideology": how people account what a "profession" should be like. Becker compares this "ideology" with the "reality". He indicates that "professionals" are perceived to be highly valued and morally praiseworthy. Hence, Becker points to way in which "professionals" are perceived and their consequent gain of a high degree of trust from others. On the other hand, however, the "reality" of "professionals" is that they do not hold absolute autonomy as they share their esoteric knowledge with others, nurses for example.

Becker does acknowledge that "professional" identity, drawn upon by an actor, concerns establishing working boundaries of "who does what". Medicine is a large area and many actors gain employment here. So how does a general practitioner know what is in their remit of "being a GP"? After conducting an interactionally-based study, where actors accounts were sought, Dingwall argues:

> "Securing social recognition as a profession involves asserting claims to a certain relationship with other occupations. These claims involve establishing exclusive claims to a particular area of work and inclusive claims to a particular relationship of symmetrical respect for other occupational groups who are recognised by the claimant as 'profession'" (1977:393).

In the discussion so far a number of issues have been raised. First, we have seen that an individual's orientation to work will involve complex and dynamic processes. It has been argued that an individual's orientation to work may change in time, in different circumstances and is guided by their biographical situation and their stock of knowledge. Second, we have seen that a variety of perspectives can be used to account for the nature of a "profession" and it has been argued that an examination of *how* the concept of "profession" is used is essential to further our understanding of its meaning. It is suggested that the idea of a "profession" is something that is used by social actors in their process of making sense of themselves and their circumstances. Third, it has been claimed, in this chapter and portrayed in other parts of the study, that the government and the "professional" representative bodies have influenced the nature of practising medicine. Furthermore, the members of the medical associations and government agents will hold different stocks of knowledge, have different priorities and hence will interpret health care phenomena in variant ways.

As well as GPs being part of a "professional" occupational grouping, they are also "employees" of a formal organisation, the NHS. I use the term "employees" because they are somewhat accountable to FHSAs and DHAs or RHAs but still maintain their independent status (see chapter 3). GPs also do not work in isolation of others. Even if they are single-handed general practitioners they will involve themselves with others, such as administrative staff, receptionists,

nurses and so on. This aspect of their work additionally will influence their sense-making processes.

4.4 Organisational Understanding

Attention is now turned to the conceptualisation of how actors' experience and report their "employing" institutions and the social setting in which they work. The actor's "employment" influences their sense-making (the third aspect of the orientations to work to be explored). The conceptual framework is elaborated to incorporate what sociologists call "organisations", "professional-organisations" and "organisational change". GPs do not work in isolation. General medical practice is part of a large formal organisation, the NHS. The idea of an "organisation" and the GP's role within it is something that is potentially used by social actors in their process of making sense of themselves and their circumstances. General practitioners are involved inextricably in this formal system because they are contractually linked to the FHSA, refer patients to secondary care and so on. What is of interest here is the experiences and "intentions" of individual actors in relation to the wider NHS context. Particular reference is made in the next section to the potential tensions and opportunities for general practitioners in relation to their involvement in larger organisational processes. That is, the conflicts between the "occupational" and the "administrative" principles of work are examined.

Until recently, studies of "organisations" neglected to recognise the importance of the individual in understanding how they functioned. Morgan comments: "It may seem strange, but many studies of organizations have failed to look at the people in organisations as anything more than mechanical parts in a machine" (Morgan, 1990a:18). Sociologists have attempted to provide functional and rational theories to study complex organisations and have assumed that they are politically neutral and that "reality" is given (Benson, 1977; Donaldson, 1985). This approach, in

my opinion, is too narrow. Interpretations, feelings, innovation, goals and interests of actors need to be explored (as suggested by Silverman, 1975; Manning, 1973; Goffman, 1959). Formal organisations are defined more suitably by Watson: they are "social and technical arrangements in which a number of people come or are brought together in a relationship where the actions of some are directed by others towards the achievement of certain tasks" (1995b:237). By defining organisations in this way, it is acknowledged that negotiations and coalitions occur. Whilst acknowledging that organisations are task or goal orientated in their function, processes of change take place as individual members draw upon different interests, orientations and perceptions. Denhardt indicates that "the organization takes shape as a result of the interaction of the individuals' store of knowledge (those norms, values, and standards of behaviour which individuals bring with them to the organization)" (1981:106). In a like manner, Sims, Fineman and Gabriel (1993:9) have argued for "a shift from the notion of *organization* to *organizing*. Organizing is to be seen as a social, meaning-making process where order and disorder are in constant tension with one another, and where unpredictability is shaped and 'managed'" (their italics). Hence, organisations here are viewed as more fluid, irrational, chaotic and processual than the more traditional functional and rational theorists would have us believe.

The organisational identity is the image that members of the organisation are expected to present to others. Manning (1973) urges researchers to give special attention to the "natural" language used by members to differentiate between roles and functions within the system. By asking actors involved in primary health care "what is your notion of an ideal GP?", for example, we can understand better the values that are drawn upon to typify the organisational identity. It is accepted that the organisational identity involves many attributes.

There are many facets to the workings of an organisation. Conceptually, we can analyse organisations in terms of their structures and cultures. The formal structure of an organisation can be summarised as being the rational planning of an organisation's activities by the management (such as the organisational design, plans, procedures and strategy). The formal culture of an

organisation incorporates the ways in which management believe individual members should behave and the ideas and values that they ought to hold, ie. their notions of the organisational identity (the system of meanings, beliefs and norms espoused by the managerial dominant coalition (Watson, 1993)).

Conceptually, as seen in Figure 4.2, the formal aspects of an organisation are only half of the picture. Social actors draw upon their orientations to work, their ideas of self and other rationales to account for their (actual or perceived) involvement with the "employing" organisation. These sense-making rationales, as mentioned above, have an impact on organisational activities. Weick (1979, 1996) has appropriately argued that organisations transform and are fluid because of interdependencies among the members which shape the organisation and are often more influential than official plans and procedures. These independencies and other facets can be conceptualised as contributing to the "informal" structure and culture of an organisation. Selznick (1948) stressed that there is huge variety and diversity in the workings of an organisation, in particular, he was referring to these informal processes. The informal structure of an organisation typifies the negotiations, conflicts and micro-politics which arise. The "informal" culture denotes the actual meanings, beliefs and norms in use in an organisation, for an individual to derive meaning from their involvement (Watson, 1993). The formal and informal aspects of organisations are typified in Figure 4.2.

By categorising organisations into "formal" and "informal" aspects and accepting that they are not static but fluid, it is argued also that individuals interact with others and shape the nature of the organisation. This is not a one way process however. There are organisational constraints which affect and control an individual's activities. There is an exchange or "trading" process in operation in organisations, between the individual and the wider organisational context. On a simplistic level, there is a "trade" between the individual and the "organisation", as the "organisation" benefits from the services that an individual performs and the individual benefits from the financial payment. Fromm (1956) argues a similar point. He states that personal identity takes on an exchange value.

For Fromm, individuals are somewhat dependent on a personal acceptance by those who need their services and employ them in order to gain material success. Exchanges can also be more abstract and symbolic, such as the exchange of discourse. This idea of exchange is akin to Malinowski's account of the *Kula*. He pointed to exchange of necklaces and armbands as being based upon reciprocity (Malinowski, 1922). Exchange, for Malinowski, distinguishes and mediates the self from other. Furthermore, exchange was accounted for as a fundamental feature of social life and is not reducible to self-interest. Exchange processes are not limited to material items and include symbolic properties.

	Structure	**Culture**
Formal	The rational planning of an organisation's activities which is designed to fulfil dominant interests whilst also coping with challenges arising from "informal" activities. For instance, the organisational aims and strategies, budgets, procedures, job designs, etc.	Managerial values as to the acceptable behaviour (organisational identity) of the organisation's members. Systems of meanings, beliefs and norms espoused by the managerial dominant coalition.
Informal	The *actual* (or perceived) conflicts, negotiations, coalitions, disputes, politics, etc. that occur within an organisation in spite of and in reaction to the official control structure.	The *actual* systems of orientations, meanings, beliefs and norms in-use in an organisation. Individual actors derive meaning from or attach meaning to organisational and occupational activities and memberships.

Figure 4.2 Formal and informal aspects of organisations (adapted from Watson, 1995b; Fook & Watson, 1992).

There is a "give and take" process in organisations. It has been acknowledged that social actors behave consciously, hence, it can then be argued that "... human action... [is] strategic in so far as it is *shaped* in some way by the need of individuals or of groups to cope with the challenges of their environment. And organisational activities are strategic in so far as they shape the organisation to help it cope with the challenges of its environment and hence to survive in the future" (Watson, 1994a:26). There is a reciprocity process which occurs between these two needs. The stock of knowledge that an actor draws upon along with the controls and constraints which constitute their

"work environment" shapes how they think and behave. Furthermore, the individual affects the shape of the organisational activities. Giddens (1984) calls processes of this nature "structuration". He states that human "agency", or action, is not simply constrained by the surrounding circumstances ("structure") because there is an interplay between the two. The extent to which humans can shape their environment is determined by their associated power that they can draw upon.

We can, therefore, conceptualise organisations as changing and dynamic. They can, furthermore, be categorised by the formal and informal aspects of structure and culture. Exchange processes occur between an individual and their working "environment" as the interdependencies among the members shape the organisational activities. Now that a framework has been established to understand organisations, attention is turned to the relationship between the "professional" and "bureaucratic" forms of work control.

4.4.1 "Professional-Organisational" Understanding

It is argued that there are tensions between "professional" and "organisational" interests, identities and commitments as the two principles differ in their forms of control and regulation of work tasks (Dawson, 1992; Mintzberg, 1983; Davies, 1983; Scott, 1966). These tensions are seen to arise primarily as the occupational members seek "professional" authority and autonomy from the tasks that they perform and consequently, they do not neatly "fit into" the organisational hierarchy. Dawson explains: "It is argued that professionally trained people have a commitment to subject matter, method of application and to their professional peers, not to an organisation" (1992:33). Therefore, these underlying principles of work structuring are opposing and, at the same time, mutually beneficial. Following Watson (1995b:170) these principles, or ideal types, are defined as:

> "*Administrative* - the structuring of work on a bureaucratic, administrative or 'formal organisation' basis. Emphasis is on the ways in which work tasks are designed by certain people who then recruit, pay, co-ordinate and control the efforts of others to carry out these tasks."
>
> "*Occupational* - the structuring of work on the basis of the type of work that people do. Emphasis is on patterns which emerge when we concentrate on the way specific

> work tasks are done. Here we take as our starting point the carrying out of a specific type of work operation, say lorry driving, or cleaning a house, catching a fish or running a business. We then concentrate on the social implications of there existing within society groups of people regularly doing similar tasks."

The individual GP can be seen to be trained in prioritising the needs of the patient and of "society" in general. This justifies the general "professional" claim to resist forms of state control, such as the more formal incorporation of GPs into the NHS structure. Attempts to control general practitioners by the state have been examined in the earlier chapters. Politicians, for example, have been accounted for wanting general practitioners to become salaried employees of local authorities. It was argued that this desire was a means-to-an-end for the state: to rationalise primary health care by reducing GPs' autonomy and making them more accountable and financially efficient. Wilensky (1964) predicted that the occupational groups of the future will entail aspects from both the "professional" and "bureaucratic" models. Historically, this has been resisted by the GP "professional-bodies" representatives and GPs have remained "independent" contractors to the FHSA. However, general practitioners have to perform certain tasks in order to fulfil the requirements of their contract and are thus, in essence, "employees".

Tensions are seen to arise as "professional" and "bureaucratic" forms of work control come together, as seen in the organisation of "professionals" in the NHS. Kornhauser (1962), studying the employment of scientists in industry, predicted that the "professional" and "bureaucratic" value systems would occur to the detriment of both the actors and the organisations involved. He questioned which of the value systems, the development of knowledge or commercial enterprise, would become the dominant. These tensions are summarised by Davies:

> "Profession and bureaucracy were thought to be antithetical both at the level of structural principles for organising work and at the level of motivation and compliance. The attempted insertion of 'professionals' into 'bureaucratic organisations' was a readily recognisable sociological problem. Terms such as 'strain', 'conflict', 'accommodation', 'adjustment' were central" (1983:177).

Sociologists have conceptualised the case of "professionals" in bureaucratic organisations as "professional organisations" or "professional bureaucracies". Health care organisations are generally typified as "professional bureaucracies" (Mintzberg, 1990). Mintzberg portrays medical work as

"complex", where some expertise is required to carry out the tasks. Mintzberg (1990) conceptually distinguishes between the "machine bureaucracy" and the "professional bureaucracy". Members of a "machine bureaucracy" are required to be submissive to the superiors and have little control over the tasks that they perform. However, in the typification of a "professional bureaucracy" the "professional operators" are seen to possess autonomy and are allowed to perfect their skills. In Mintzberg's terms, the work in the "operating core" of a "professional bureaucracy" mainly concerns a long training period and the "indoctrination" of receptive skills, which are fundamental to the process of maintaining some degree of control (1983:638). The power in a "professional bureaucracy" is understood to be held by the "expert" (the general practitioner). Hence, the system of organisation is highly decentralised and the role of the administrators, in this model, is to "buffer" the "professionals" from external threats to their autonomy and to provide financial and moral support for the "professional". Mintzberg (1988) stated that "professional bureaucracies" include individual-orientated practitioners who come together only to draw upon resources and support services. Furthermore, he indicated that the "professional" is loyal to their "profession" rather than their place of work. With this ideal type, Mintzberg claims that the "professional" benefits from this alliance: "The professional has the best of both worlds: he is attached to his organisation, yet is free to serve his clients in his own way, constrained only by the established standards of his profession" (1988:205).

Mintzberg (1988) points to a number of problems arising in practice with "professional bureaucracies", such as problems of co-ordination, problems of discretion and problems of innovation. First, in comparison to the "machine bureaucracy" where the work is standardized in order to achieve co-ordination, the "professional bureaucracy" is uncoordinated if we take it that the "professional knows best". Second, there is a problem of discretion as the relationship that a GP has with a patient is a "private" affair. So, there are problems of output-accountability. Furthermore, incompetent or inadequate GPs could be difficult to identify. Last, where change is perceived to be required from the organisational perspective, political clashes will almost certainly arise. "professional" workers are good at deductive reasoning, as they "pigeon-hole" to find solutions,

rather than inductive reasoning where inferences are drawn from general concepts or from particular experiences. Hence change, argues Mintzberg, will be slow and incremental: "Everybody, not just a few managers or professional representatives, must agree on change. So change comes slowly and painfully, after much political intrigue and shrewd manœuvring by the professional and administrative entrepreneurs" (1988:648). Furthermore, Mintzberg, ironically in the present circumstances, indicates that change in the "professional bureaucracy" does not "sweep in from new administrators taking office to announce major new reforms, nor from the government technostructures intent on bringing them under their control" (1988:649).

The forms of control from the administrative and the occupational principles are in tension. If a consensus-management approach is to be taken, then the changes will be incremental and involve negotiation and compromise. Mintzberg concludes that change, in this context, can only effectively arise from changes in the education and training of the "professionals".

4.4.2 Understanding Organisational Change

Under these circumstances it would be reasonable to expect that change in health care organisations would be incremental (Mintzberg, 1990; Lindblom, 1959). As Quinn (1982) indicates, there is a lot of "muddling through" to be done in the negotiation process involving many different interest groups. This was apparent in the consensus-management approach (eg. see 2.2). However, Pettigrew, Ferlie and McKee (1992) are doubtful as to the usefulness of this approach in describing the current health care climate. They state, "While incrementalism has perhaps been the dominant approach to the study of decision making in health care systems, it is doubtful whether it is an adequate explanation of the discontinuities now evident" (1992:28).

There are a number of problems with Mintzberg's approach when considering the case of general medical practitioners and the recent "state-initiated managed change strategies". Although GPs have been targeted in recent years to become more accountable and resource-conscious they do remain "independent" contractors to the NHS organisation. Additionally, these change-strategies have not originated from their immediate "employing" institution, the FHSA, but rather from the government. It has been accounted that there was little negotiation or consensus between the state and the "profession" in the planning of *Working for Patients*. The majority of the recent "state-initiated managed change programmes" were "imposed" and directly linked to performance-related pay. Mintzberg (1988) does indicate that change can only be brought about from outside the "profession", by clients, administrators and the state. However, he saw this as an unlikely scenario.

There is a need to understand the management of change not as an end in itself, but rather as a means to achieve certain actions, goals and mechanisms. Furthermore, the NHS, generally, has been neglected as an area for studying change processes. Pettigrew, Ferlie and McKee (1992), rightly in my opinion, criticise the NHS literature for being insubstantial

> "...because it is *insufficiently* processual (an emphasis on action as well as structure), comparative (a range of comparative case studies as well as a single case), pluralistic (a description and analysis of the often competing versions of reality seen by the actors in change processes), contextual (operating at a variety of different levels with specification of the linkages between them) and historical (taking into account the historical evolution of ideas and stimuli for change as well as the constraints within which decision makers operate)" (their italics, 1992:27).

Moreover, studies on primary health care tend not to follow the above approach. Investigations on general practitioners mainly concern specific areas. For instance, Wilkin, Hallam, Leavey & Metcalfe (1987) focus on the GP-patient relationship in urban practices; General Medical Services Committee (1994) and the NHS Women's Unit (1994) look at women in general practice; Morley, *et al.* (1991) study urban general practices; and Honigsbaum (1979) investigates the historical divisions between general practitioners and their hospital counterparts. These examinations are significant in aiding our understanding of general practitioners and GMP, however a broader study would enable a more thorough awareness and comprehension. What is required is an understanding of the dynamic organisational change processes in terms of the political, historical and

cultural elements. An important aspect in understanding these processes of change are the individuals and how they draw upon their stock of knowledge to make sense of and contribute to their working lives. Pettigrew *et al.* (1992) attempted to operationalise their conceptual approach, presented above, by documenting and analysing others' accounts from their interviews. They claim fittingly that "the processes of change refers to the actions, reactions and interactions of the various interested parties as they negotiate around the proposals for change" (1992:7). However, despite the promises, they do not document these accounts. Mangham reviewed their book and said:

> "We are told that over 400 people were interviewed to secure a variety of perspectives; few make their appearances in these pages and we learn little directly of what they had to say... The authors prefer the broad sweep to the detailed study of interactions" (1993:26).

Furthermore, Pettigrew *et al.* have been criticised for taking the historical analysis as "objective" and as a "given". Also the aim of their study is to look at change and continuities in the NHS. General Practice, a major facet of the NHS organisation, is mentioned rarely and is marginalised as a topic.

What, in my opinion, is needed to understand the process of "professional" change in general medical practice is a "micro" analysis of how social actors make sense of the ambiguous world and link this to a broader sociological analysis. In this way processes of change, more generally, can be understood better. Day-to-day activities, as well as the broader organisational strategies, shape organisational activities. Therefore, as a result of these observations, a strategic exchange perspective is to be taken in this investigation.

4.5 Rounding Up

The conceptual framework developed here concentrates on the orientations to work of medical actors. For some GPs, their "employing" organisation is important as they attach meaning from or to their work. Those with a strong association with the NHS organisation, as opposed to the occupational grouping, could be said to have a "local latent role" (Gouldner, 1957a&b). Gouldner categorises "locals" as committed and loyal to their "employer", unlikely to be mobile and willing to cooperate with the organisational procedures and rules. This typification corresponds with Goldthorpe's *(et al.)* "bureaucratic" orientation to work. Those who identify with the occupational grouping, are what Gouldner typifies as having a "cosmopolitan latent role". These actors draw upon their commitment to the occupational, are highly mobile, desires autonomy and thus are not easily controlled by managers.

Orientations to work are different between general practitioners, and may change over time and in different settings. Here it has been argued that there are three essential aspects of the medical social actors orientations to work: the self, the occupation and the organisation. This is represented in Figure 4.3.

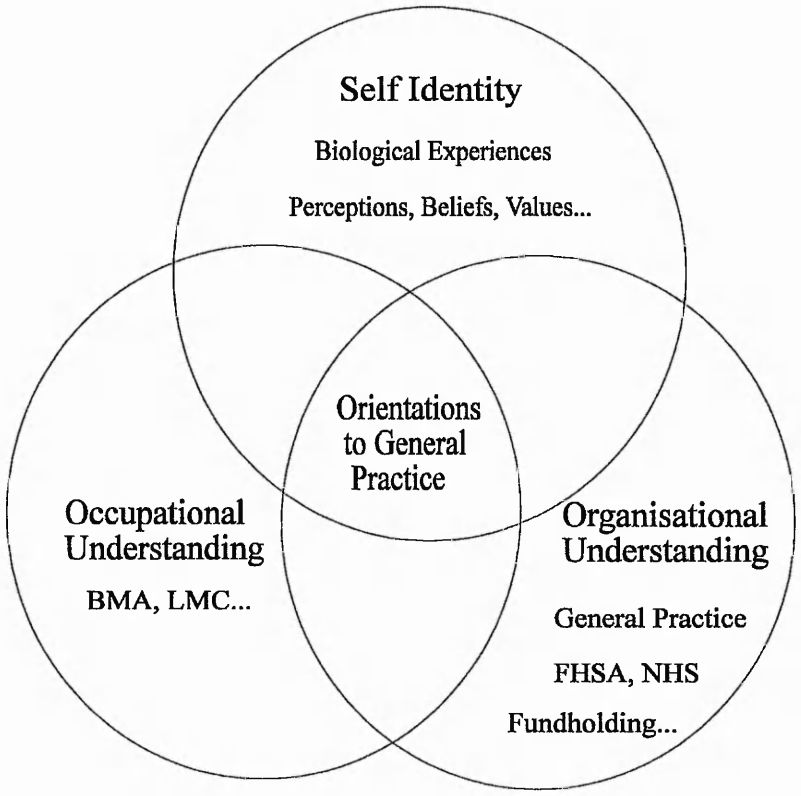


Figure 4.3 Aspects of orientations to general practice for general practitioners

It has been suggested in this chapter that there are three logically-formulated (or ideal types of) orientations to work for GPs. First, that the individual draws primarily upon biographical experiences and ideas of self to derive meaning. Second, GPs may draw mainly upon their perceived or actual attachment to their occupational-grouping. Third, the individual may derive most of their meaning and account for their actions in relation to the NHS organisation. Of course, general practitioners generally will not account for their actions in terms of these neat divisions. However, by using this structure, we can see more clearly how GPs make sense of their changing worlds, derive meaning for themselves in terms of their orientations to work and engage in strategic exchange.

The conceptual framework suggested here, in a simpler version, helped to shape the research process. The research process, in turn, helped to refine the details of this chapter. The main purpose now is to analyse the general practitioners' accounts gathered during the research process. This is presented in chapters 6 and 8. But first it is necessary to describe how the research was conducted, as

well as some of the problems and pleasures involved in the process. Attention in the next chapter is thus given to the research design and the methods used.

Chapter Five

Investigating General Practitioner Orientations

5.0 Introduction

In this chapter I discuss some key aspects of the research process. There is a particular emphasis on the methods used and finding an appropriate structure to present the "data". Additionally some of the problems and pleasures encountered in this investigation are also explored. The aim of this chapter is to make explicit to the reader the main processes engaged in when conducting the "data" collection, interpretation and presentation. By explaining these processes readers are able to judge for themselves, to some degree, the impact that I have had on the investigation. A further aim is to show future researchers some of the issues to be confronted when tackling research problems of this nature. Following Ely *et al.* (1991), there is a need to make more public the interplay between the emotional and intellectual when researching social science puzzles. Hence, in this chapter, some of the emotional aspects are explored alongside the more technical and intellectual aspects.

This chapter is divided into six sections: first (5.1), I distinguish methodology, method and design and explore the value of explicitly considering the process of the research act. Second, in section 5.2, I explore briefly how the project began and, third, there is a discussion of gaining access to

"the field" (section 5.3). In the fourth section (5.4), the way in which the informants were chosen for this investigation is examined. Fifth, in section 5.5, the research methods of "data" collection and interpretation are described. There is particular reference to the use of observation, interviews and the subsequent transcribing and recording. Furthermore, the use of secondary information is explained. In the next section (5.6) I examine using the "self" as a bench-mark in the research process. In section 5.7, I explain the practical aspects of finding an appropriate structure in which to present this "data". In line with the spirit of reflexivity, some obstacles that I came across in this process are presented. Furthermore, in the light of this discussion a general framework is presented for analysing and interpreting rhetorical and discursive resources. Finally there is a rounding up of the main points raised in this chapter (section 5.8).

5.1 Methodology, Method and Research Design: a Point of Departure

Before the detailed analysis of the research methods takes place it is useful to distinguish between what is meant by methodology, research design and research methods. When I use the term "methodology", I am referring to the philosophical issues that are raised when investigating the world scientifically. The methodology of this study has been specifically explored in the last chapter (sections 4.0 to 4.5), where the importance of studying the individual was stressed. To be succinct, the methodological approach that I am taking can be described as in the tradition of "methodological individualism" (Cuff & Payne, 1979). Individuals are put at the centre of the analysis and are not viewed as static things or "objects", but rather as changing, fluid and processual in nature. Collectives of individuals, such as organisations, are regarded in the same manner. Furthermore, concepts are regarded as devices which "sensitise" us to the social world (Blumer, 1969b).

The research design is the overall structure and orientation of the investigation. This structure provides a framework within which "data" can be analysed and presented. Research designs can take different forms, such as action research, experiment, and qualitative research (Bryman, 1989). At the start of the process the specificity of the design is different for each of these. For the experiment the process tends to begin with a hypothesis, where the variables are identified, which is then "tried and tested". For qualitative research, the process is more flexible and defined more broadly. In Lincoln and Guba's (1985) terms, an essential facet of qualitative research is an "emergent research design". Agar, whilst discussing the problems of submitting a qualitative research proposal, highlights the reasons why:

> "It's not necessarily that ethnographers don't want to test hypotheses. It's just that if they do, the variables and operationalisations and simple specifications must grow from an understanding from the group rather than being hammered on top of it no matter how poor the fit. You can't specify the questions that you are going to ask when you move into a community; you don't know how to ask questions yet. You can't define a sample; you don't know what the range of social types is and which ones are relevant to the topics that you are interested in" (Agar, quoted in Burgess 1984:35).

What is acceptable for a qualitative research design, in my judgement, is a broad indication of the theoretical "tools" that are to be used, an indication of the kind of questions which are going to be asked, as well as the type of "data" which is more likely to be required. The research design then, is "not a static model of the research process indicating procedures which were to be followed doggedly, but a base against which modifications could be made as the research continued" (Burgess, 1984:38).

The initial research design is in appendix G. This can be seen in comparison to the aims of the study now (see section 1.1 for a precise). The changes in the design were due to a multitude of factors, for instance: the problems with the original access, emergent opportunities, as I developed a more focused interest, and hearing informants' accounts. These, and others, have influenced and affected the way in which the investigation has taken shape.

The use of the term "methods" denotes the research techniques or tools used whilst conducting and interpreting the "data". The methods in use need to be appropriate for the methodological position taken. Hence, in line with the methodological position and the research design in this investigation, it is appropriate to use, in main, "non-participant" observation, secondary or archival information (when viewed as accounts rather than "givens"), semi-structured interviewing and recording and transcribing. By utilising these methods, the typifications that are in-use by the informants, in their accounts and story-telling, can best be heard. These are discussed in more detail in section 5.5. Attention is now given to the research processes undertaken in an investigation.

There is a presumption amongst writers on research methods that the research process is smooth and linear (for example see Bryman, 1989:180 or Giddens, 1989:663), where there is a pattern that the researcher will follow whilst conducting their project. This linear model does not depict the experience that I encountered. The nature of this research evolved as circumstances changed and as I engaged in interactions with the informants being investigated. Others, in their accounts of the research process, have documented a similar haphazard process (Aldridge, 1993; Burgess, 1984; Roberts, 1981; Bell & Newby, 1977): there is no set format or formula to follow when conducting qualitative research.

Silverman (1993) states that there are many versions of qualitative method (also see Tesch, 1990:58). However, Silverman presents a prescriptive account of what qualitative research should focus on. Silverman calls for a more coherent and theory-based approach, recommending that qualitative researchers should concentrate on "hypothesis-testing". He suggests that much conceptual ground-work has been established in previous qualitative research and the "agreed" concepts should now be "tested". There have been few studies which focus on interpretations of "state-initiated managed change strategies" in primary health care. Hence, I argue that new ground needs to be covered in this context, as well as employing and "testing" some of the more "established" concepts (such as "orientations to work"). Silverman's (1993:29) prescription,

which is followed in basic principle in this investigation, can be summarised as follows. First, field research should be theoretically driven rather than determined by what can be measured - following Cicourel (1964), there needs to be an integration between social science theory and methodology. Second, it needs to be acknowledged that social actors construct theories to make sense of the social world. Hence, questions that should be asked in an inquiry are not "why do they do that?" but rather "why do they keep on doing that?", that is, a *procedural* analysis is required (this point was also stated by Hammersley & Atkinson, 1983). Third, the common-sense terms that people use to make sense of the world such as "organisation", "profession" and what constitutes "the field" should guide the research puzzle. Fourth, following Kirk and Miller (1986), the collection of "data" in the qualitative tradition should take place in the natural setting of the social actor whereby the researcher "watches people in their own territory" (1986:9).

There is an additional requirement when writing qualitative research, in my opinion; the research process needs to be made explicit. As Burgess (1984) states, accounts of this nature are few and far between. In line with a reflexive style, I attempt to make my involvement in the research clear.

5.2 Starting Out

In the introduction I described, in brief, how the project was established. Here I expand on this and account for some of the processes that brought me to study change-strategies in primary health care. I also consider some of the aspects of my experience that have influenced the perspective that I bring to the study. In the spirit of reflexivity (see section 4.1.5), I feel that my own experience is important to document as it has provided a guide, or a framework, to my analysis and interpretation. Others supporting this approach include Rosen (1991), Ely *et al.* (1991), Agar (1980) and Spradley (1979). Rosen comments: "The selection of a research topic

and a corresponding method are in many ways also a life choice. They are indicative of that which the researcher believes is important to 'see' the world, to investigate and know" (1991:21).

I came to The Nottingham Trent University after graduating with a BA Economics and Social Studies degree from The Victoria University of Manchester. It was during my degree that I developed an interest in and identified with an interpretative understanding of the social world. It intrigued me how different people understood a particular event or occurrence in different ways. The interpretative approach also seemed consonant with my world view, in that it treats the individual as a unique resource of information. I have, for as long as I can remember, been fascinated as to how people watching the same event, a film say, chose different aspects to portray the meaning. This still puzzles me. I found it stimulating to be given the opportunity to continue my education and to explore theoretically these issues further.

I was employed as a Research Administrator / Demonstrator (RAD) to investigate a "niche marketing strategy for a national accounting firm". The original research outline can be seen in appendix G. The brief for my research was to investigate potential niche markets for the firm which included health care sectors. After a year researching the firm I was denied further access for reasons beyond my control. For a more detailed account of this process see Watson, Riggs & Fook (1991). Whilst I was researching the accounting firm I had begun to question the role of "professionals" and their apparent resistance to organisational changes that were being pushed. It therefore seemed appropriate to re-focus my study on primary health care settings where similar changes were being introduced. In the next sections I describe aspects of the processes undergone when investigating primary health care actors.

5.3 Getting Going and Getting in

The rest of the discussion primarily concerns the investigation at hand: the case of primary health care. However, as I had an opportunity to start my "fieldwork" in the accounting firm, I was a little "wiser" as to how to conduct myself and to come to terms with some aspects of how I would feel entering a new "field". The original research project was a kind of "dress rehearsal". At least, because of this experience I was aware of some of the politics involved in the research process, the feelings of marginality and the constant access negotiations that are often required.

Gaining access, or permission, to study in a particular setting can prove to be a difficult task and maintaining access is, arguably, always under negotiation. Furthermore, "how it is successfully done" is particular to each case, in relation to the actors, the circumstances and the period of time. An effective prescriptive account of such a process can never exist. Hughes remarks that "the situation and the circumstances in which field observation of human behaviour is done are so various that no manual of detailed rules would serve" (1960b:xii).

Access which is successfully negotiated is influenced, amongst other things, by the nature of the study, the researcher, the participant, the "gatekeepers" and the particular circumstances (Lofland & Lofland, 1984). The researcher certainly needs to be aware of the political dimensions involved in this process (Punch, 1986), both in relation to the individual and to the wider context. This seemed, to me, to be a great deal to take into consideration when starting out. For myself, and others when entering the "field", experiences of angst, self-doubt and fear of rejection are frequently felt (see also Ely *et al.*, 1991:15-25). An essential ingredient of successful qualitative research, in my opinion, is getting going and learning by doing.

When I began going into the "field" of general medical practice, it coincided with *Working for Patients* being implemented (in April, 1991). I perceived advantages and disadvantages of

researching this setting at this time. The advantages include the possibility of gaining actors' accounts as they were trying to make sense of the changes that were being introduced. This is akin to Lewin's (1951) notion of the "unfreezing" stage, where assumptions, ideas and the norms drawn upon are believed to be questioned. The disadvantages of researching at this time include the restraints that actors in PHC were experiencing as the administrative systems were changing. GPs' time, it was perceived, would be spent on understanding the new paperwork and installing the new computer systems. Both perceptions were apparent, although not all practices were introducing information technology. The increased paperwork was accounted for making them "extremely busy". This latter aspect resulted in my desired access to be a difficult task.

To gain a point of entry proved trying at times and various strategies were used. Bryman (1989:162-3) proposes four common ways in which access is gained: the opportunistic approach, access at the top, giving a clear indication of the research intentions and offering a form of formal report. A combination of these strategies was employed. I had some contacts with general practitioners through the accounting firm which turned out to be crucial. This use of informal networks has been well documented elsewhere, for instance, by Kimball and Partridge (1979), Werner and Schoepfle (1957) and Whyte (1955). I felt that I would be more favourably regarded, by the "gatekeepers", being associated with the accounting firm rather than as being perceived as "just-a-student". I had either a letter of introduction from or a personal contact of Vic Cowlam which I used to gain entry to the practices which the accounting firm had done work with. This form of introduction, I felt, boosted my creditability (this is discussed with more detail in section 5.6). For other practices "cold-calling" was used initially and then "snowball sampling" after some contacts had been made (I also discuss the latter in the next section). The "gatekeepers" to general medical practice were important in this process. "Gatekeepers", as defined by Burgess, are "those individuals in an organisation that have the power to grant or withhold access to people or situations for the purposes of research" (1984:48).

The first "gatekeepers" to primary health care centres were identified as being the practice manager or, in their absence, the head receptionist. When I began to negotiate access, I (mistakenly) approached the general practitioner directly. This approach tended to provoke two responses: the first, a referral to the practice manager or receptionist or; second, an outright refusal. I was learning about the politics of general practice administration systems and the importance of "getting it right" for the person and practice involved. A problem with this approach has also been identified by Murphy, Spiegal and Kinmonth: "We discovered that while, in theory, the practice managers were the organisational heads of the primary health care teams, in reality they had very little power to negotiated on behalf of the doctors" (1992:164).

The only experience that I had had of primary medical care, before this research project, was as a patient. The line of approach that was required for this investigation was certainly different. Learning how not to be too hard on oneself when access is denied is crucial, one of the joys of doing qualitative research is the realisation that one is not perfect and that we can only learn from making mistakes.

After I had identified the first "gatekeepers", a new problem emerged. It was often presumed, by the "gatekeepers", that I was a pharmaceutical representative trying a novel approach to get to see a GP to sell them a product (this presumption was also drawn upon by receptionists, nurses, doctors and others at the practice when I went to interview). This role of the practice manager has been also highlighted by Murphy, Spiegal and Kinmonth: "It is generally seen as part of the practice manager's remit to protect the doctors from unsolicited approaches, and so refusing access could be seen as a legitimate course of action" (1992:164). Generally, it seems that these representatives are not welcome to general medical practices. My dress became an important issue to overcome this apparent confusion. I observed and heard that the "reps" were normally very smartly dressed (mainly suits), so I changed my appearance and wore smart-casual clothes (trousers, waistcoat and blazer) which I felt depicted more an academic researcher.

The acceptance of my project by the first "gatekeeper", was often just the starting point. Negotiations were also required with the senior partner (the second "gatekeeper") and then the GP, or the person I wanted to interview. As it was a time of change in PHC, a great deal of media attention was given to the actors involved. One of my "selling" points or "trades", in the negotiation process, was to emphasis that an interview could be their opportunity to "say how it was for them". Burgess (1984) indicates the benefits from encouraging the "gatekeepers", of formal organisations, to believe that the research will report favourably on an issue they wish publicised. Thus the research proposal needed to be more than just theoretically interesting and needed to be understandable to all concerned.

The process of access, generally, took the following pattern. I first telephoned the practice, or organisation, to identify the "gatekeeper", their name and a convenient time to call. The question which I tended to ask, after stating who I was and my employing university, was "could you tell me who is the best person for me to speak to, to organise a meeting with a general practitioner (or other post) as part of a research study?". Once identified, I talked briefly to the "gatekeeper" again about who I was but also about what I wanted to achieve (the aims of the research), the areas that were likely to be covered in the interview and what I expected the interviewee to gain from the experience. I developed a conversation outline for these calls, to ensure three things: first, that I did not omit any information which I felt important; second, to give me some confidence (I am not very comfortable talking on the 'phone) and; third, as I had established what I wanted to say, I was able to concentrate on and be sensitive to what the "gatekeeper" was saying. The conversation outline that I used is displayed in appendix H.

After the introductions, I asked them (depending on how I interpreted the rapport) if they would either give me some indication as to who they felt was appropriate in the practice (or organisation) for me to approach, or to leave it to them to raise the issue with the partners. I sent the "gatekeeper" (or the named potential interviewer) a follow-up letter, reiterating the points raised in the initial telephone conversation and also the research outline (presented in appendices I and

J). After a few days, I telephoned the potential interviewee in person, as stated in the letter, to discuss any questions or problems that they had concerning the research. This aspect of gaining entry was particularly frustrating. GPs' days tend to be very structured as they have set times for surgery, home visits and other appointments. However, as health care demand is sporadic and often unexpected (emergency situations for example), finding a convenient time to 'phone became problematic. The times given by the receptionist would often be very precise: "If you try at 4.25pm, you might get her then", for example. Six telephone calls was the norm before I made contact. I was aware that I needed to suppress my frustration in this process, especially when I eventually got to speak to the person in question and was refused access. It was a time-consuming and learning operation.

When speaking to the potential interviewee for the first time, I wanted to know if: (a) they had received my explanatory letter, (b) they had any questions that they wanted to ask (most were concerned with the amount of time the interview would take) and, (c) I wanted to stress particularly the confidential nature of the interview. By confidentiality, I referred to the anonymity of the interviewer and of their place of work. I stated that all names would be changed and that individual practices would be unrecognisable.

I have so far discussed, in general terms, the issues which I felt important in getting-going in a research project. More specifically, the problems that I faced in gaining access have been examined. Some of these issues raised need looking at in more detail, therefore, attention now is turned to the selection "procedure" used and then (in section 5.5) to the research methods employed.

5.4 Choosing Informants

The process of choosing informants to take part in my research, in the main, was determined by the context in which I am studying. Following Johnson (1990), I use the term "informant" to refer to those actors interviewed in an informal (semi-structured), in-depth way in their natural setting. Informants are distinctive from "subjects" (associated more with the laboratory-type experiment) and "respondents" (associated more with formal, structured interviews as used in surveys) (Johnson, 1990). As mentioned before, the time of my "fieldwork" was a time of many pressures and constraints for actors in primary health care. Getting in, was a difficult process as outlined above. When I started studying primary health care, I thought it desirable to conduct a comparative case-study (Lupton, 1963) with a focus on the government's fundholding invitation. It was my intention to study three practices in depth (interviewing all members more than once and observing over a period of time). I depicted the three practices to be: a practice in which the partners intended to become fundholding in the first wave; a practice in which the GPs were undecided about entering the fundholding initiative and; a practice whose partners were against the scheme and did not wish to participate. This method of sampling corresponds to Arnold's (1970) "dimensional sampling". With this form of sampling, the cases studied are few and the dimensions by which the cases vary are explicitly stated. The aim of this method is to "provide a framework for drawing a purposive sample representative of the universe to which one wishes to generalise" (Arnold, 1970:47).

As my fieldwork progressed, I realised that due to the access problems my focus would have to change. This, however, is not an unusual scenario as others have reported similar experiences (Ely *et al.*, 1991; Burgess, 1984; Tremblay, 1957). I felt rather naïve, in hindsight, as I had expected the actors in the practices which I approached to be just as excited as I was to be involved in the investigation. One of the useful qualities of research of this nature is that it is flexible - I could alter my approach. There are, generally, two types of access to the "field": access to the

organisation and access to the individual (Gummerson, 1991; Brown, Guillet & McCullough, 1976). As I have mentioned, my initial aim was to gain "open" access to three organisations, both to the physical setting and to the actors involved. Hence, the approach shifted to gaining access to the individuals.

As indicated in the above section, the method of "sampling" which I followed was by use of informal networks. This is referred to as "snowball sampling" (cf. Berg, 1989). Snowball sampling is classified as a non-probability sampling technique because there is no way of testing the probability of an actor being included in the "data" collection process (this is in opposition to probability sampling where all actors, in the working population, have an equal chance of being selected) (Burgess, 1984). As my original sampling technique was abandoned, I was becoming increasingly concerned that entry would not be adequately made. The introductions that I gained by taking up various opportunities redeemed the situation. This is also known as "scoring a change" (Kirk & Miller, 1986).

Whyte (1984) later questions the usefulness of gaining access by using informal networks (and hence, snowball sampling). He cautions researchers to be aware of the social context which is likely to tint an informant's perceptions, beliefs and norms. The (stock of) knowledge that actors draw upon has been identified as being significant in informant selection (Johnson, 1990). However, as it is my intention to draw theoretical generalisations from my analyses, I argue that the process of changes accounted for in the interviews with myself, can be understood better in a close in-depth investigation.

The second focus of the research, which I identified, concerned the "imposed" (indicative budgets) and "invited" (fundholding) changes arising from the "state-initiated managed change strategies". This focus was derived from the initial interviews conducted. These strategies were seen to be reprted as having changed the way things were done in general medical practice. Furthermore, as I learnt more about how the informants accounted for their experiences other

broader issues came relevant. The emerging themes (cf. Glaser and Strauss, 1967) were: general practitioners' orientation to work; the differences between the GPs (in their accounts of their actions) and; general practitioners accounts compared to other actors' accounts involved in different aspects of primary health care (this latter point has not in fact featured in this investigation). This focusing process has been aptly described by Hammersley and Atkinson, as they compare the process to a funnel:

> "Ethnographic research has a characteristic 'funnel' structure, being progressively focused over its course... over time the research problem is developed or transformed, and eventually its scope is clarified and delimited and its internal structure explored. In this sense, it is frequently over the course of the research that one discovers what the research is really 'about', and it is not uncommon for it to turn out to be about something quite remote from the initially foreshadowed problems" (1983:175).

The research design, for this investigation, was originally constructed to encompass actors in general practice and actors from associated organisations to correspond to the overall conceptual framework that I was developing. Figure 5.1 indicates the interviewed informants' organisational context and the type of "data" collection that was used. The number of informants interviewed is shown in section 5.5.2.

Although not all of these interviews feature in the final presentation of this investigation they have allowed for a wider perspective to be gained. This thesis has been restricted or "funnelled" to focus on general practitioners: it was felt to be more fruitful to explore the case of general practitioners intimately at the exclusion of other groups to do justice to the richness of "data" gained from their interviews and to the unique and complex nature of their occupational development. I suggest that the exploration of these facets could easily be confused, diffused or diluted by diverting the attention to other areas of the NHS. (See also the limitations (9.3) and future research recommendations (9.4).)

Information Sources	"Data" Collection (main source)
Department of Health	Secondary
Regional Health Authority	Primary and secondary
District Health Authority	Primary and secondary
Family Health Service Authority	Primary and secondary
Hospitals (Trust and DHA)	Primary
British Medical Association	Primary and secondary
Local Medical Council	Primary and secondary
Community Health Council	Primary
General Practitioners	Primary
Practice Managers	Primary
Practice Nurses	Primary
Health Visitors	Primary

Figure 5.1 Information Sources and the forms of "data" collection.

After the informants were chosen, various methods of "data" collection were used in this investigation. The primary research methods used are observation and interviewing and the secondary methods include the use of publications and sociological and historical accounts. These methods of "data" collection are now examined in the next section.

5.5 Research Methods

As indicated in the introduction to this chapter, the methods used to investigate general practitioner orientations to work are observation, interviewing, secondary information and recording and transcribing. Using a selection of methods in an investigation is referred to as "triangulation" (cf. Campbell & Fiske, 1959), "multiple strategies for field research" (Burgess,

1984) and "mixed strategies" (Douglas, 1976) for example. Triangulation traditionally refers to situations where "a hypothesis can survive the confrontation of a series of complementary methods of testing" (Webb *et al.*, 1966:174). There is some debate as to the usefulness of using a triangulation approach in qualitative research (cf. Silverman, 1993). Triangulation is used by some as a means by which to get "closer to the truth" (Denzin, 1970) whereby accounts are compared and contrasted to see "who is right". The use of triangulation in this investigation is not to achieve this aim, it is instead a means by which a fuller picture of that being explored can be gained. By using different methods of "data" collection allows for a better understanding of the *situated work* in which actors account for what they do (Dingwall, 1981).

Each of the methods used in this investigation are now discussed in turn, where both the technical and some emotional aspects of the process are examined. There is particular attention to the interviewing method as this was used as the main form of "data" collection. The term "methods" has been defined, in section 5.1, as the tools or techniques that are used in the collection and interpretation of "data".

5.5.1 Observation

A significant aspect of "data" collection involves looking and listening. Following the phenomenological approach, observational methods were used as a means to understand better the actors in their natural setting (in this case, their "working environment"). The term "participant observation" is often used as an umbrella for all qualitative "data" gathering (Ely *et al.*, 1991). It is my belief that this is appropriate as researchers will always influence actors being studied because of the inter-subjective nature of interactions (the rare exception being when the researcher is observing behind a one-way window). However, it is useful to have some typifications to differentiate between participant-observation styles. Wolcott (1988) provides this distinction and

categorises: the active participant, the privileged observer and the limited observer. The active participant has a formal job in the setting being studied, whereas the privileged observer has access to information and is, generally, trusted by the members. The limited observer, most often used, has no additional role other than being a researcher, and is someone who will only build trust over time.

It needs to be noted that the distinction made between observing and interviewing (discussed in the next section) is an artificial one. The two methods cannot be divorced from one another. When interviewing, the researcher would find it hard to separate the spoken words from the non-verbal communication and mannerisms that are used, from the belongings and objects that are in the room or from the way that the person interacts with others.

Before entering the "field" I felt confident that I was able to observe others. I considered myself to be attentive at observation, able to be a sympathetic listener and interested in hearing what others had to say. I had been doing these things for most of my life and felt suitably qualified. When the time came to observe, both in the interviews and when observation was conducted, I found that my skills were somewhat deficient. I was able to observe, interact and sympathise, however I was unfamiliar with the double role that was required. To gain rich "data", I found it integral to be *explicitly aware* of the things that I had previously taken-for-granted, in addition to watching myself and others at the same time. There is a plethora of information to make sense of and also the need to cope with the marginal position. Spradley articulates this position of the researcher clearly and offers useful advise:

> "It will be important to take mental pictures with a *wide-angle lens*. You will experience the feeling of being both an *insider* and *outsider* simultaneously. As you participate in routine activities, you need to engage in *introspection* to more fully understand your experiences. And, finally, you will need to keep a record of what you see and experience. These ... features of the participant-observer role distinguish it from what you already know as an ordinary participant" (his italics, 1980:58).

In this investigation the limited observer role was the one most adopted, as the other roles were, on large, inaccessible. I began the process with a view of noting as much as possible (the wide-

angle lens approach), however, to cope with the volume of observable information available I began to focus my technique. I noted observations of who was who, what the waiting room was like, how the members interacted with me and so on. The observations that I made in the interview were more formalised, to some extent, as I filled in an observational sheet (presented in Figure 5.4, section 5.5.4).

Along with these observations I successfully negotiated permission to conduct a week-long observation at the Dove Practice. As a "privileged observer" I sat with the practice manager for a week, had limited access to information and was able to ask how things worked. This was an invaluable time as I witnessed "behind the scenes" activities and learnt, in more depth, the political nature of general medical practice. Additionally, various health care meetings were sat in upon such as at the LMC and the public consultations for hospitals to become trusts. I was fortunate, also, to be an "active participant" as I co-facilitated on the Advanced Diploma in General Practice Management in association with a FHSA. This was towards the end of my "fieldwork" and I provided "critical incidents" (cf. Yukl, 1981) from my observations and analysis for practice managers to explore. A selection are displayed in appendix K. The feedback and discussion in response to the incidents has been precious as I was able to "fine-tune" my understandings.

5.5.2 Interviewing

Whereas the use of observation enables me to have an insight in some detail into a "normal" working day and hence gives me the opportunity to note specific details within which the informants interpret and act, the use of interviewing enables access to wider contextual issues that are perceived to influence the actions of the participants. Baker (1982, cited in Silverman, 1993:90), raises two important questions about the interviewing process: first, what is the relation

between the interviewees' accounts and the world they describe? Are such accounts potentially "true" or "false" or is neither concept appropriate to them? and; second, how is the relation between the interviewer and interviewee to be understood? Is it governed by standardised techniques of "good interviewing practice"?, or is it, inevitably, based on taken-for-granted knowledge of interpersonal skills?

To answer the first set of questions, it needs to be reiterated that the interviews are not tools to gain access to "truths" or insights into so-called "realities". What we say and do does not emanate internal psychic structures such as personality (Shotter, 1993a, 1993b). Rather, interviews are means (which they can only be, in my view) for the interviewer and interviewee to construct some version of the world which is deemed appropriate when the interaction is taking place. Hammersley and Atkinson state: "That interviews must be viewed, then, as social events in which the interviewer (and for that matter the interviewee) is a participant observer... Interview data, like any other, must be interpreted against the background of the context in which they are produced" (1983:126). In this way, to use Silverman's (1993:107 his italics) term, they are "*displays* of perspectives and moral forms". The second question that Baker (1982) raises is addressed in part 5.6.

In this investigation, intensive semi-structured interviews were conducted. The use of semi-structured interviews was chosen, as opposed to structured or unstructured interviews, as I did not have a clear understanding of the issues that were likely to arise. That is, I did not use just theory-driven questions to guide my analysis as one would with structured interviews. Appreciative listening, rather than a determination on the interviewer's preconceived notions of phenomena, tends to build a good relationship and to allow the informants to guide the process. Furthermore, it is my belief that "unstructured" interviews cannot truly take place as the interviewer will always colour the process - some form of introduction is often required and the researcher's own interests and priorities will shape the nature of the interview (see Spradley, 1979, for a more detailed

discussion). The use of semi-structured interviews is widely supported (by Pettigrew *et al.*, 1992; Hickson *et al.*, 1986; Weick, 1979, for instance).

The interviews for this investigation took between 20 minutes to six hours. For some of these I visited the informant on several occasions. The interview with a LMC representative, for example, took three separate interviews over a six hour period. As I stated earlier (and as suggested by Bryman, 1989), prior to the interview the participants were given an outline which included the aims and methods of my research project and what they could expect to gain from an interview (see appendix J). On meeting the participant, a summary of this outline based on my conceptual framework, was presented to give a broad structure to the interview (see appendix L). This provided two functions: the first, to remind the interviewee of the nature of the investigation and the general areas which I wanted to cover and; second, to give them something to serve as a symbolic exchange. The latter point is, in relation to the strategic exchange perspective, a "trade" between myself and the interviewee (albeit of unequal status). At the end of the interview there was also the symbolic gesture of giving the interviewee my business card. I wanted to do this for a number of reasons - a means by which they could contact me, to signify the close of the interview and to serve as a symbolic thank you "present". Once returned to the office I sent an official letter of thanks to the informants and reiterated that they could contact me if they wanted to elaborate on a point or discuss any aspect of the research (a copy is displayed in appendix M).

The number of informants and practices that I visited was dependent on three things. First, the access problem which has been addressed, second, when I felt that nothing "new" was coming out of the existing informants' accounts (this is what Glaser and Strauss (1967) refer to as the "saturation point") and third, I had set a time-frame of about a year for the "data" collection. As it happened the latter two points coincided. The interviews in general practice are listed in Figure 5.2, where the pseudonym of the practice and which occupational-groupings from each practice took part in the interview process.

Name of Practice	Fundholding	Number of GPs	Number of Practice Managers	Number of Practice Nurses	Others
Blackbird	Wave 2	1	1	1	
Dove*	00	2	1	1	3 P/T Reception -ists
Goose	Wave 2?	2	1	-	
Heron	Wave 1	3	1	-	
Kingfisher	00	2	1	-	
Nightingale	Wave 2	2	1	-	
Robin	Wave 1	3	N/A	1	
Seagull	00	2	-	1	2 Health Visitors
Starling	00	3	1	-	
Swan	00	1	1	1	
Wren	00	2	-	-	
TOTAL (41)	**-**	**23**	**8**	**5**	**5**

Key:

00	Not applied for fundholding status at time of interviews.
Wave 1	Practising fundholding from April 1991.
Wave 2	Applied for fundholding status (to commence April 1992).
Wave 2?	Considering becoming fundholding at time of interviews.
N/A	General Practitioner is also the Practice Manager.
*	Non-participant observation was also conducted.

Figure 5.2 Interviewed informants in general practice.

In Figure 5.3 the number of other informants and their organisation is listed. Please note that the list cannot be more detailed due to the promised confidentiality given to the actors. It can be stated, however, that all the informants hold posts that are directly related to the provision of primary health care. Again snowball sampling proved the most effective way of arranging the interviews.

Informants' Employing Organisation	Number of Interviewees
Regional Health Authority	4
District Health Authority	4
Family Health Services Authority	6
DHA Hospitals	3
Trust Hospitals	3
British Medical Association	2
Local Medical Committee	4
Community Health Council	2
TOTAL	**28**

Figure 5.3 Interviewed informants in general practitioner -associated organisations.

Although the questions that I asked in the interviews varied to some extent, depending on the priorities, beliefs and interests of the informants, I did use a "topic guide" (displayed in appendix N). The guide became more refined when I became more sensitised to primary health care cultures. (For interest, the original questions can be seen in appendix O.) Following Whyte (1960), a feature of the interview was to have a relatively neutral starting point to ease the interviewee and myself into the process. I was often nervous at the start of an interview as my only previous experience with general practitioners was as a patient where I often felt patronised and dis-empowered. I needed to overcome these personal barriers and preconceptions when conducting the interviews. It was I who needed to be the "professional". The "props" that I took to support my "role" included the tape-recorder, a pencil and the clipboard which held my paperwork and questions. The establishment of "roles" was also an issue for some of the GPs.

This, for instance, was manifest in who was going to sit where during the interview. I wanted the informant to indicate where was appropriate for me to sit. I was often invited to sit in their chair as one GP joked "I want to have a go at being the patient".

Particular concerns that I had about the interview process involved the fear that I would ask "irrelevant" questions or not "live-up-to" the image of a "professional researcher". I could see the benefits of being "naïve", however, I was not comfortable with the role. After my introductions, I tended to test-the-water with non-confrontational questions such as "how long have you been here" and "tell be a bit about your job - what does it entail?". This enabled me to identify "safe" areas to return to if I lost direction in the interview.

5.5.3 Secondary Information

As seen in the first three chapters, the use of secondary "data" has been significant. In order to provide a contextual and historical framework, the use of others' accounts and the study of government policy publications has been paramount. The question arises, then, as to how useful is secondary information to the understanding of change in health care settings and what inferences can we draw from the analysis? It has been mentioned in the earlier chapter that the secondary information should be regarded as an account. As Abbott (1991) has indicated, the *outcome* of policies tend to be documented rather than the processes and the negotiations which precede them. However, it is only these accounts which are available to us and we, as all historians, can only infer from what documentation is available to us. With this in mind, the use of secondary information, nonetheless, enables a more in-depth investigation and permits comparisons to be made.

I have attempted to use the secondary "data" to indicate the major changes which have occurred in the NHS since the beginning of the century and as a means to interpret the different strategies that the government has employed in attempting to shape the way in which the Health Service has been managed. In addition, documents and papers have been gathered to aid the

analysis of general practitioner orientation to work, such as LMC newsletters, practice leaflets and FHSA correspondence with GPs.

5.5.4 Recording and Transcribing

Before examining the technical aspects of recording and transcribing, it is useful to look at some ways in which to judge the recording and analysis of an ethnographic study. Dingwall (1992) provides three criteria for this purpose which guide the following discussion. The first criterion discussed here refers to the importance of comparing and contrasting the empirical "data" and isolating the deviant cases. The second criterion looks at some ethical considerations which need to be addressed when analysing and presenting research. The third criterion that Dingwall uses, which in part is questioned, concerns the presentation of "raw data". These criteria are looked at now.

Dingwall assesses ethnographic writing by looking at how the researcher deals with deviant cases. Dingwall explains: "Social science deals in a vocabulary of types. The typical can only emerge from the collection of numerous instances which can then be compared to induce a classification which reflects their similarities and differences" (1992:169). He goes on to comment that these types are highlighted by focusing on those cases which are not classified as the typical. Becker and Geer (1962) point to a corresponding advantage in recognising the deviant. They state that if it can be shown that an actor draws upon a different world view, is socially isolated from the rest of the group and their actions are perceived to be inappropriate or unsuitable, then it can be argued that those who draw upon the dominant world view can be identified as a comparison to the deviant position. The cliché "the exception proves (tests) the rule" summarises this approach. It is my intention to proceed in my analysis in this way.

A second criterion by which Dingwall judges ethnographic writing is the need for the writer to avoid being "right on" (1992:172). The importance of emphasising the "underdog's" case should be avoided, it is argued, if it is at the expense of the other informants in the investigation. Parker and Burman (1993) make a similar point and stress that care needs to be taken when conducting discourse analytical studies. They observe that writers on political discourse are prone to this pitfall. Dingwall insinuates that we, as researchers, should ask ourselves, "Have we conveyed an equal understanding of the goodies and the baddies?". In Dingwall's terms, there needs to be an ethical "fair dealing", giving all a "fair go", in the analysis and interpretation (1992:172). In the same vein, I have stated (in section 4.1.3.i) that the search for *the right* interpretation and comparing and contrasting others' accounts to those "in charge" (where the "top dogs" views are emphasised) is not a feature of this investigation.

The third criterion that Dingwall (1992) uses regards the presentation of "raw data". Two different issues are raised: Dingwall calls for the writer to separate the "data" from the analyses and for the ethnographic researcher to provide sufficient "raw data" (transcripts) so the reader can interpret and analyse the transcripts for themselves. Concerning the first point Dingwall states that the "data" and the analysis should not be confused:

> "What I am taking exception to... is the kind of report that is purely a re-description of the researcher's impressions or sensations. Empathy has its place in ethnography but it should enter after recording rather than being confused with it" (Dingwall,1992:169).

Spradley (1979) raises a similar concern. What can be inferred from Spradley's suggestion to routinise fieldnotes in order to make them more of a reliable source, is the requirement to distinguish between the *emic* (primary constructs) and the *etic* (secondary constructs) analyses. Following these suggestions, the GPs' narratives are featured substantially in the forthcoming chapters, their comments are differentiated from mine and their talk is drawn upon as much as possible to illustrate their rhetorical processes. For instance, in this separation I have intended to highlight how general practitioners are themselves theorisers and have aimed at presenting what they say in line with Rose's (1990:55) idea of "...privileging of the objects of enquiry

along with the subject or author who writes...". Theorising is not simply confined to academics. I have stated that everyone constructs sense-making rationales, or "lay" theories, about their lives, their work and so on which influences how they chose to act and behave. It is important though to separate and not to confuse these primary constructs with the secondary constructs as they are different in nature. "Lay" theories and sociological theories serve different functions: whereas "lay" theories enable people to understand the practicalities of everyday life, sociological theories endeavour to build systematic and rigorous generalisations which do not immediately concern everyday matters (Watson, 1995b).

Dingwall's second point on the presentation of "data" I suggest is more problematic. Dingwall (1992) advocates that ethnographic researchers should provide interview transcripts for others to be able to see, interpret and analyse. Ethnographic studies have been criticised by others too for seldom providing readers with forms of "data" other than the brief, supporting and convincing extracts used in the text (eg. Silverman, 1993; Bryman, 1988; Burgess, 1984). According to Dingwall, the validity or "truth" of research "findings" cannot be judged without this more contextual information. Dingwall is perhaps suggesting that one can be "objective" about analysing "data" which can then be organised into a factual report or summary. It is these assumptions that I treat with caution. I have not included my interview transcripts in this investigation for a number of reasons. First, if one agrees with Dingwall then *all* of the transcripts would have to be included otherwise the writer could still "distort" their findings by selecting only those transcripts which support their thesis. Second, even if all the transcripts were presented would the reader have a "true" representation of the interviews? I suggest that this would not be the case: the form has changed (from the spoken word to the written), some of the content has changed (places, names, organisations) to provide the promised confidentiality and other pieces of information which influenced my understanding of what was said are not always documented (body language, phonetic emphasis, tone and pitch of voice, surgery décor etc.). A third reason for not presenting the transcripts is the claim that, in the same way that GPs will interpret health care phenomena in varying ways because their stock of

knowledge, priorities and beliefs are unique to them, different researchers and readers will interpret the transcripts in differing ways because of thier unique stock of knowledge, priorities and beliefs. In an attempt to reveal some of the ways that I as a writer have influenced the study, a reflexive style of writing has been taken (see 4.1.3). Watson, rightly in my view, suggests that

> "social scientists should turn their investigative searchlight onto their own performances as social actors and manipulators of meanings just as they more typically direct its beam onto the activities of lay "subjects". They need to be conscious and open about their role in shaping the material that they produce" (1995a:303).

I have claimed that the researcher cannot be removed from or separate to their empirical "data". Researchers play an integral part in influencing, shaping and manipulating research projects and cannot be removed from this process. It is for these reasons that the transcripts have not been included. Subsequently, I have aimed to produce a plausible "scientific" account based on the empirical "data" analysis and to show the role that I play in this investigation.

In order to provide some continuity in the recording of the interviews I used the format displayed in Figure 5.4. This is an adaptation from Perkins, Nadler and Hanlon's (1981) observation form.

Date\Time:
Duration:
Interviewee:
Informant Status:
Interview Code:
Site:
Interview Setting:
My Presentation (clothes, confidence, performance...):
Emerging Themes:
Categories:
Interpretations:
Detailed Discussion:

Figure 5.4 Recording sheet for interview "data" adapted from Perkins, Nadler and Hanlon (1981).

The recording of observational "data" however took a more informal approach. The observational resources which were available to me varied greatly from organisation to organisation. I was wary of being restricted by an imposed "tool" to document observational information. In some practices detailed observational "data" was recorded in the waiting room, such as who was present, what they looked like, their actions, my attitude towards them, the organisation of the waiting room and what was said to me.

The material that has been gathered from the different research methods is examined using Glaser and Strauss's (1967) grounded theory loosely. Glaser and Strauss state that the generation of theory can be derived from comparative analysis between or among groups within a substantive area. When the "saturation of data" is reached then theory formulation can proceed. Bryman describes the process as follows, where the researcher "seeks to generate theory which is grounded in data and entails a constant moving backwards and forwards between data and emerging theoretical notions" (1989:167). There are four stages that Glaser and Strauss identify and can be summarised as: first, the researcher compares events relevant to each category; second, the categories and their appropriate theoretical properties are integrated; third, theory reduction and delimiting the saturation of the "data" is done and; last, there is a write-up of the major themes that have been analysed. Glaser and Strauss have been criticised (amongst other things) for neglecting to recognise that the researcher brings their own ideas and conceptions to the project (Silverman, 1993; Williams, 1976; Brown, 1973) and for implying that "theory" is solely derived from fieldwork (Rose, 1982; Bulmer, 1982).

Whereas a grounded theory approach on the one hand aims at a saturation of "data" by thoroughly comparing and contrasting, an analytical induction approach on the other hand involves the analysis and integration of *all* "data" by comparing and contrasting where particular attention is given to deviant cases. Znaniecki (1934) was the first to use the approach as a means to draw causal inference whilst remaining loyal to field "data" (Burgess, 1984). Robinson (1951) identifies six stages involved in analytical induction: first, the phenomenon to

be explained is defined; second, a hypothetical explanation is devised; third, a case is examined to "test" the hypothesis; fourth, if the hypothesis is inappropriate then the phenomenon studied may be redefined or the hypothesis is changed accordingly; fifth, some certainty is achieved as to the plausibility of the hypothesis although some negative cases still exist so the explanation needs to be redefined and; sixth, the cases, hypothesis and explanation is re-examined until a universal relationship can be established. The use of analytical induction has been criticised because of the presumption that universal laws can be generated to explain all cases (Turner, 1953).

In this investigation, the grounded theory approach is loosely followed as my ideas, sociological theories and other influences have tinted the way in which this study has been conducted. Furthermore, explanations are sought to explain "normal" and "deviant" cases, however, analytical induction is not followed in its strong version as the methodological position is different to the one taken in this investigation. The interviews were recorded on a tape recorder and transcribed. Categories and themes are broadly defined to get an overview of the account. This system corresponds to what Spradley (1980) calls the "grand tour". Then, when this has been achieved the closer details are analysed as the categories can be sub-divided and membership categories can be developed. This is what Spradley (1980) refers to as the "mini tour". The emphasis for the analysis after the "grand tour" may change as the unknown becomes known (Lincoln & Guba, 1985).

5.6 The Researcher as a "Bench-mark"

Phenomenologists use themselves explicitly as a "bench-mark" to gain an understanding of a lived experience. The researcher is a "tool" in their own right: their emotions, observations and experiences influence the study and guide the analysis (Reinhartz, 1979). My response to

Baker's (1982) questions (raised in section 5.5.2) will guide this discussion. Baker asked, how is the relation between the interviewer and interviewee to be understood? Is it governed by standardised techniques of "good interviewing practice"? Or is it, inevitably, based on taken-for-granted knowledge of interpersonal skills?

The use of "self" in this kind of investigation is paramount and it is suggested that it must be "tuned" in order to gather "valid data". Lipson states: "Researchers need to know how they themselves behave, verbally and non-verbally, and the impact of their own feelings and reactions on data-gathering and analysis" (1991:77). This, in its strong version, is an impossible task. We, as others, change, interact with different actors in different ways and are unable to access comments on how we have an impact on others. It is, however, possible to note our characteristics, the roles that are intended to be portrayed to informants and for us to become more self-aware. Although we cannot control how others perceive us, we can influence our "impression management" (cf. Goffman, 1959). Implicit in this chapter are some of the attributes that I desired to hold, such as being introduced in association with the University or the accounting firm rather than "just-as-a-student" and wearing certain clothes to distinguish me from the pharmaceutical representatives.

Richness of "data" can only be fully achieved if there is some rapport between the researcher and informant. Similarity of background can aid this process, however, there are benefits of being seen as a "foreigner". As I am a young(ish) researcher and was initially unfamiliar with the workings of primary medical care, I felt that I could ask naïve questions without appearing too foolish. This could only be achieved, in my view, if I was seen with some other credibility. That is, I accounted for my "status" as a Research Officer (in association with the accounting firm or the University) and stated that I had some "organisational expertise" but wanted to learn about the ways in which the informants saw the world.

Certainly the personal characteristics of the researcher influences the nature of "data" gathering. The experienced ethnographer often has a high tolerance for ambiguity and uncertainty, is able to maintain a double role and is able to cope with "culture shock" (Agar, 1980). Keiser (1970) also indicates the need for the researcher to control strong emotional responses and recognises that this is not only difficult but exhausting. If this can be done and preconceived ideas can be "bracketed" then the world view of the informant can be understood better. The process is a learning one, the taken-for-granted assumptions that I held about myself have changed. As I became familiar with the interview process I became more aware of what I brought to the fieldwork setting. Lipson uses an apt analogy to describe a process similar to the one that I experienced:

> "Assuming that the field worker is basically a sound instrument, picture the difference between the a novice musician, who can play the right notes and rhythms and get the job done and a master musician, who makes the instrument express a broad complexity of colours, feelings, and tone that really speaks to a broad audience. The ethnographer as a research instrument is capable of progressively finer tuning with effort and time" (1991:88).

A danger in writing qualitative research is a failure to report or deliberate upon the effect that their gender had on the gathering of interview and observational "data" (Silverman, 1993). This has somewhat been addressed by female researchers, especially those taking a feminist approach to understanding (Golde, 1970 for example was the first to focus on gender with the impact of subjectivity in fieldwork). There is a requirement to handle what Warren (1988:177) calls "subtle and not so subtle sexism". In all correspondence in my research for example I signed my name "S A Riggs". This was not a deliberate ploy to hide my gender, however, some informants (one in particular) interpreted this to be the case. A general practitioner said, when I arrived for an interview, "I thought that you would be a man". I replied jovially, to lighten the tone, "No, I am a woman, some academics are you know!" His response was, "I don't like people who lie to me... If I had known that you were a woman at the start then I might not have had agreed to this". But he did agree and I bit my tongue. I decided that the focus of my research did not directly concern gender issues, so it was more appropriate to open the discussion on change in primary health care. Scott (1984) also notes the need not to engage in

arguments when confronted with sexist comments whilst interviewing her sociological peers. As the researcher becomes more self-aware during the fieldwork process, these issues can be ignored or not taken personally. Personal issues need to be "forgotten" during the process to avoid inhibiting the informant from accounting their "story".

In summary, the aim of using self in an investigation is to gain close, in-depth, rich "data". In summary, the quality of the "data" collected derives from five characteristics: closeness to people; contextualisation; process analysis; flexibility and openness; and credibility (for a more in-depth analysis of these characteristics see Watson, Riggs & Fook, 1991).

5.7 Finding a Structure

Here I explain my rationale for how I have presented the "data". The structure of this study reflects the many ways in which the "data" can be analysed and presented. The broader, more theoretical, concerns of presenting qualitative "data" were examined in chapter 4. However, it is important to describe the courses of action that I have followed in attempting to present an analysis. I conclude this section by explaining the strategy that I adopted for the analysis. This is what Stanley calls an "intellectual autobiography". She urges the "teasing out of *how* research processes are understood [by researchers] so as to produce any particular product" (Stanley, 1990b:120).

As identified earlier (section 5.1), the research process is not a linear continuum, where one stage "naturally" progresses onto the next; but rather it is more haphazard in nature. Aldridge, for example, when re-accounting her thesis in an "alternative" version, states, "In the thesis account of my research, it is implied that a review of the literature occurred first, followed by the event development of the hypotheses, followed by the choice of method. In fact, however, I

began with the method" (1993:61). Researchers often "try out" different approaches in their thinking and writing, until they feel an acceptable outcome has been reached. An integral part of the research process which could be described as "muddling through" is often not documented. It is my intention to reveal the procedures that I have undergone and account for, in general terms, the paths that I have taken. The purpose of describing this process is two-fold. First, it will give the reader some knowledge as to the progression of my thinking and second, it will describe the chaotic and ambiguous aspects of doing scientific research.

The structure of the thesis to this point led me to approach the analysis of my interview material from a particular stance. I have written the thesis in just about the order that it has been presented (apart from general editing changes, the introduction and abstract which are addressed last). It seemed logical to analyse the "data" with reference to the historical context of organisational and occupational change but also with particular attention given to the individual orientations to general practice. This latter decision was taken partly as it seemed rational and consistent to focus on how GPs attach meaning to their everyday lives and it is an area which, I feel, has been neglected in other studies. The conceptual framework developed in chapter 4, provided a structure within which to categorise the informants - drawing on an "occupational orientation" or an "organisational orientation" to work. Abbott (1991) similarly suggested that the understanding of "professions" should consider three elements - the individual, the "professional" organisation and the state. Therefore, I interpreted the interviews and placed certain actors that "conformed" to this structure. I began my interpretation after categorising the actors accordingly.

There were, however, several problems with this approach. I found that there were several GPs that I could not categorise in terms of having either an occupational-orientation or an organisational-orientation. The categories devised were too general. For example, the organisational aspects of their talk were very broad and far ranging. While for some, the focus of their attention was the NHS as a whole (both politically and/or administratively), for others

it was the relationship between themselves and the FHSA and for some it was restricted to the organisation of their practice. Consequently, I sub-divided the organisational category in this manner. I purposively avoided defining in detail the orientations to general practice as these would, I predicted, be provided for me by the informants - that is, following Glaser and Strauss's (1967) grounded theory loosely as explained in section 4.1.4. This was not so - these themes did not emerge as expected. The actors did talk about their likes and dislikes of the organisational and occupational aspects of their job, for example, however, there were no clear-cut distinctions within what was said. I carried on the trying to categorise the informants and renamed the occupational and organisational categories as "professional orientation" and "business orientation" to general practice. These categories, I felt, were more fitting to the informants' experiences. For instance, instead of an orientation to the representative bodies (such as the BMA) as implied by the category "occupational orientation", the actors told of their clinical medical practice that they were conducting and the importance of the relationship with their patients. Furthermore, those categorised as having a "business orientation" were identified as oriented by the administration and income generation aspect of general practice. The initial category used, the organisational orientation, I felt denoted an orientation to the NHS organisation as a whole. Hence, I also devised a new category - an "administrative orientation". The actors that I identified in this category drew on aspects of a "professional" and "business" orientations in equal measure. Figure 5.5 summarises the direction that I was taking.

On closer examination of the interviews, however, the informants' orientations were more diverse. As the analysis proceeded, similarities between the interviewees dwindled. After much deliberation and what felt like "trying to put square pegs into round holes", I abandoned this approach and sought to find one that would be more fitting to the "data" that I had.

Typified as more worthwhile in general practice	Typified as less worthwhile in general practice	Expressed as...	Typification of orientation to work
Clinical work	Administrative work.	"I'm too busy with clinical work to do the administration or I'm too busy with the administration to do my clinical work properly."	"Professional" orientation to medical practice.
Clinical and administrative work	Even balance between clinical and administrative work.	"Sound clinical work is based upon good administration, or there is too much of both to do either properly."	"Administrative" orientation to general medical practice.
Administrative work	Clinical work.	"This is a business and the administration of it is what ensures our income or we are doing too much for the patients and neglecting ourselves."	"Business" orientation to general medical practice.

Figure 5.5 Typifications of worthwhile and less worthwhile attributes of general practice and orientations to general practice.

The next strategy that I took involved using the dilemmas identified by Klein (1989) examined in the earlier chapters. This approach was intended to mirror the more historical and contextual analysis with a micro analysis. In chapter 3, I explored the usefulness of these categories in aiding an understanding of *Working for Patients*. Therefore, it seemed realistic to expect that the same structure would be useful to understand better the accounts of the informants. Again, as with the orientations to general practice structure, some accounts fitted into this scheme, however, there were more deviant cases than not.

What I felt was missing from both of these schemes was the scope to do justice to the richness of my material and the complexities of general practice. Each scheme had some benefits, but in the main missed the active and creative constructions which the GPs gave. The schemes were too one-dimensional and the accounts did not fit neatly into the categories that I used. Although

I knew that categories often had to be developed and changed (cf. Ely *et al.*, 1991), the problem was more fundamental than slight alterations would allow.

Next, I began thoroughly to examine the intricacies and complexities which each general practitioner constructed in the interview setting. I kept the ideas that I have been developing, such as the tensions between the administrative and occupational principles of work, but these were at the background of my thinking with the hope of seeing the "data" afresh. While looking at each informant's story, their sense-making rationale, I found that many tensions that Klein identified were apparent and also the GPs were accounting for their orientation to general practice, but the ways in which they were doing this were jumbled. The problem that I was encountering before - bracketing off and trying to categorise each informant - was in fact the solution. I had set up ideal types, but instead I found contradictions. The GPs were drawing on notions from theoretically conflicting perspectives in order to construct the discourse that they were presenting in the interview situation. GPs were not taking fixed positions or ideas, such as a "professional" orientation to work or an "organisational" orientation, but working through their confusions and discrepancies taking ideas from each "camp". This process, which I call "messy" accounting, can be argued to be a reflection of confusions that are apparent in the NHS organisation. This state of confusion is a theme that runs through the interpretation of the interviews in the next few chapters. Subsequently, the analysis of the "data" needs to take a different form. Instead of only focusing on the content of what the informants said, as I attempted in the previous strategies, attention needs to be given to *how* GPs are battling with paradox and ambiguity. Therefore, in Spradley's (1980) terms, the "grand tour" needs to be travelled in a different vehicle.

With this new focus, the categories needed were of a different nature than before. Attention, in this scheme, is given to the *ways* in which the informants' account for this confusion and to the discourse that they use. Thus, a central question arises: how do informants attempt to produce plausible accounts of their actions? To accomplish this analytical task, the kinds of accounting

practice that are in use need to be examined. In Wetherell and Potter's (1987) terms, the required emphasis needs to be on the "interpretative repertoires" drawn upon. Potter and Wetherell, who develop Gilbert and Mulkay's (1984) ideas, define interpretative repertoires to be

> "...recurrently used systems of terms used for characterizing and evaluating actions, events and other phenomena. A repertoire ... is constituted through a limited range of terms used in particular stylistic and grammatical constructions. Often a repertoire will be organised around specific metaphors and figures of speech (tropes)" (1987:149).

The use of discursive resources (Watson, 1995a) is not linked intrinsically to social groups. Therefore, the problem of finding natural parameters or boundaries, which I attempted before, does not arise. Potter and Wetherell raise the same issue:

> "Rather than make the somewhat unlikely assumption that all these people [in certain occupations]... are members of the same social group, it is much more fruitful to accept that repertoires are available to people in many different group memberships and patterns of accounting may not be the neatest way of dividing up society, or confining conventional group categorisations" (1987:156).

Accordingly, in the next chapters, where the orientations to general practice and the responses to the White Paper are examined, I do not assemble the GPs into neat and all-inclusive "social groups". Instead I focus on the rhetoric used and the discursive resources that are drawn upon to elicit patterns and themes to aid a social scientific understanding of primary health care phenomena.

Guided by the exploration here and by the more conceptual discussion developed in the last chapter I suggest that the following framework is useful in the interpretation and analysis of the empirical "data". In the following figure (Figure 5.6) I present a framework on the relationship between informants' accounts (their rhetorical dimension), linguistic devices drawn upon (discursive resources) and sociological typifications (ideal types) which aid our understanding of how the present health care "reality" is constructed. This framework will be used as a guide for analysing and interpreting rhetorical and discursive resources used by general practitioners.

Rhetoric

The act of speaking and writing using linguistic devices. Linguistic devices, such as figures of speech, expressions and statements, are drawn from discursive resources which aid and guide our interpretations of phenomena, situations and events. The rhetorical devices in-use are functionally designed to achieve specific tasks and to persuade others to see the world in particular ways. Speaking and writing can be contradictory when the function of the talk is "confused".

Discursive Resources
(Discursive Construction)

Discursive resources are culturally-defined and are drawn upon to construct arguments and persuasions: they are a set or pattern of linguistically-shaped ideas, principles, beliefs, etc. selectively drawn on by social actors. Different discursive resources are drawn on or ignored by actors depending on the functional and situational nature of their argumentation and persuasion.

Accounts are interpreted as "messy", paradoxical and ambiguous when opposing or contradictory discursive resources are utilised and recognised when interpreting the same phenomena.

Possible Discursive Resources Drawn upon by GPs

To frame their understanding of the present health care situation.

* Professional discursive resources

* Administrative discursive resources

* Market discursive resources

Ideal Types
(Analytical Construction)

Abstract models or simplified representations of the discursive resources in-use by social actors. Ideal types are constructed by social analysts. By conceptualising and typifying social actors' primary constructs into secondary constructs aids our understanding of how actors make sense of phenomena, situations and events.

In this way, social analysts elicit themes and patterns in their "pure" or "abstract" form in order to generate theoretical generalisations.

Possible Ideal Types Constructed by Social Analysts

To aid a social scientific understanding of work control in the present health care system.

* Occupational principle of control

* Administrative principle of control

* Market principle of control

Figure 5.6 A basic framework for rhetorical and discursive analysis: discursive and analytical tools used for constructing and interpreting what is said and written.

5.8 Rounding Up

In this chapter the philosophical aspects of an investigation (explored in chapter 4) have been complemented with pragmatic considerations. As this is not a textbook on research methods, I have discussed those aspects which have been significant to this study. The research methods employed (observation, interviewing, secondary information and recording and transcribing) have been examined and some issues involved in recognising the researcher as a "bench-mark" in investigations of this nature have been looked at. Furthermore, I have presented, in general terms, the obstacles that I overcame to find an appropriate structure in which to present the "data". As Silverman (1993:viii) succinctly states, "learning through doing is a wonderful way of appropriating knowledge and turning it into useful skills" - it is only the actual *doing* that teaches and develops the researcher.

In the next three chapters, attention is given to the analysis of the "data" using the conceptual framework developed in the last chapter and the methods which have been discussed here. Furthermore, the general framework for analysing and interpreting rhetorical and discursive resources presented above will be used as a guide in the forthcoming analyses. In the next chapter I focus on the ways that some GPs are seen to report their orientations to general practice. Hence, a more specific analysis begins on how they manage their day-to-day lives. In this analysis attention is given to the ways in which the informants describe their lives, views and so on. In particular, the grammar and style of language used is looked at - that is, the rhetorical repertoires used are highlighted (as explained in section 5.7). It has been argued that language is culturally-defined and is seen not just as a tool for saying things but is also seen as an act of doing - "to order and request, persuade and accuse" (Potter & Wetherell, 1987:32).

Part III

Rhetorics, Rationales and Reasonings

How can I know what I think
till I see what I say

G. Wallas

Chapter Six

Dreams and Pragmatics: Prior and Dynamic Orientations to General Practice

6.0 Introduction

The next chapters are devoted to the analysis of the empirical "data". In these chapters the focus is in the main on the individual. Chapter 7, however, links the individual and health care phenomena with the broader structural and conceptual exploration. Here I concentrate on and analyse how individuals describe their reasoning for becoming general practitioners and how they present ideas on what it means to "be" a GP. The purpose of this exploration is to highlight that general practitioners are not an homogenous group of people which act, interpret and behave in exactly the same way. I have asserted previously that the aim of an inquirer, in an investigation such as this, is to enter actively the worlds of the actors and to accept that people hold different perceptions of the world. Perceptions of the world are guided by our stock of knowledge - the unquestioned assumptions that we use to typify, categorise and to understand the world. GPs are no exception to this. They draw upon their experience and understanding of general practice, the health service and the world in general. Subsequently, I contend that each general practitioner will respond differently to the recent "state-initiated managed change strategies" in a manner which is unique to them. How they respond is dependent on how they view the world (general practice and the health service) and how they see their role and place within it. However, although I contend

that GPs are unique individuals, they are also they are part of an occupational group. The group identity can be defined by the GPs themselves, the state, patients or by others. Attention here though is given to the GPs accounts. Therefore, in this chapter I examine and interpret the individual orientations to general practice and seek to identify specific themes which may categorise or unite the GPs as a group. Links are made between the analysis in this chapter and chapter 8 where the perceived affects of the implementation of *Working For Patients* are examined.

Before I start the analysis, it is useful first to review the shape that the thesis has taken so far. In chapters 1, 2 and 3, I explored the major changes that have affected the NHS structure as a whole and consequently individual GPs. Integral to this exploration has been the use of Klein's (1989) categories of the dilemmas, or tensions, which he uses to make sense of the NHS. For instance, Klein identifies the dilemma between ensuring professional autonomy and enforcing bureaucratic controls. Focusing on this dilemma is crucial because it is apparent in the GPs' sense-making rationales. The general practitioners spoke explicitly and implicitly about the relationship between these two opposing forces (this tension is examined in detail in the next two chapters). In chapters 4 and 5, consideration was given to the philosophical, methodological and design issues that underpin an investigation. The conceptual framework developed here, resulting from a discussion of the individual, the organisational and the occupational, comprised three logically-formulated aspects of orientations to general practice. These three aspects of general practitioner work are interconnected in the informant's accounts. How these relate to each other is explored in the analysis. Furthermore, it was argued in chapter 5 (5.7) that using stringent categories inhibits the richness and complexities of talk to be examined. Consequently the accounting practices that are used by the GPs are interpreted where particular attention is given to the rhetorical repertoires which are drawn upon.

To summarise, in this chapter (and chapter 8) I examine the talk of GPs' who are involved in and experience the processes of change as they unfold in the 1990s. How the historically-rooted tensions manifest themselves in their experience and talk are analysed. Thus, the structural sociological analysis is balanced by the more microscopic emphasis on process, whereby individual actors make sense of situations and express in their personal lives certain dilemmas and tensions. The use of "rhetorical devices" (Wetherell & Potter, 1988) is introduced as I explore how the informants are seen to report their ideologies and everyday actions in a coherent but often paradoxical way. The rationale for a focus on language was argued in the last chapter (section 5.7). The close examination of the general practitioners' accounts provides a springboard for the next chapter where there is a particular emphasis on the tensions between the "occupational" and "organisational" principles of work control in the light of *Working for Patients*.

This chapter takes the following form. In section 6.1 I state my approach to understanding better how actors are seen to report their orientations to general medical practice. Then, in section 6.2, the reasons that general practitioners use to define why they entered general medical practice (their "prior orientation") are explored. Next, I interpret how the informants related in the interview process what it is like to "be" a GP (their "dynamic orientation") (Watson, 1995b) in section 6.3. I conclude that GPs' expectations and understandings are unique. In the second section, 6.4, I examine how obstacles, pressures and constraints are seen to be reported by general practitioners. A central theme arises from this discussion - the perceived constraint to practice medicine as they would like because of their sense of "loss of control". Last, in section 6.5, I draw some inferences from the analysis and round up the main points raised in this chapter.

6.1 The Nature of Practising General Medicine

In the following sections I explore the reasons that the general practitioners used to describe why they entered general medical practice and then I examine what resources they drew upon to describe what it is to "be" a GP. Hence, the GPs' "prior" and "dynamic orientations" to general medical practice are examined (Watson, 1995b). Instead of analysing the groupings of GPs which were formulated previously (described in section 5.7), I view the general practitioner's account individually. The emphasis of this analysis is on the interpretative techniques and the rhetorical devices that are used by the GPs as they talk about their orientations to work. I acknowledge that by focusing on this aspect of their talk, their orientations, I deny the reader some wider context of what was said. This denial, however, does allow for some degree of clarity in the discussion, and the actors are reintroduced in other sections of this chapter and in chapter 8.

One conclusion drawn from the forthcoming analysis is that GPs are not a unified group of people who view the world of general practice from the same perspective. Each general practitioner is unique, however certain themes in their accounts can be identified. The accounts constructed by the general practitioners are viewed as flexible, inconsistent and sometimes contradictory. It has also been argued previously that the accounts are constructed and reconstructed in the interview process. With an analysis of this kind, common themes are highlighted as to the ways in which the GPs define their work. This method of analysis is in opposition to the more traditional psychological approaches to investigating occupational choice where there has been a tendency to view the actors' responses as an indication of underlying structures which govern their decision (Moir, 1993). Alternatively, it has been argued that we account for our reasons in a retrospective manner as we justify the (occupational) course of action followed. This rationale is what Garfinkel calls "assigning outcomes their legitimate history" (1967:114). Throughout this chapter comparisons and references are made to the discussion on individual, occupational and organisational understandings already presented (mainly in chapter 4). Attention is first given to

the discussion on prior orientations to general medical practice them to the dynamic orientations as described in the interview setting.

6.2 Prior Orientations to General Practice

It was argued in chapter 4 that our identities are "emergent" and change in accordance with the perceived "environment" in which we are operating. In order to achieve a better understanding of GP experiences it is beneficial to concentrate on how they explain their expectations before entering general practice and the reasons that they account for their choice - their "prior orientation". By focusing on the "prior orientation to work" we can see some of the values, priorities and beliefs that the informants spoke of, which are potentially matched with their occupational choice. Two broad categories are presented here - the first (6.2.1) includes those who are seen to report definitely wanting to work in general medicine and second (6.2.2) those who talk of more uncertain reasons of entry such as "drifting into it". The distinction between these categories is unclear as some of the GPs contradict themselves and speak of definite and uncertain reasons.

6.2.1 "Fighting Lions in Africa": Proactive Reasoning Rhetoric

Dr Skerne is an example of someone who says he always wanted to be a doctor and hence is typified as drawing on a proactive reasoning rhetoric. Initially, he describes the decision as an "unconscious" one which he made early on in his life. He said, in response to, "I want to know why you became a GP in the first place".

> "Right. Erm, well why I became a doctor in the first place I had never wanted to anything else as far as I can remember from when I was at primary school really,

> although I have no family connections, my dad was a baker, huh! I suppose that I did well enough at school to get into medical school and er <<shrugs>>".

I felt that there was more to this than that stated, so I asked the "follow up" question, "You don't know why?".

> "Well I can remember when I was five or so that I dreamt of being a missionary doctor for some reason. Then I didn't really figure initially that er missionary doctor had to, was initially related to religion than fighting lions, I had the idea that fighting lions in Africa was what missionary doctors did for some reasons. Then after a few years I dropped the missionary bit and wanted the doctor bit for what I wanted to be. Why general practice erm, I suppose that after I mean, everybody has to do the house jobs in medicine and surgery and after that you make your choice really for what career that you want to follow, and it seemed that the vocational training scheme in general practice would keep my options open at least at that time, then perhaps when I had a bit of experience of general practice I found that I liked it and thought that I would suit it".

In the first response Dr Skerne suggests that his occupational choice is surprising as he knew no one who was a doctor when he was a child. His father was a baker, he says, and he justifies the choice by saying he "did well enough at school". Allen (1994) found that over 70 per cent of doctors who qualified in 1981 and 1986 had fathers in social classes I or II. One way of understanding Dr Skerne's process is by inference from looking at what he did not say. He did not say if his father worked for himself or for someone else. If the father was self-employed then parallels can be drawn from the two "different" occupational groups - both jobs exhibit some degree of autonomy of task control. However, when asked for clarification he draws from his childhood fantasy of "fighting lions in Africa" and then from more pragmatic resources such as "keeping his options open". First, he links his decision to fighting. He goes on to say that he "dropped the missionary bit", implying that he kept the fighting "doctor bit". This fighting metaphor is seen in many guises throughout the interview. He describes a political outlet as a means to voice his opposition to the implementation of *Working for Patients*. This political orientation is seen as a means to "fight the changes". Dr Skerne is suggesting that he is a fighter who is always on guard, keeps his "options open" and is ready to take action.

Looking at Dr Foston's response, he says that it was a definite decision to do general practitioner work. However, he goes on to suggest that he originally wanted a hospital career. He does say that his decision was made when training at medical school. He comments,

> "Oh yes, it was a very definite decision. When I was in (sigh) the fifteen minute industry. I think originally I had thoughts of going into surgery, something surgical and then I sort of changed my mind. There was probably a fair influence from going out to see GPs as a medical student as well, I trained in Bristol and one of the things that we did was to actually spend all night actually living with a GP in the community **Oh, right**, as well as spending sessions actually going to GPs in the term. I think that had quite a profound influence on me as well (Voice getting quieter and quieter)".

This general practitioner can be seen as drawing upon an intellectual rhetoric device. He talks of "thoughts" of a surgical path, his "changing mind" and "profound" influences. Dr Foston is telling me that it was a rational decision that he made after he had spent sometime with a general practitioner. Additionally, he briefly suggests his discomfort with pursuing a hospital career (which he calls "the fifteen minute industry"). From this comment, it is implied that he is not satisfied with seeing patients for a short period of time and that he needs some degree of continuity in his work.

Coincidentally, George Rudston gives a similar account as he talks of his negative orientation to hospital medicine. He began his medical career wanting to be a surgeon. When he conducted his houseman training, he tells of being criticised for spending too much time with the patients. In his terms, this is where his "conceptual view" changed as he became aware of the possibility of becoming a general practitioner. He said:

> "My boss there [at his training hospital] decided that I spent too much time with people and he said that it would be a good idea if I became a GP... So, he put me out to meet some of his friends who were GPs... he changed my sort of contact with various things... it changed my conceptual view, at that stage I was going to go straight on into surgery. I wasn't one hundred percent committed to surgery otherwise I would have done it".

What Dr Rudston and Dr Foston are both describing here is what we might call the inter-subjective nature of being human. In section 4.1.2, I described the interrelation between the individual and the world and how people are influenced by "outside" influences. What we can

interpret from the above accounts are that the experiences of what it was like to be a general practitioner was outside their stock of knowledge. As Dr Rudston became encouraged by others and as he became aware of the appeals, through talking to those practising in general medicine, general practice came to be the medical path that he chose to follow. In other conversations with Dr Rudston I understood that he wanted to be seen as an assertive individual and here we can see a continuation of this theme. In the above words, Dr Rudston suggests that the advice and influence of others had an affect on his decision. We can infer that he was assertive enough not to change his ways of spending "too much time with people" and found an "environment" that was more suited to his method and to his personality. It is suggested that Dr Rudston's prior orientation to general practice was positive and he saw it as an opportunity to fulfil his satisfaction of spending time with patients.

Similarly, Dr Barmston stated that his orientation to general practice was an "easy option" and a result of a negative orientation to the insecurity that he perceived in hospital medicine. "Why did you choose to become a GP?", I asked. He replied,

> "Because it was an easy career option. The original choice was made when I was in house jobs and general practitioner post-graduate training at that time it was reasonable secure because you had a package of training that was produced with an end product basically. As opposed to at that time to other speciality training which was less secure".

Hence, Dr Barmston wanted to make sure that he had some security in his work. What he means by security, he implies, is knowing what he is to get from a situation - "the end product". He suggests this was not available to him if he took up a hospital career. This, as we shall see later, is a concept that he uses to criticise what I term the recent "state-initiated managed change strategies".

What the above narratives have in common is, what I call, a "proactive reasoning rhetoric". In the processes of speaking, people are interpreting, constructing and reconstructing a story of what happened and shape their story to suggest various rationalities of what occurred. Accounts can

alter in many ways but may vary in the extent to which they emphasise a degree of personal control, rational thought or positive decision-making on the one hand and chance, fate, confusion or accident on the other. The proactive reasoning rhetoric, explored above, is in the former category. In comparison other GPs spoke in more indecisive terms for their occupational choice. The latter category is examined in the next section.

6.2.2 "Falling into it": Reactive Reasoning Rhetoric

Dr Thorpe's account is an example of drawing from a reactive reasoning rhetoric. This category of reasoning is typified as informants emphasise reasons of chance, fate or a "drifting" into general medical practice. He responded to the question "Have you always wanted to be a GP?" by saying,

> "I suppose so, but only very vaguely because the undergraduate medical course contains very little information about General Practice, or it did then. Erm so one gained ideas from being a GP from being a patient, and one's own GP in terms of what they did to you as a patient when you were a kid et cetera, and that's what it's like then you get another view from the hospital angle that you see it as a rather crude and a hotchpotch of activity when I think that it is in fact very well organised, and things appeared not to be very satisfactory and you think that you go into that and be a different sort of person, the sort of person that the hospital doctor would approve of because that's you angle of the time".

Edward Thorpe states that the information he had about general practice, when he was at medical school, was minimal. He raises two experiences which he defines as influencing his decision to go into general practice. He states, primarily, that his stock of knowledge of general practice was restricted to his childhood relationship with his GP. He does not, however, state if this was a positive or negative experience for him. Dr Thorpe then suggests that his hospital experience was an influence. He distinguishes the two occupations, surgeons and general practitioners, into what he calls two different "disciplines or philosophies". He goes on to a political analogy to explain his distinction, he said,

> "They are like chalk and cheese... you know you can never expect a Socialist to understand a Tory or vice versa, there are different sorts of philosophies and

> attitudes that they are trying to serve. So one will always see the other as getting it rather wrong. It is the same in hospital medicine [compared to a] GP".

He goes on to develop this distinction, which is summarised as follows. On the one hand, he says hospital surgeons, the chalk, see people as patients in that the "patients are there for them", are "isolated from reality", and have "enormous empires [which include] GPs, nurses and so on". On the other hand, he is seen to report that GPs, the cheese, "need to see people as people" and "see the reality" of their patients' everyday lives.

Therefore, Dr Thorpe accounts for the difference between the two occupational groups with regard to the power position which he perceives each to hold. He says that hospital doctors hold a powerful position in the health service which he sees being supported by other medical workers such as nurses and general practitioners. He implies, by omission, that he sees general practitioners as not having such a station of control and he indicates that GPs are not able to be "isolated" from the "real" world and from the lives of the patients that they treat. Dr Thorpe states that he sees the power balance becoming more equal between the two groups (surgeons and GPs). He says, "Well it [the power imbalance] is much less nowadays because people who are in hospital medicine are having to face the realities of needs of people rather than people as patients". Furthermore, he claims that "people have more power in terms of being able to complain about the treatment and the length of time that they wait in hospital they [hospital surgeons] are having to do something about it". This "consumer power" aspect of his talk is discussed in the next section. Returning to his original statement and how he accounts for his decision to enter general medical practice, two points can now be inferred in the light of the above context. First, Dr Thorpe implies that he wanted to gain approval from the hospital doctors by proving that he could be a "good GP". What he insinuates by "being a good GP" is that he wanted to be organised in his activities (not working in a "hotchpotch" manner), sophisticated in technique (not "crude") and be seen to be "isolated" from his patients in that he does not get involved in their lives. Further, he suggests that the people from the two occupational groups will not appreciate the work of the other because of the different priorities and methods of practice that

he associates with each - in his terms, the "different sorts of attitudes that they are trying to serve". He implies that he did not understand the philosophy or the "workings" of general practice until he entered this work. For instance, he is seen to be reporting his satisfaction from the "intimate and close relationship" that he has with his patients - a practice which he suggests is criticised by hospital doctors. Second, he implies that he saw a personal challenge in "sorting out" the "disorganised activities" which were perceived in general medical practice. (Some contradictions in Dr Thorpe's account are discussed in the next section.) These are more "reactive" reasoning styles and are of a different nature to those which I termed "proactive" (discussed in the last sub-section).

The next general practitioner that I consider is Dr Elliot Woodmansey. Dr Woodmansey talks of "falling into" medicine. He is persuading me that things just happen to him and that he is a drifter in life. Responding to the same question as above he said,

> "I don't know. It just seemed a logical choice, it just happened. The UCCA form filled itself in, my tutor decided that I would be applying for medicine. I have never really thought about it, I do not make conscious decisions. Why do things happen? Having got this far it was the right way for me".

Like Dr Skerne he implies that he was bright enough for medicine, or he implies that his tutor thought so. However, unlike Dr Skerne, he dissociates himself from the decision. Dr Woodmansey thus suggests that he sheds or disowns his responsibilities. This is not to say that he necessarily does so with his patients but rather in his job choice or personal life. This disowning rhetoric is something that I return to in chapter 8 as Dr Woodmansey again draws upon this to explain why he does not think the recent state changes will not affect him and his work.

In this discussion of "prior orientation" to general medical practice some categories and themes have been devised and analytical tools have also been used. The purpose of this is to compare and contrast how the actors are seen to report their reasoning for entering this occupation. As explained in section 5.7, particular attention has been given to the discursive resources used and less attention to the general categories identified earlier. However, two broad categories emerged -

those who gave more definite reasons for entry and those who suggested less certainty. Similarly, Pavalko (1972) identifies two approaches in the literature to occupational choice. He said,

> "One approach emphasises the deliberate, planned, rational and purposive nature of occupational choice. The other characterisation views occupational choice as more spontaneous, non-rational and adventitious. According to this perspective, individuals are seen as 'drifting' into occupations by virtue of situational influences and pressures" (1972:78).

Although it can be assumed from my interpretation that both approaches are applicable to the understanding of why people enter medicine, the picture that Pavalko describes, I argue, is too simplistic. Neither approach described takes into consideration the structural constraints that can inhibit a person from entering a particular occupation. This constraint corresponds to what Giddens (1984) refers to as "structuration" (see p.129). The structural constraints which prevent someone from entering medicine include the restricted entrance to medical schools and academic achievement. Furthermore, family, class and educational background are important aspects in the shaping of an actor's prior orientation (MacKenzie, 1974). It must be remembered that the above excerpts do not necessarily represent the "actual" expectations, desires and wants prior to general practice entry. They do, however, indicate some values, ideas and orientations that the GPs draw upon in the present situation to explain their course of action. Two broad categories were devised to present how the GPs account for their reasons for entry. As we have seen there is not a clear cut distinction between the two categorised groups - some GPs talk of both definite and vague or unsure reasons for entry. What we are witnessing is an act of doing through language. The general practitioners are constructing and reconstructing a story of why they took a certain course of action. If we concentrate on the function or consequence of their talk as a form of self presentation, then we can divide the GPs into those who seemed to want to present themselves as more or less decisive and those who want to present themselves as more uncertain or vague in their decision-making.

A further theme can be identified from these narratives - what has been apparent is the decision was told to be made, in the main, whilst the actor was at medical school. Although some say they

definitely wanted a job in medicine and some say they drifted into it, the choice was generally made later on in their academic lives. It is to be remembered that because orientations to work are argued to be dynamic the reasons, expectations and wants described are likely to change in varying work and non-work circumstances. Correspondingly, Becker, Geer, Hughes & Strauss (1961) identified a similar theme in their American study. They described and typified medical students' selection criteria for deciding between a hospital specialism and general practice. In the next section there is an analysis of how the general practitioners construct rationales to explain what it means to them to be a GP.

6.3 Dynamic Orientations to General Practice

"Dynamic orientations to work" prevail once the actor has entered the organisation (Watson, 1995b). These are said to be "dynamic" as they are liable to change according to the perceived working and non-working situation of the person involved. This was argued in section 4.2. Similarly, Becker, Geer, Hughes and Strauss in *Boys in White* (1961) state that individual conduct is influenced by situations and actors outside the immediate context and by the personal constraints and generalised values that the individual draws upon. Most importantly Becker *et al.* "contend that much of human conduct is oriented to the immediate pressures and social controls originating in the situation in which the person is presently acting, and that he [or she] will organise his [or her] behaviour so as to take account of and in some way adjust to them" (1961:442). Therefore, the reports of "prior orientations" to general practice are prone to change as present circumstances are perceived to change. A focus then on how "dynamic orientations" to general practice are seen to be reported allows for a closer examination of how the GPs perceive the present health care situation. Thus, the (potential) impact that *Working for Patients* is seen to be playing in their everyday lives in general medicine underpins this analysis.

A key feature in the study of orientations to work is the "trades" or "exchanges" that the general practitioner perceive they are involved in. In section 4.4, I introduced this notion of exchange where it was stated that there is an exchange relationship between the individual and the "organisation". This exchange involves material objects, such as payment for services from the "employing" organisation, and also more abstract and symbolic "trades". Conceptually these exchange processes compare with the terms "effort bargains" (Baldamus, 1961), "psychological contracts" (Schein, 1978) and what Watson calls the "implicit contract". Watson defines an "implicit contract" to be "the tacit agreement between an employer and the employee about what the employee will 'put in' to the job and the rewards and benefits for which this will be exchanged" (1995b:139). "Implicit contracts" are hence, to put it simply, the perceived relationship between the employer and employee. For general practitioners, however, this is not a straightforward relationship. Although GPs hold formal contracts with the FHSA, they still possess an independent status. The concept nevertheless is still useful because there is nevertheless a "bargaining" relationship between general practitioners and the management of the NHS. What will be discussed in the forthcoming analysis is how general practitioners are seen to be reporting "implicit contracts" which are perceived in their work. These exchanges are seen by some as equal in "give and take" and by others as an unequal relationship. This is discussed in more depth in chapter 8. How the "implicit contract" is perceived, I argue, is dependent on the wants, desires and expectations that the actors seek in their work.

Furthermore, as I focus here on the "dynamic orientations" that the informants described, the GPs' ideas and said priorities in their day-to-day work are examined. What I will present is the different ways in which they characterise what it is to "be" a GP. "What is a profession?" has been a topic of academic debate for the most part of this century. In chapter 4 I explored the different approaches to this matter. In the exploration, the "trait" approach was rejected to allow for an examination of how people use and ascribe meaning to the term (cf. Dingwall, 1976). What follows then, is an assortment of circumstances that the GPs use to define what they do - the

various "implicit contracts". Therefore, when I asked the GPs "What do you do? Can you briefly describe your work as a GP?", I wanted to hear, as constructed in the interview setting, their priorities, values, orientations and so on. The most common response, not surprisingly, focuses on the relationship between the general practitioner and their patients. However, others offer a more contractual definition or are seen to be reporting general practice as an alternative to hospital medicine. It is argued that the ways in which GPs define their day-to-day working lives is reflective of their overall experiences, expectations and aspirations, albeit presented through a variety of rhetorical devices.

As a starting point to this analysis, I look in detail at the statement made by Dr Elizabeth Wansford. I had initially categorised her as having a leaning towards a "professional" orientation to work. When I asked her what she does as a GP, she first stated all of the responsibilities that she has in the medical world. These responsibilities ranged from being a clinical assistant at an ENT department, working at a "top security hospital for the mentally ill" and running a family planning clinic at a nearby hospital amongst others. We can infer that Dr Wansford portrays herself as a busy person who has her "fingers in many pies", When asked again, "what does she like about being a GP?", she said:

> "The bit that I like - and there's many a time when I think that this is crazy - I want to work when my children are away at university because my life is empty. But then they come home and I never see them. I thoroughly, thoroughly enjoy it, it is a life, my life. The thing that I love about it is being a proper family doctor. When I was working in family health, I love working with children, but you never get the continuity, in general practice that is the whole bit of it, you belong to a very select group. You have the privilege to enter into their lives, it is fabulous. There are always surprises, for example, seeing how people who are related to each other. Now we know our patients so well, we know everyone by their first names and it is lovely. You are not really anonymous in a small town though... You become somebody who is a symbol in the community it is great, I love it".

Elizabeth Wansford is describing here her work as being more than "just a job". She says "it is a life, it is my life", thus suggesting that her identity is closely attached to her work. Dr Wansford is using language here to persuade me (and possibly herself) of the importance of her work in her life. In an earlier conversation she used the comparison of what her life was like before she was a

GP when she implies that her self-identity was attached to her family and especially her children. This attachment could have been in being a "mother", homekeeper" or "wife". However, as her family have left the home her perception of self is oriented to her work. In the above passage, Dr Wansford draws on an expressive orientation as she uses words and phrases such as "I love it", "fabulous" and "lovely". Thus, her statement is subjective as she talks of the personal gains that she receives from her work. Parallel to this expressive orientation to general practice she suggests a prestigious orientation. Elizabeth Wansford talks of the "privilege" of being a GP - a "proper family doctor", the belonging to a "select group" and being "somebody who is a symbol in the community". She is drawing on discursive elements from (what I identified earlier as) professionalism where doctors are seen to be highly valued and morally praiseworthy. Dr Wansford uses the phrase "symbol in the community" - a concept also used by Becker (1970). Although I guess that she is unaware of his work and is ascribing a different meaning by drawing from another resource, it is useful to refer briefly to what he said. Becker advocates that the word "profession" is a "folk concept" and a "symbol". In that "symbols 'help people' and groups to organise their lives and embody the conception of what is good and worthwhile" (1970:102). Becker goes on to say that the use of "symbols" denotes an "ideology" of what a "profession" should be like. The tensions that Dr Wansford perceives and this ideological dilemma is returned to again later. However, I can infer that Dr Wansford in part defines having importance and influence in the community is "good and worthwhile" and "being" a GP gives her a more personal gain as she attaches her self-identity to this work. Because her "ideological" stance is far-ranging a number of problems, such as coping with the "loss of control", are experienced. This is discussed in more detail in section 6.4. It can be deduced that Dr Wansford compartmentalises these two aspects of "being" a general practitioner, not in opposition to each other as we would expect but rather as separate entities or as alongside each other.

As we have seen Doctor Wansford raises a number of points which she says are important to her in her work. She reflects on the changing nature of her orientation as her personal circumstances

changed. Now I focus, more generally, on how some other general practitioner describe their work to me. I have categorised in the accounts in the following manner: a patient-centred orientation; fulfilling a contract and; being a part of a "professional" group. These divisions are, to some extent, arbitrary as some GPs talk about a combination of these aspects. Central to all the descriptive approaches is the relationship that the general practitioner has with their patients. Other themes can be identified in the informants' accounts for instance, general practitioners talk about the variety in their work, compare general practitioners to hospital surgeons and locate the patient in a wider context (such as with family or the community). The patient-centred orientation category that I devised is considered next.

6.3.1 "Peculiarly Intimate": Patient - Centred Orientation

The government has been keen to stress the importance of the GP as an advisor to patients and gatekeeper to the NHS in *Working for Patients*. For instance, the government increased the rate of capitation payment that the GP receives with the aim of giving GPs "a stronger incentive to satisfy their patients if a greater proportion of their income is attributed to the number of patients on their list" (Secretaries of State for Health, 1989a:54). The government's ideas for the role of the general practitioner was more fully outlined in chapter 3. The scheme does suggest a view that general practitioners have a "strong" instrumental orientation to work. In the following discussion I examine how the informants describe their work and their satisfactions. In chapter 8 I draw on this analysis to understand better the GPs' responses to and interpretations of *Working For Patients*.

The doctors that I have grouped together here talked, at some length, about the importance of their relationship with their patients indicating a more professional orientation to their work. Each actor describes how they achieve their personal gains which they receive from this exchange relationship. For instance, some view that they are regarded with "high esteem", some perceive

themselves to be in a position where they are able to "influence others" and others say they see themselves as "wanting to be needed" by their patients.

To start the analysis in this section, I introduce Dr Tom Beverley. Initially I categorised Dr Beverley as having an "administrative orientation" to general practice (see section 5.7) because he talked of his patient orientation and also his practice responsibilities. He is the senior partner at the Blackbird Practice. As stated previously, the label "administration orientation" does not do justice to the complexities and intricacies of his interview. Therefore, I have interpreted what he said in the following manner. "What do you do?" I asked,

> "I think that a great priority is in assessment, social assessment of a problem. Be it a problem of diagnosis or be it a family problem or even in these days be it a social problem and then evaluation, following the assessment and then future management of the case. The mass majority of cases we take through from start to finish, it is only about one-to-two per cent that we refer on for either consultation by a specialist or for involvement of some other agency. So that's in this particular practice".

In this description Dr Beverley uses a distancing technique to separate himself from his work. The rhetorical repertoire that he draws upon here is what I call clinical. He speaks of "assessment", "diagnosis", "evaluation" and "the management of care". He "prioritises" his work and says the assessment of a problem is paramount. He defines three ways of categorising problems: diagnostic, family and social. He suggests that social problems are a new phenomenon in his work. He speaks in a proud manner about the low referral rate to secondary and tertiary care and suggests that he is part of a team at his practice - the use of the term "we" denotes this latter point. I am hesitant to state that he has a clinical orientation to his work as the clinical linguistic repertoire that he uses here is not feature in the rest of the interview. For instance, when he speaks of his patients and his relationship with them his language changes and he speaks more readily in the first person. When he did speak in the first person, he avoided eye contact and rubbed his face often hiding his eyes. This behaviour suggested to me that he wanted to be seen as a shy and modest man and indicated that he felt uneasy talking about himself.

As the above comment was made early on in the interview the meaning can be interpreted in a different way. I suggest that he was not sure of what I wanted to know - what was an "acceptable" answer. That is, the parameters of the interview were being negotiated. I wanted to know more about his personal experience, his "implicit contract", so I asked a follow up question about what he liked about his work. When I asked a more personal question "So do you like about being a GP?" he drew upon a different set of discursive resources. Dr Beverley stressed the importance of working closely with people and draws upon a patient-centred orientation. He said,

> "I like the one-to-one relationship above all, I mean that's why I came into practice. That's what I like and always have liked... I also like the involvement with the families. Not only the individuals but the family structure which surrounds them, that's interesting".

He states that the reason for entering general practice was his expectation of gaining satisfaction from the relationships with his patients. Furthermore, he described later the relationships that he has as being "peculiarly intimate" and "unique to general practice". I felt his consultation room was very conducive to relaxed discussion and I thought that it was more like how I imagined a psychotherapists' room to be than a clinical setting. (This was an interview that I felt "flowed well" and where I felt comfortable and confident.) The windows were covered with dark blinds and the main source of lighting was a green lamp which sat on his large antique oak desk. The décor encouraged a feeling of seclusion and safety. Although he does not expand on why he "likes" this relationship I infer that his work allows him to be close with people (on his terms). I felt that he was uncomfortable talking about himself, however, he takes great interest in the lives of his patients - in the "family structure which surrounds them". He insinuates that he feels satisfied by perceiving that he has some importance in his patients' lives and by offering them a comfortable and "safe" environment in which to discuss their "ever increasing social problems".

Furthermore, I have categorised him as having a "progressive" orientation. There were lots of books and journals around the room and on his desk. As we left the consultation room he pointed out a pile of books on the floor and said "This is what I have to get through some time". I interpreted this as him wanting to indicate his continuous learning and "keeping up to date" with

medical and practice advancements. In a similar spirit he spoke later about the problems he was having in learning about the new computer system which had been recently installed in the practice. He spoke of his motivation to be involved as "mainly because I don't want to feel that I am falling behind". The practice is also a training practice (since the mid 1970s) and became a fundholding practice in the second wave. A key aspect of his interview was his stated desire to keep up with new technologies and developments in his field. These points indicate to me the appropriateness of defining him as having a progressive orientation to general practice.

Looking at Dr Skerne, who was identified above as drawing on his childhood fighting fantasy and as having a political orientation, he suggests here that there are other satisfactions that he seeks in his day-to-day work. In addition to his political orientation I suggest that also he orientates himself by the relationship with his patients. Although he is more explicit and expressive than Tom Beverley, similarities can be drawn. James Skerne said,

> "Erm, I suppose that it is a feeling that it is in close contact with people and directly being able to influence their lives for the better, if you like. I am sure there is an element also of needing to be needed, erm people generally do have a fairly, hold doctors in a fairly high esteem and I suppose if I am honest that part of it is attractive to me".

Dr Skerne's words imply that his implicit contract involves being in "close contact" with people so as to satisfy his want to "feel needed", to be in a position to "influence their lives" and to be held in "high esteem". "Professional" rhetorical devices, as discussed above, are being used here but also parallels can be drawn here with his political orientation. He entered the party political arena to get his voice heard (he said he was opposed to the changes introduced in *Working for Patients*). In response to Margaret Thatcher and the NHS "reforms" he commented, "She was going to drive that through and at that point in my life, I said, What do you do about these people given that scenario? That has made me politically active: to question".

Dr Skerne wants to be seen to be "proactive" and seen to be doing. He says "I am an enthusiast and an activist. I guess and I make the best of what is going on". Confirming this suggestion, he goes on to say about his involvement in party politics as

> "a stand and er feeling a bit that when my little boy is twenty one or so and says 'What do you know about this great NHS Dad? What happened to that?'. I would say, 'Well I tried my best to do something about it'".

It can be inferred that these two aspects of James Skerne's orientation are similar in nature, wanting to take control, wanting to influence others and being seen to be doing something "worthwhile".

Dr Michael Foston also talks about the importance of having a sense of continuity with his patients (also discussed in how he accounts for his "prior orientation"), but also he indicates that the "variety" and the element of surprise appeals to him. He implies an expressive orientation, as did Dr Wansford, and implies that his work with the terminally ill rewards him with a feeling of being needed and influencing others lives. He said,

> "Err. I think the variety, not knowing what's going to come through the door next, erm, I think the relationships with the people, I've been here 10 years now so the majority of my patients I actually know fairly well now, and that's very pleasant. Erm and I think those relationships ... I enjoy, it actually sounds quite bizarre in some ways, I actually enjoy working with terminally ill people, I think that relationship is actually very, very important and may even make a difference to their lives. I think mostly it's the variety of not knowing what I am going to see next and the actual relationships with the patients".

Certain themes arise from the above analysis. All of the doctors that I have categorised in this section account for, in various ways, what they gain from being in close contact with their patients. The rewards or what they "take", are personal and unique to each actor. However, the satisfaction of influencing others and seeing themselves as an important part in their patients' lives is also a theme. In the following section I describe an alternative discourse which is drawn upon. I call this a legal or contractual repertoire. Although in the following explanations the patient is not a central theme of their orientation, the patient doctor-relationship is a feature of their talk.

6.3.2 "I'm Their GP": General Practice as Fulfilling a Contract

Here I concentrate on two GPs and their accounts. Both doctors account for their work drawing from, what I term, a legal or contractual rhetorical repertoire because they use legalistic language to define their work. The first general practitioner, Dr Bracken, is considered in brief to show the use of this repertoire. Dr Bracken draws from what I describe as a clinical repertoire where there are no apparent tensions or dilemmas in his narrative. The second doctor's narrative however, that of Dr Thorpe's, is looked at more closely as his account can be understood sociologically as identifying with two forms of occupational control (cf. Johnson, 1972). Edward Thorpe refers to these controls as the "expert" doctor and the "customer relations" types. Hence, this analysis is more in depth, than that of Dr Bracken's, in order to highlight and follow the rationale of his argument. In this second analysis especially, language is seen as an act of doing where Dr Thorpe is seemingly battling with paradox. So, initially I focus on Dr Bracken's description of what it is to "be" a GP as no such tensions are apparent. Then Dr Thorpe's interview is looked at more extensively.

Dr Bracken spoke of "purpose", "provision", "registers" and "making the appropriate arrangements" when I asked him what he did. He commented,

> "My job as a general practitioner is to provide all necessary general medical services which are to be found prior to the attack to those patients that are registered with me for the purpose of such care. That means that I am [responsible for] the full provision of both minor and intermediate medical services and making the appropriate arrangements for the investigation of those and the treatment elsewhere of more major matters. There is an obligation on me to make the steps to see that specialist care is [provided when] necessary".

Dr Bracken, and Dr Thorpe (as seen next), are defining what they do in terms of their legal obligation to fulfil the requirements of their contract. This is what I have termed a contractual repertoire. Furthermore, Dr Bracken is also using clinical discourse here (which I introduced when interpreting Dr Beverley) as he uses phrases such as "investigation", "attack" and "treatment". I suggest that Dr Bracken is asserting his importance and the responsible nature of his job by using

this technique. As pointed out above, there are no apparent tensions for him in defining his work in this manner. He states that he has an obligation, a contractual relationship with the FHSA, which he suggests is a straightforward situation. Dr Thorpe uses a similar language to begin his explanation, however he continues to suggest a more confused imagine. This is now looked at.

In the following quote it can be suggested that Dr Edward Thorpe uses a contractual discursive discourse as he defines what is expected of him as a general practitioner. In Dr Thorpe's interview he is seen to draw from two different perspectives on how general practitioner work ought to be and uses "repair" work (cf. Wooffitt, 1992) to give a plausible conclusion to account for his actions. When I asked him to describe his job to me he stated,

> "I'm in contract with the Family Health Services Authority to provide general medical services to a population of people who are registered with me, they are going on to two and a half to 3,000 in this area who are actually on my list and I'm their GP, and I have to provide general medical services for 24 hours a day for 365 days a year. What that actually entails is actually set out in a, what we call a 'Red Book', which is many hundreds of pages that are laid out with the regulations, but in actual fact what a general practitioner does and family health services are defined at what the GP normally does more or less, whatever those patients need in terms of medical care. That's it, that's what my job is in sort of contractual sense".

Here he suggests that he meets the needs of his patients in terms of their medical care and talks of his work being credible and worthwhile in relation to the contract that he has with the FHSA. The way he uses the terms "me" and "I'm" and "actually" is a device by which he suggests his own importance, for example, he says "I'm their GP". Returning to his construction of why he entered general practice (discussed above), the notion of power (perceived to be held by the hospital doctors) was said to be a concern for him. With this context in mind, it can then be implied that Dr Thorpe is indicating that he has, as a GP, a powerful position in the health service. He talks of "contracts", "regulations" and registers of population to support his argument.

These contractual and power repertoires can be seen in contrast to his previously stated desire to treat "patients as people". This can be viewed as a paradox or contradiction in his talk. Festinger

(1957) points out that when people are aware of tensions or inconsistencies in their talk they will be motivated to change their thoughts to be more consistent. Festinger states that a feature of our society is to presently ourselves in a consistent manner. He continues to say that "It is often the case that if people become aware of contradictions or inconsistencies immediately, as they are talking, they will attempt to gloss over or make sense of the inconsistency" (Festinger, 1957:37-38). Similarly, this glossing over technique was identified in conversation analysis as a form of "repair" work used in self-correction (see Schegloff, Jefferson & Sacks, 1977). It can be argued that Dr Thorpe, later on in the interview, makes sense of this contradiction as he "finds" a plausible argument. Answering a different question he introduced the idea that there was "another side to general practice". He distinguished between "medical care" and "patient care". For him, medical care is the "prescribing and monitoring of diseases" and patient care concerns the "quality" of the relationship between the two parties. He explains this distinction by stating "those two things are very difficult to juggle with as patients generally have no way to judge the quality of medical care but they can judge the quality of relationships". What can be inferred is his creation of two distinctive "roles" for general practitioners. The first concerns a provision of medical care which involves him drawing from his "expert" knowledge to treat his patient. This provision is suggested to be irrefutable by his patients because they are perceived to have no criteria to judge the quality of the clinical decision-making. Johnson (1972) typifies this doctor-patient relationship as being "collegiate" where the doctor defines the needs of the patient and the means by which they are met. The second "role" Dr Thorpe identifies directly concerns the relationship with patients. He suggests that he sees his patients as wanting a "customer relationship" approach to medical care. Dr Thorpe implies that if this approach is followed, greater attention is given to the patient's definition of the problem and to their needs and wants. He says this is not what his "role" as a general practitioner should be. Johnson typifies this form of relationship, where the patient defines their needs and the methods by which they are met, as a "patronage" or "communal" control. It is significant to note that this contradicts his stated desire to treat "patients as people". Although, of course, we do not know of the "actual" relationship that

Dr Thorpe has with his patients, we can, however, look at the language that he uses to describe his actions. Edward Thorpe has problems juggling these two "roles" of general practice because the forms of control are different. This "juggling" can be expressed as, on the one hand, he perceives that he has the medical knowledge to treat the patient and, on the other hand, he perceives that he is being judged by his patients by non-medical criteria.

It seems then that Dr Thorpe draws upon his medical knowledge to care for patients rather than say, negotiating with his patients to determine their course of treatment. It also can be inferred that the number of patients on his list is important to him to satisfy his feeling of importance. Therefore, it can be presumed that conceptually he needs to justify his position of "collegiate control" at the risk of losing patient numbers. He supports this viewpoint in his distinction between the "best" and the "worst" doctors. He commented,

> "It is a truism that patients generally like the worst doctors best and dislike the best doctors because a doctor is not actually about pleasing the patient so it isn't like a customer relationship where you actually define your work when the customer is pleased... To be a good doctor you have to do what the patients don't like".

He uses the following example to support his argument,

> "I mean that people [GPs] who take an exception to people who smoke and people smoke because they like smoking, and if the doctor says, 'Oh, all of this is nonsense about smoking doing you harm'. You will love that doctor saying that. It doesn't matter if it is true or not. If a doctor says to you that you are really ruining your health by smoking and I would like to see some plan by the time that you come to see me again to give up, the patient would say, 'I don't like that doctor, he makes me feel quite uncomfortable'. Well whose the best doctor? Well it cannot be the one who encourages me to smoke".

Thus, Dr Thorpe justifies this perspective and the "I know best" rationale by stating he is in the position of power because he has the "expertise" and knowledge of medical care.

We have seen above that he expresses his dismissal of the patient's defined needs if he sees them as hindering their health. In his battle between the two different perspectives of occupational control, typified by the second order constructs the "collegiate" and "communal", Dr Thorpe is

persuading me that "in the end the doctor knows best". We have seen a rhetorical battle about the nature of Dr Thorpe's work finishing with a suggested conclusion that medical care is more important than patient care. As we saw in the last section, the patient plays a key role in orienting this GP, however Dr Thorpe's definition of what he does and what he ought to do concerns in the main his idea of medical health care. In chapter 8 I return to Dr Thorpe's account where I explore further how his rationale and orientation to work guides him in interpreting *Working for Patients*. The ambiguous nature of the general practitioner-patient relationship is featured again in section 6.4 where some GPs said that the felt constrained by a perceived increase in demand from their patients on their resources. Next, I look at Dr Cranswick's account. He differs from the other GPs in this study as he does not mention explicitly his relationship with his patients.

6.3.3 "Definitions of Disillusions": Part of a "Professional" Organisation?

Dr Cranswick uses a disowning rhetoric to account for his work. He frequently refers to "you" and "it" rather than speaking in the first person. This denotes that he feels he does not belong to this occupational grouping. He reifies the medical "profession" as something, an object, beyond his control and as "outside" his life. He says,

> "You don't really think about it. You hear some people call themselves professionals and think are they really in their roles? It is not really worth thinking about". **Why isn't it worth thinking about?** "Well because you are called the medical profession anyway and actually don't need to define it **Right** and it is difficult calling what you do by any other title, you can stand in your professional way. It avoids making definitions".

Doctor Cranswick is seen to be reporting his dissatisfaction in his work. He told me that he wanted to leave general medical practice and had attended a course on alternative careers for general practitioners. He also had a hangover on the morning of the interview which he said added to his pessimism. He spoke of his disillusionment of the present health care situation and said in reply to "what do you like?", "Not much". He implies in the above comment that he is unwilling

to define his work as it "all seems too inconclusive". Therefore, it can be implied that general medical practitioner work for Dr Cranswick is ambiguous and unrewarding. He justifies his decision to stay by stating later it is a hard thing to do, but general practice is probably like any other job and he sees few other job opportunities because of his "very specialised training". Dr Cranswick suggested that he has changed his orientation to where he seeks to gain his satisfactions. He says that he did enjoy being a GP, however now he looks to his non-working life to fulfil his needs. It can be argued that Dr Cranswick has a negative orientation to general practice and justifies his distancing from his work by starting "its not how it was, I wasn't a GP to be forced into things". He said that he felt "forced into things" because of the implementation of *Working For Patients.*

In this section we have seen an array of rationales and sense-making devices in use which were used to describe to me what it is to "be" a GP. Some general practitioners offered what I have called contractual language resources and others more patient-centred resources. Central to all of these narratives, apart from Dr Cranswick, is the importance which has been ascribed to the relationship that the GPs have with their patients. This perceived importance of general practice also identified by Wilkin, Hallam, Leavey & Metcalfe in their 1987 study of Manchester GPs. They concluded that out of their 552 GP sample, all drew upon this relationship as sources of satisfaction. Two thirds solely drew upon the patient relationship and the other third were seen to report rewards from dealing with a variety of patients' problems and from challenges in their work. Therefore, it can be argued that the patient is an integral part of the general practitioner group ideology. The term "group ideology" in this sense means "a set of ideas which are located within a particular social group and which fulfils functions for that group. It helps defend, justify and further the interests of the group with which it is associated" (Watson, 1995b:378). I attend to this notion again in chapter 8.

It can be argued that Dr Cranswick, the exception, does not identify with how I have typified the general practitioner group ideology. He accounts for his actions in, what I have called, a distancing manner as he suggests that he does not use the relationship to orient himself. As stressed before, because I have identified a common theme it does not reject the idea that GPs are unique individuals. However, the patient-doctor relationship aspect does unite them as a group. In the following section I explore, in a similar fashion, the perceived constraints, obstacles and pressures that the general practitioners spoke about in their work. I conclude this next section by identifying another common theme in all of the accounts - the perceived loss of control in their work.

6.4 Aches and Pains in General Medical Practice

In the above accounts we have seen GPs describe their work with varying degrees of enthusiasm. Whilst Dr Wansford, for example, says that she loves her work and it is her life, Dr Cranswick says that he has distanced himself from his work and seeks his satisfactions, in the main, outside of his working life. Here, I focus on how the GPs in this study describe the features of general practice that they perceive as constraints. These constraints, pressures and obstacles were expressed as dislikes in their work. The central theme identified in this analysis is a feeling of losing control over how and what they perform in general medical practice. The analysis here is relatively brief as many of the issues raised are returned to in the next chapters where the tension between the two principles of work control are examined extensively. It is important, however, to consider these responses here as some GPs indicate a growing negative orientation to general practice. How the general practitioners' account for, what I have termed, feelings of loss of control in their work takes different forms. Dr Woodmansey succinctly summarises this frustration of "losing control" as a source of dissatisfaction. He said, "There is also the frustration of having control taken away from you. One of the plus points that I didn't mention earlier is the

feeling of being in control of what you are doing. Before the contract you could do what you wanted to ... It's frustrating having these constraints".

I have grouped discursive resources used to express their dislikes of general practice into the following categories: lack of time; administrative responsibilities, patient demand and the forced changes. The responses which were directly related to *Working for Patients* are looked at in detail in chapter 8. Furthermore, the doctors do not fit neatly into these categories as some drew from a combination of reasons which they used to describe the constraints and pressures in their work.

Those doctors seen to be reporting a lack of time to carry out their work in a way that they would like, indicated this in various ways. For instance, "I don't have enough time to visit people when they come out of hospital... Consultations are sometimes rushed"; "I suppose that at the moment I dislike not having sufficient time to do what I like to do work-wise". Whereas these GPs suggest that they do not have enough time to meet their own expectations in their work, some are seen to be reporting pressures from meeting others' expectations. For example, it was said that there was "Not enough time to get the [government's target] completions". Additionally, it was reported that an encroachment of work on the GP's personal life was perceived. These general practitioners suggest that the work has become more demanding, especially since the implementation of *Working For Patients*. Both of these next remarks were made when the tape recorder was turned off. This indicated to me that these GPs saw this constraint as inappropriate or that they were embarrassed to state they wanted to have some free time. This encroachment perception was seen to be reported as "I have a flat in the Lakes which needs doing up. I have not been free to go up there for ages. I just have not had a weekend free for so long now". Alternatively, another GP said "I do not get a proper holiday now. Holidays do give me time to get the books sorted out, so that's good I suppose".

These next GPs stated that they perceived constraints resulting from the administration or "paper work" involved in their job. For example, it was said, "I'm not all that keen on administration. I get very irritated by paper work, that's about it really"; "Its all about paper work, I wasn't a GP to be an administrator"; "Paper work, paper work, paper work, I loath it". "General practice is about filling in forms now, it's ridiculous". The administrative responsibilities described here are implied to be an additional aspect of their work which they have to do in order to be a general practitioner. It is implied that administration prevents them from treating patients as they would like, for example. The administration and lack of time is indicated to be sources of frustration. Conversely, it is patient care demand which is seem as a source of frustration for the GPs grouped in the next section.

The next group of general practitioners refer to the demands of their patients as a source of frustration. What has been emphasised in the above analysis of how GPs describe their work is a focus on the patient relationship. When I asked "What do you dislike about your work?", this relationship also was seen to be reported as a source of dissatisfaction in their work. Generally, the GP informants which spoke of this stated an increase in patient demand as contributing to their inability to maintain their sense of control. Dr Barmston exemplifies this view point. He said,

> "I don't like some of the pressures because I say that we try and control our workloads and there is still consumer demand which is beyond our control because people do become anxious at different rates than how we can control them. Therefore I dislike the days when you are unable to work to plan".

Here, Dr Barmston is drawing from a market rhetoric as he refers to his patients as a "consumer demand". He suggests that his work is demand-led as he cannot control the amount of work that he has. Dr Thwing also talks of the patient demand which she suggests has increased. She said,

> "Also patients are more and more demanding, I see that. For people who are based in this area they come here with a virus, I cannot do anything concerning a virus... They still want to see me for me to tell them that it is a virus. I cannot find the time for me to do the paper work, it is very hard for me as a single handed GP".

Furthermore, again regarding a sense of "loss of control" is the perceived enforcement on GPs to practice in a certain way. Dr Cranswick, in the last section, suggested that being told what to do takes away the enjoyment of his work. In a similar vein, Dr Bracken stated,

> "We are being interfered with more. Being told broadly what you do in your contract, we agreed to provide the services and he contract can be enforced... There are still not a lot [of directives] but it is getting more, the foundations have been laid for a highly structure and controlled general practice. This is a bad thing as it does away with individuality which makes this job fun for us and it makes it better for the patients because it is horses for courses, you can get to pick and chose a doctor that you get on well with".

Dr Skerne echoes a similar perception. He said,

> "One of the things that was attractive to me [in general practice] is that it was very much dependent on individual initiative, what you make of it, you can make of it what you want. Now with the changes that is something that has been taken away from us - we are being told what to do".

In these two accounts the GPs talk about "being interfered with", losing scope for "initiative" and being "told what to do". For Dr Barmston, this fear rests in the future and for Dr Skerne his perception is based on the present. We can infer that both these general practitioners seek to be autonomous in their work which is perceived to be taken away from them as a result of *Working for Patients*.

The aches and pains, or the constraints and pressures, seen to be reported in general medical practice are looked at again in chapter 8. However, some generalisations, or inferences, can be made from the analysis here. There is a general perception, suggested by the GPs, that they are experiencing a loss of control in how and what they practice. This perception is attributed to different influences such as an increase in the demand of their patients, the "forced" government's and the administrative responsibilities. As argued in the last section, this loss of control is viewed as an aspect of the group ideology of general practice as it is common to all. This loss of control can be viewed as a threat to their "professional" autonomy, a theme which has been identified in the historical analysis of general medicine.

6.5 Rounding Up

What we have seen is a diversity of reasons that GPs ascribe to, or attach meaning from their occupational choice. As argued in chapter 4, no two individuals are the same and general practitioners are no exception to this. Other studies report a similar view and indicate the different ways in which GPs go about their work activities. For instance, Wilkin *et al* (1987) showed a large diversity between GPs (in Manchester) in their rates of consultation, prescribing, out-patient referrals and so on. They concluded that this diversity was not a result of the sex, age or social composition of the GPs populations, as they had originally imagined, but rather the diversity was due to the personal characteristics of the doctors involved. Each general practitioner has their own interests and particular pursuit in their health care work and, hence, they will be more receptive to identifying particular medical conditions. In this investigation, GPs were seen to report these interests in areas such as the terminally ill, heart complaints and in psychiatry. Other studies have indicated a similar conclusion (for example, Rice, 1990; Cartwright & Anderson, 1981; Williams, 1970; Wright, 1968). Therefore, it is argued that general practitioners are not a homogeneous group of people who act in the same way. A common remark in the interviews was that the informants wanted to stress that they were only speaking for themselves and not for the "profession" - "We are all different", "That's the case for me, I'm not sure about the other GPs" and "I cannot possibly speak for anyone else".

What has also been indicated earlier is that individuals' perceptions and orientations change as circumstances in which they find themselves in alter. Although I conclude that GPs are different, some common themes can be identified. A linking themes in these excerpts is, for example, the importance attached to the GP-patient relationship. Such relationships will take different forms in line with the GP's (and patient's) different needs. In this chapter some of these needs (as presented to me) have be related and interpreted. Although general practitioners are individuals, I also argue that general practitioners are part of an occupational group. As suggested common

themes of interests can be identified. These interests, the patient relationship and the feeling of loss, are "objectively" evident common interests (Watson, 1995b). How a GP acts is somewhat dependent on how these "objective" interests are "realised". The argument that I am suggesting is akin to Marx's distinction between "a class *in* itself" and "a class *for* itself". I will use an example outside the remit of this investigation to highlight this point. It can be argued that women are oppressed by the forces of patriarchy in western countries. This oppression may not be realised or articulated by some women. Even though the patriarchal oppression structure is not recognised by all women it does not suggest that these processes do not occur. Some women, however, who do recognise "subjectively" (Watson, 1995b) the common consequences of such a structure, can then form coalitions to mobilise and legitimate actions to combat patriarchy. The degree of recognition is argued to be on a continuum. At one end women are grouped together by objective common interests - "a class in itself". The women here may not realise the common interests, however they are grouped by others who draw from this ideological position. At the other end of the spectrum, the commonalties are realised whereby coalitions are formed which are used to legitimate and mobilise the group's interests in order to achieve certain goals or aims. This latter category can be called "a class working for itself". Therefore, it is when a set of beliefs, interests or values are "commonly held by the actors" (Dunlop, 1958) then (political) action can take place. Parallels can be drawn with the occupational grouping of general practitioners. In this chapter I have identified some themes which unite GPs together. Some GPs may not recognise or realised these "objective" interests, however there are processes which unite them as a group. Also, it can be argued that the "subjective" recognition of collective interests, especially by those in positions of power (leaders of the BMA, for example), can be used to further the interests of the whole group. Therefore, I propose that on the one hand, general practitioners are individuals and on the other are part of a group. If a group ideology is identified - the set of common interests, values and beliefs that GPs draw upon - then these commonalties can be legitimated and mobilised to further the powers of the group.

In addition, GPs also are grouped together by "external" forces. GPs are often viewed as an homogeneous and cohesive group by members of society (patients), the government and by other groups. There are some causes for this grouping. It can be argued, for example, that GPs undergo the same training, hold the same contracts and are all affected by government legislation. The implementation of *Working for Patients*, for instance, will have an impact on all their lives because of the changes to the way in which general practitioners are paid for instance. Such changes may or may not be acknowledged, recognised or accepted by the GPs. I explore how GPs interpret *Working for Patients* and explore whether a group ideology can be identified within this context in chapter 8.

Next attention is given to a more structural and conceptual analysis: the tensions apparent in the structure of the NHS, explored in the first part of the thesis, are explored in relation to the tensions experienced at an individual level. Hence, the individual and structural aspects of health care phenomena are brought together.

Chapter Seven

Battling with Paradox and Ambiguity Part One: Conflicting Principles of Work Control

7.0 Introduction

This chapter has been written in tandem with the next. Here, specific links are made between the structural and conceptual framework and *Working for Patients*. I have claimed in chapter 3 that the recent "state-initiated managed change strategies" outlined in *Working for Patients* can be interpreted to be ambiguous and unclear. It is argued that this ambiguity can be understood better by focusing on tensions between two opposing principles of work control: the occupational and the administrative. In the next chapter, where the individual GPs' responses to the changes are explored, these theoretical constructs are argued to be beneficial in aiding our understanding of their accounts. Hence, a specific aim of the discussion here is to provide a clear and focused structural foundation for the more complex and ambiguous micro analysis in the next chapter. The division between this chapter is simply for stylistic reasons. The two chapters are inextricably linked. Central to both analyses is the notion of work control.

The occupational and administrative principles of work control were introduced in chapter 4. These principles are explored here in the light of the present health care situation with an aim of simplifying this complex phenomena. Furthermore, in the light of the government drawing seemingly on economic

and market discourses, I evaluate the possibility of a third form of work control - the market principle of control. It can be argued that the government is espousing the market and consumer demand are to be the means by which the activities of general medical practice are controlled.

This chapter takes the following form. First, in section 7.1, I reflect on a news item which highlights the tensions relating the two sociologically defined forms of work control. Second (7.2), I focus on and interpret the rhetoric used by the government in *Working for Patients*. I suggest here that it is potentially useful to develop a third form of work control - the market principle - to understand better the government's rhetoric. Put simply, the government implies an aim of deferring control over general practitioners' work activities to the patient (the consumer). However, in section 7.3 I argue that the government's rhetoric and actions are understood better by conceptualising and typifying their rhetoric and discursive resources in relation to an administrative principle of control. This chapter is concluded by rounding up the main issues raised.

7.1 An Initial Reflection: Tensions in Action

The tension between what can be sociologically identified as the occupational and administrative principles of work control has made national news. The following news item allows for an opportunity to illustrate how the two established principles of work control can be seen to be in polemic. Roy Lilley, the Chairperson of the Homewood Trust in Surrey and who was reportedly a pioneer of the internal market scheme, has claimed that doctors should be primarily accountable and responsible to their organisation rather than to their "profession" or their patients. This view was opposed and questioned by two medical practitioners, Elizabeth and Peter Murray who responded to Lilley's comments in a letter to The Guardian. Whereas Roy Lilley can be typified as advocating an administrative form of work control where the emphasis is on designing work procedures and meeting organisational requirements, the Murray's can be typified as advocating an occupational form of work control as they

emphasise the need to organise work tasks according to the skills of practitioners and the needs of patients.

These articles are of great significance to the present study: they allow for a simple comparison to be made between two ideologically opposing viewpoints and, furthermore, the discussion highlights the relationship between rhetoric, discursive resources and ideal types (see 5.7). Although the articles concern the hospital sector and particularly Trusts, parallels can be drawn with the primary health care sector. Parallels can be drawn because, first, corresponding "state-initiated managed change strategies" affected secondary and primary care can be identified (see chapter 3), such as the rise of general management. Second, it is suggested in these articles that an ideological tug of war is apparent between two forms of task control in the NHS and similar interpretations and tensions can be seen to be in play in the primary health care sector (see chapter 8). Third, it is implied in these news reports that how the NHS and the role of the practitioner is interpreted is somewhat dependent on the orientation of the individual - a theme I return to in the next chapter when I examine how GPs' interpret their role in the light of *Working for Patients*. Here, however, I present Lilley's suggestion on how the NHS should be organised first and then second consider the responses from two practitioners to his comments. In the following section, I explore the sociological significance of these polemic positions and then compare these to the government's rhetorical devices drawn on in *Working for Patients* in the next section.

Roy Lilley, writing for a health management audience, said, "Patients are at the very centre of everything that we do but, first of all, doctors have to get the relationships with the organisation they work for sorted out" (quoted in Summers, 1994:9). He went on to stress that "doctors needed urgently to sort out their attitudes towards their work" as he suggests that doctors are inappropriately "flexing their muscles in the NHS" (cited in Brindle, 1994:2). Furthermore, he criticised doctors' actions by stating, "You cannot put the patient first if that causes organisational chaos" (quoted in Brindle, 1994:2). The "organisational chaos" was seen to refer to the recent resignation of two key Trust officials resulting from disputes with doctors. Mr Lilley suggests that the BMA is directing its members

to oppose the state-imposed performance management scheme. He said the BMA "just waved two fingers at everybody and that's made the relationships that managers have with their doctors very difficult indeed" (cited in the *Financial Times*, 14 November, 1994:9). Mr Lilley is insinuating that for hospitals to function effectively and efficiently doctors need to be managed, have their output measured and be excluded from any strategic decision-making. That is, Mr Lilley is stressing that hospital consultants are simply employees. In its extreme form it can be argued that, on the one hand, Roy Lilley wants ultimate control over what and how doctors perform their tasks and, on the other, he sees the doctors as wanting sole control over what and how they practice.

What is apparent here is that the same tension that the state was trying to resolve, to control the activities of doctors, is now being confronted at the grass-root level. At the "coal face", Roy Lilley said, "there are some real difficulties with working relationships with doctors" (quoted in Summers, 1994). Alternatively, a different view on and interpretation of the role of health care practitioners is argued by Dr Elizabeth Murray, a senior registrar, and Peter Murray, a nurse tutor. In response to Mr Lilley's comments, they wrote in a letter to *The Guardian*, "Doctors, nurses and all other health care professionals recognise that the first priority is the patient: anything else comes second" (15 November, 1994:25).

Elizabeth and Peter Murray stress that the most important duty of health care "professionals" is to prioritise the needs of their patients. They insinuate that the primary function of hospitals is the treating and caring for patients where the trained practitioner is the only person who is qualified to select a course of medical action. Furthermore, Peter and Elizabeth Murray indicate what might be called a culture clash of expectations between the practitioners and the managers. This clash could be the reason that the NHS is in what they term a "parlous" state. They commented,

> "If ... [Mr Lilley's] belief that the first priority of doctors is not their patients, but the organisation for which they work, is shared by other managers within the NHS, this explains its present parlous state. His views indicate that the people charged with running the service has no understanding of the organisation whatsoever..." (Murray and Murray, 1994).

In the same article the Murrays suggest that the differing emphasis of prioritising, of the management and health care workers, could result in some practitioners leaving the health service. They stated, "If this ethos changes we, along with many other highly trained and dedicated health care professionals, will feel unable to continue working in such an organisation".

Sociologically, we can understand these two perspectives as related to two ideal types of control. It is useful here to draw once more on Mintzberg's (1983) notion of bureaucracies. In chapter 4 (4.4.1), I typified machine bureaucracies and professional bureaucracies. It can be argued that Mr Lilley conceptualises the organisation of the Homewood Trust in a similar manner to Mintzberg's "machine bureaucracy". In this typification of organisations, the workers are required to be submissive to authority and have little control over the tasks that they perform. Work in these organisations is characterised by highly routinised and standardised tasks, is defined by a profusion of rules, regulations and formalised lines of communication. Also, Mintzberg states that there is a clear divide between the operators and administrators. These organisations have a centralised decision-making system and the environments which they operate in are stable. Mintzberg includes such industries as airlines, postal services and steel companies in this category. Similarly, comparisons can be made between how the Murrays conceptualise the NHS and Mintzberg's "professional bureaucracy". This typification is the antithesis to Mr Lilley's suggestions. In Mintzberg's terms the "operating core", doctors, possess autonomy, have the freedom to perfect their skills and the manager's role is simply to buffer external threats (Mintzberg, 1983). Mintzberg contends that in this form of bureaucracy the administrators cannot rely on a formalisation process of "professional" work or on any system to plan or control it. This, he argues, which is also implied by the Murrays, is because the power in these organisations is held by those at the base of the structure - the "operating core".

These two different perspectives on what is important in the NHS can be viewed as incompatible. We have seen Lilley putting great significance to the administration of the NHS and the Murrays stressing the importance of the practitioner and their meeting of patients' needs. Therefore, on the one hand,

similarities can be drawn between Lilley's comments and a sociological understanding of administrative forms of work control. On the other hand, comparisons can be made between the Murray's statements and a sociological understanding of occupational forms of work control. The two contrasting statements (above) are also of interest as they question the role of the patient in the present health care setting. Whereas Roy Lilley suggests that the patient should come third in order of priority, the Murray's indicate that the patient should be the top priority. In the next chapter we can understand the informants' accounts as drawing from either or both of these discursive resources. However, before the general practitioners' accounts on the current health system are looked at in detail, attention is first given to the rhetorical devices used and discursive resources drawn upon by the government.

7.2 The Government's Rhetoric - the Need for a Market Principle of Work Control?

In this section I explore the rhetorical and discursive resources used by the government in *Working for Patients*. *Working for Patients* is interpreted here as an account, where, following Potter and Wetherell (1987), the rhetoric used is viewed as an act of doing (see also figure 5.6). Thus, I intend to interpret the function of the language used in the White Paper. The terminology used by the government is examined to understand better how they construct, in sociological terms, an NHS "reality". The aim of this analysis in this section and in the next is to consider whether we, as sociologists, need to establish a third ideal type of work control to understand better the recent "state-initiated managed change strategies". It has been suggested above that two existing principles can be discerned when attempting to understand controls in the NHS: the administrative and the occupational. At first glance the government seems to be advocating an alternative form of task control - what I term, a "market principle of control". Therefore, besides the administrative and occupational ideal types of work control, it can be argued that the idea of a

market principle of control potentially is useful in helping us to understand and analyse *Working for Patients*. These principles of work control, as all ideal types, are "tools" to abstract and simplify complicated phenomena. In the next section I raise some difficulties with the usefulness of such a model.

Working for Patients has been argued to be a means to rationalise the NHS (see chapters 2 and 3). The government implies that the implementation of a market system, putting "patients first", will ensure the success of this rationalisation strategy. Following this rationale it would seemingly be beneficial to explore and question whether there is a need for a third ideal type of work control - the market principle. This logically-formulated second order construct is defined as follows: *The market principle is where work is controlled and defined by the needs and requirements of consumers*. Therefore, the consumers define what tasks the providers perform, rather than, say, the state or the occupational bodies. In this typification, competition between providers stimulates and manages the efficient production and delivery of goods and services in response to customer demand. Providers of goods and services have an incentive to reduce costs and to increase quality of what they produce in order to ensure long term survival in the competitive market place. The consumers, in this typification, are supplied the goods and services that they want and demand. That is, individual choice presides over other bodies, such as the government or occupational groups, deciding individuals' needs and requirements on their behalf.

This principle of control is similar to Johnson's (1972) "patronage" typification of occupational control. In *Professions and Power*, Johnson suggests that consumer-power (patronage) can act as a constraint on occupational behaviour. The focus of Johnson's attention is on oligarchic and corporate patronage, however, he states that consumer power is a growing institution which can affect "professional" organisations. This power at its most is effective when it is systematically exerted as a source of pressure on the provider or practitioner. In his terms: "Fully developed institutions of patronage arise when consumers have the capacity to define their own needs and the manner in which those needs are

catered for" (1972:65). Johnson suggests then that when consumers know what they want and when practitioners know and do what is expected of them, then "consumer uncertainty is reduced at the expense of occupational autonomy" (1972:70).

I examine here some of the details and rhetoric used by the government in part to decide whether the market model of work structuring is useful in helping us to make sense of *Working for Patients*. Hence, I examine those aspects of the White Paper which seem to advocate a market mechanism of control. Although the term was not used explicitly, the "market" is considered here to be an integral feature of *Working for Patients*. The broader aspects of what is known as the "internal market" were explored in chapter 1 (section 1.7). Also, those aspects of the "internal market" concerning general medical practice were presented in chapter 3 (section 3.5). It is not my intention to repeat such accounts here. It is beneficial, however, to recount some of the main points made in light of the discursive resources that are drawn upon.

The government stated two broad objectives in *Working for Patients*. The first concerns giving patients an improved health care service and the second regards increasing the level of satisfaction for those working in the NHS "if they respond to local needs". The phrase "if they respond to local needs" is most significant to this discussion as it introduces, albeit implicitly, this idea of a market mechanism of control. It can be argued that the government is stressing that those practitioners which heed to the market's demands (ie. to their patients' wants) will be rewarded. GPs are "encouraged", in the main, by financial gains to meet the needs of their patients (see chapter 3). The government increased the capitation fee for general practitioners, for instance, in order to give "GPs a stronger incentive to satisfy their patients" (Secretaries of State for Health, 1989a:54). The fifth proposal in *Working for Patients* also highlights these points. In the White Paper it is said that "... in the interests of a better service to the patient, GPs will be encouraged to *compete* for patients by offering better services" (Secretaries of State for Health, 1989a:5, my italics).

It is suggested here that competition between GPs will improve the quality of patient care. Those practices (and hospitals) that attract the most custom, the government states, will receive the most money. "Money will flow with the patient" is a phrase that is repeatedly used in the Paper. Therefore, it can be deduced that the government is persuading others that competition, along with the financial incentives for general practitioners, will improve the quality of care given to patients. The government gives little guidance however as to the level of competitiveness is allowed in the NHS. Also, the role that the government would take in this market system is unclear. Therefore, the extent to which a market system could operate is ambiguous. We can nonetheless infer that the idea of a market in some sense was an integral feature of the White Paper with an aim of encouraging "accountability" and "efficiency". Butler (1992) supports this claim. He says that "the market was intended by the review group to achieve a level of competitiveness commensurate with the attainment of genuine gains in efficiency" (1992:43). If this interpretation is accepted, we can further infer that the split between the providers and purchasers of health care, at least in part, is to enable a competitive market to operate. It was advocated by the government that the providers of health care (DHA managed hospitals, Trusts and private hospitals) would compete for the custom of the NHS purchasing bodies (DHAs and GP fundholders). In a Working Paper, it was stated that eventually "DHAs and GPs holding practice funds will, by exercising choice, create competitive pressures and by specifying service quality, improve value for money" (quoted in Butler, 1992:43). In summary, the government is implying that competition within a market system will improve patient choice and the quality of patient care.

Throughout the White Paper the government draws on what can be called a "market discourse". Usage of the terms "competition", "individual choice" and "performance-related pay", among many others, are indicators of this rhetorical repertoire. From the 1980s onwards and parallel with the rise in general management, the government draws increasingly from this discursive resource. Other writers such as Pettigrew, Ferlie, Fitzgerald and Wensley (1991) have noted this trend. Pettigrew *et al.* state that there has been a significant shift in the discourse used: "Behind these changes lie much wider shifts in language and agenda across the NHS: a new emphasis on 'performance', on securing competitive

advantage in the internal market, and more purposive management, including that of professionals" (1991:1). Furthermore, it can be argued that the discursive resources traditionally drawn upon in the private sector have now entered the NHS vocabulary. Gunn (1989), for example, draws this parallel and typifies the Thatcherite public sector management strategic approach as the "five E's": economy, efficiency, effectiveness, enterprise and excellence. The term "excellence" in particular has private sector connotations after Peters and Waterman's (1982) influential book, *In Search of Excellence*, became popular management reading (Cox, 1991).

Additionally, in support of the need to develop a market principle of work control, is the argument that the government is changing its health care approach away from a paternalistic model to a market and consumer model. The benefactor of the implementation of *Working for Patients* is suggested to be the patient. We are being persuaded that the government intends both to "empower" the patient and to make the service more responsive to their needs and requirements. The Prime Minister stressed the importance that was being attached to the patient in the Foreword to *Working for Patients*. Margaret Thatcher said that "all the proposals in this White Paper put the needs of the patients first" and that "the patient's needs will always be paramount". Patient care and patient choice are claimed to be enhanced after the implementation of the Paper. Therefore, it is logical to presume then that the internal market mechanism is a tool to defer the control of what general practitioners practice away from the government and away from the occupational groups. Patients, according to this document, will have the ultimate control over GPs' actions. If this line of reasoning is accepted then it follows that it would be useful to develop a third ideal type of control - the market form of work structuring. Aspects of *Working for Patients* which support this claim can be generalised in the following way: it recommends using the power of the competitive market to improve health services; the patient, the main benefactor, determines which services are maintained; and the linguistic repertoires in-use can be seen as an attempt to change the ethos of the NHS to become more business-like (see also Elston, 1991 for example). There are some difficulties in viewing the government's actions and discursive resources in this manner. These problems are explored now.

7.3 Difficulties with a Market Principle of Work Control

Above I have offered a rationale for developing a third principle of work control with the aim of enabling a better understanding of the government's ideology and actions. I have suggested that attention needs to be given to the role of the market and to the role of the patient in the NHS in order to determine the usefulness of developing such a model. When closer attention is given to how these components operate in the current health care situation, difficulties then arise in applying a market principle of work control. In conclusion of this discussion I argue that *Working for Patients* is viewed more appropriately as a means to increase the government's administrative controls in the health service. First I focus on the role of the patient and then on the workings of the internal market.

The government and the Murray's both stress the importance of the patient and the need to prioritise their needs. However, on closer examination their views differ greatly - the government and the Murray's advocate contrasting approaches to achieve the meeting of patients' needs. The Murray's state that "professional" practitioners are the best and only people qualified to make informed decisions on this issue. Alternatively, in *Working for Patients* it is suggested that a market mechanism will allow for patients' needs to be met. This latter belief, that a competitive environment encourages efficiency and patient choice, has been a theme of the government's over the last decade (Robinson, 1989). Subsequently, the success of a market system of control depends on the willingness and ability of patients to exercise their power and freedom of choice and for practitioners to compete for their custom. Leavey, Wilkin and Metcalfe (1989) question the extent to which patients in practice can wield their powers and question their ability to make informed decisions. For instance, Leavey *et al.* state that convenience and tradition rather than a wider evaluation of the available alternatives largely determines a patient's choice of GP. In America, where the health care market is believed to be more advanced, only 40 per cent of patients were willing to find out information about different general practitioners, exercised independent judgement and exhibited a readiness to make educated comparisons between doctors (Hibbard & Weeks, 1987). A leaked Audit Commission report mirrors a similar pattern. In

1996, five years after the implementation of *Working for Patients,* the Audit Commission is believed to to have stated that "there is no evidence that patients are changing practice in large numbers for other reasons other than changing address" (Brown, 1996a:1). Other restrictions that Leavey *et al.* (1989) identify include GPs limiting their list size and the restricting of geographic locations from which patients can register. What is generally thought of as a market system cannot operate effectively with these controls in place.

Furthermore, there is no provision in *Working for Patients* to increase the collective powers of consumers. Johnson notes that a "patronage" form of control is proficient when "the dominant effective demand for occupational services comes from a small, powerful unitary clientele" (1972:65). Thus, if the government was serious about increasing the powers of the patient they would have involved the consumer groups, such as the Community Health Councils (CHCs), in their decision-making process at a local and national level. This involvement did not happen. A leaked draft document from the DoH in 1990 stated that the government did not endeavour to take such action (Brindle, 1990a). Hence, quite possibly the patient has lost some of their powers in the workings of the NHS. Certainly, according to the CHC director, the Community Health Council in effect has lost some of its rights in scrutinising the NHS. Highlighted the decreasing consumer group participation in health care decision-making, the Director is reported to have said: "There will be no consumer scrutiny of purchasing decisions by GP budget holders... no mechanism to ensure that the service standards and quality are built into the contracts between GP and service providers, and no guarantee even that CHCs will be able to monitor the services purchased in this way" (MacLachlan, 1990:1062).

There is a further discrepancy in the government's proposals. As we have seen, the government suggests on numerous occasions that the patients' needs are of paramount importance and that it is the patient that is the main benefactor of the White Paper's implementation. However, patients do not have the means or resources to dictate or demand a course of action in the NHS. Patients generally do not determine which services, referrals or treatments they will receive. GPs are what have been called the

"gatekeepers" to the NHS. Thus, even if patients are consulted fully about a course of action, general practitioners remain to be "agents" which act on their behalf. Moreover, it can be argued that GPs have now greater (financial) incentives to meet the government's health care provision targets and less incentive to focus solely on satisfying their individual patient's demands. Appendix F exemplifies the changes to GP remuneration. What is apparent in the comparison of GP pay (before and after the implementation of *Working for Patients*) is the propensity for GPs to increase their earning capacity if they fulfil the government's agenda (eg. minor surgery, health promotion, child health surveillance). In chapter 3, it was argued also that the implementation of *Working for Patients* introduced a significant increase in financial and managerial arrangements for GPs. Therefore, because of these reasons it could be more appropriate to typify the government's actions as a pertaining to an administrative form of work control.

A further intrinsic problem with the idea that the patient being a "consumer" regards the service that the patient receives is an imperfect means to a desired end. The commodity sought by most patients is not medical care *per se*. but a state of health (Wilkin *et al.*, 1989). Patients do not necessarily have the means to judge the quality or appropriateness of the medical care that they receive. Health care is a different "commodity" to other goods and services. "Consumers" of medical care cannot sample readily different alternatives or use different suppliers as and when they deem suitable. The freedom of choice in the NHS is restricted to the choice of GP, choice or refusal of admission, the date of an operation and so on. Devlin *et al.* (1989) in *Medical Care: Is It a Consumer Choice?,* use a supermarket metaphor to highlight this issue. They say,

> "From the patient's (customer's) perspective the issue is choice, choice of family practitioner, of consultant, of hospital of admission date, etc. Thus there is choice of which supermarket to of to and when to visit the store, but the choice exercised in the store is not applicable to medicine. The choice in the supermarket does not operate, patients do not choose between a heart transplant and a knee replacement as they choose between smoked salmon or kippers in the store" (1989:4).

Another reason for why it is problematic to view NHS patients as "consumers" is that patients do not directly pay for the services, treatments and referrals that they receive from a GP. The agencies which "pay" for services are fundholding practices and the DHAs. The only ways in which patients can

exercise their freedom of choice is constrained to using private health care or by changing their general practitioner, however, there are limitations even to the later (as described above). With regard to private health care it has been suggested that growth in this industry is an indicator of consumers expressing their individual choice (Mohan, 1995). However, Mohan refutes this claim and states that "... this growth has in part resulted from deliberate government decisions - for example to facilitate private practice by NHS consultants, subsidise insurance coverage for the elderly, and pay for long-stay residential care through social security" (1995:225).

The usefulness of applying a market principle of control to the NHS is questioned also when attention is given to the operation of the internal market. To recapitulate, in its "pure" form, a market system of control would encourage providers of health care to reduce costs and increase the quality of their produce to ensure their long term survival in the competitive market place. Mohan (1995) points to a number of failures in the effectiveness of a market system. He states that the government have been lobbied to introduce greater regulations for certain NHS services such as the private acute care sector.

Furthermore, when we look at the government's rhetoric during the early 1990s, the "market discourse" has been drawn on less frequently: the government's language has changed when referring to the content and, potentially, the intention of the White Paper. Such language changes are of interest to the study as they may provide a means to understand shifting or competing sense-making rationales. Since *Working for Patients* was published the market discourse has been "toned down". For instance, "budget holders" became "fundholders", "buyers" of health care provisions became "purchasers" and "indicative prescribing budgets" became "indicative amounts" to name but a few. It has been reported that Mr Waldegrave, when speaking to the Royal College of Surgeons in 1990, conceded that the language was too business-oriented. Mr Waldegrave in this speech did stress the need for a more efficient management structure in the NHS, however, he said, "We have overdone the language of commerce. Without remitting for one moment the pressure to get a better management system, let us watch our language a bit" (Brindle, 1990b:2).

Another difficulty in applying a market principle of work control to aid our understanding of health care phenomena in the 1990s, arises from the empirical "data" exploration. In the next chapter where a market discourse is seen to be drawn upon, the patient or consumer is not typified as the main benefactor of the government's changes. References to a market system tend to be presented predominantly in a sceptical or dismissive manner where the effectiveness and even the existence of such a market system in operation is questioned (see 8.2). Alternatively, where a market discourse is seen to be drawn upon it is interpreted to be a means of furthering "professional" or personal interests rather than as a means of satisfying patient's individual choices and powers (see 8.3).

In summary, the government's intention of putting patients first and introducing a market system to increase the effectiveness of their treatment have been questioned. I have argued that the patient representative bodies' powers and influencing abilities have been curbed. Furthermore, a number of discrepancies have been highlighted. A conclusion drawn from this structural analysis and from the empirical analysis in the next chapter is that a market principle of work control does not enable a better understanding of the NHS.

7.4 Rounding Up

In this chapter I have aimed to pull together some of the sociological theories and concepts to build a more focused, particular and concise foundation for the more complex analysis in the next chapter. The tensions between the occupational and administrative principles of work control have been highlighted by Elizabeth and Peter Murray's and Roy Lilley's comments to the media. Furthermore, the rhetoric and actions of the government have been explored. With little support or "empowerment" to the patient, the shift in the language of the government and tighter managerial and administrative controls in GMP, the development of a market principle of control to aid our understanding of the NHS is deemed inappropriate. Instead, it may be more pertinent to view the government's actions in terms of an

administrative form of work control. Although the state is encouraging general practitioners to meet the needs of their patients, the scope by which this can be achieved is being defined by the government more than ever before. In Johnson's (1972) terms there is seemingly a shift away from the collegiate form of control traditionally enjoyed by the medical profession to a state mediation form of control. The government has intervened in the relationship of practitioner and patient and defined some of the needs and the manner in which these are met.

In this analysis some clarity and light has been cast on the different rhetorical devices in-use, the divergent discursive resources drawn upon and hence the variant perspectives on making sense of the NHS today. The linguistic devices expressed here can be seen in the next chapter where a more confused picture is apparent.

Chapter Eight

Battling with Paradox and Ambiguity Part Two: General Practitioners' Interpretations of Working for Patients

8.0 Introduction

Here I look in detail at how general practitioners talk about their views and beliefs on and understandings of the National Health Service in the 1990s. The structural or macro analysis presented in the last chapter is complemented with a more individual or micro analysis on how the informants interpret *Working for Patients*. In Chapter 7, I proposed that the two sociological forms of work control, and possibly three, could enable a better understanding of how general practitioners account for their sense making rationales about the recent governmental changes. An underlying theme in this discussion is a focus on the tensions between forms of work control in the light of *Working for Patients* - an integral theme identified in the informants' accounts. In particular, attention is given to the tensions between what have been called the administrative and occupational principles of work control.

Caution needs to be taken though in this exploration. It would be too simplistic to argue that all GPs perceive, say, a threat to their "professional" autonomy due to an increase in the administrative procedures and controls - known sociologically as the process of "deprofessionalization" (cf. Rothman, 1984). Similarly, it would be erroneous to argue that all GPs perceive *Working for Patients* as a means

to increase their autonomy - known sociologically as the process of "professionalisation" (cf. Hughes, 1960a). Although some do speak in these more abstract or conceptual terms, it is only part of the picture. Some do not reveal such clear divisions in their talk and use what I have called "messy" accounting (see section 5.7). In part, the ambiguity in the talk of the general practitioners is most clearly confronted when we as sociologists attempt to apply these forms of work structuring to the health care setting. When we focus on this issue, it is then that we get into muddy waters. I suggest that the water is muddied as a result of the identified tensions arising from the early stages of the NHS, both prior to and after its establishment. In previous chapters, for example, it has been argued that Bevan had problems in managing the individualistic GPs and with integrating primary and secondary health care. To overcome these problems, amongst other strategies, it has been attempted to make GPs salaried employees. However, referring back to chapters 1 and 2, it was claimed that the BMA was opposed to this decision and that general practitioners have maintained their independent status in the NHS. This status was argued to have been an unacceptable situation for the government. Therefore, what others and I have claimed is that a compromise position was sought to manage GPs. This compromise takes us today to the present ambiguity and the battle of who is seen to be in control. Central to this analysis is a discussion of how GPs make sense of this ambiguous position.

This chapter takes the following form. First, in section 8.1, I introduce how the informants' accounts are to be interpreted and discuss the issues which will guide the following analysis. The empirical analysis is divided into two sections. In section 8.2, I have grouped together those aspects of the informants' talk which suggest a rationale which is incongruent with their interpretation of the government's intentions and actions. It is argued that this discursive resource is drawn upon when general practitioners perceive a threat to their beliefs and assumptions of an NHS "reality". In the second section (8.3), I categorise those repertoires which are presented as being in agreement with and congruent with the informants' interpretation of the governments' intentions and actions. These rhetorical resources, it is claimed, are utilised when such a threat is not perceived. Hence, rather than grouping and categorising the actual informants, there is a focus on what is said as it is argued that some GPs draw on both of these

competing discourses. References also are made in these sections to themes raised in earlier chapters. Fourth, in section 8.4, I draw together the themes identified in this chapter.

8.1 GPs' Interpretations of Working for Patients

Here I introduce how the general practitioners' interpretations are to be considered and raise a number of issues which will guide the analysis. Specifically, the focus in the next two sections is on how they make sense of *Working for Patients*. It will become apparent in the analysis that the White Paper has been interpreted in varied and diverse ways by GPs in the Midlands. It is argued that there is not a unitary or homogeneous response to the Paper. The individual GPs interpret and make sense of *Working for Patients* in ways which are unique to them. It was suggested in chapter 6 that general practitioners, as all individuals, orient themselves by various and distinctive means which may change over time. Hence, I argue that, in a similar way, GPs make sense of the White Paper in a manner which is particular to them. Therefore, to give justice to the GPs' accounts, I continue the in-depth analysis and give attention to the discursive resources drawn upon by the general practitioners. By analysing the interviews in this manner I aim to gain a better understanding of how the general practitioners interpret their work and how they *use* language (Austin, 1962) to account for the present health care situation. Although GPs are unique individuals who have different stocks of knowledge, expectations and beliefs which shape their sense-making rationales, certain linking themes may be identifiable in the accounts which group the general practitioners together. In chapter 6, I looked at the GPs' accounts of what was called their prior and dynamic orientations to work. A conclusion drawn from that exploration was that themes were discernible which linked the informants together as occupational group. This assumption also underlies the analysis here. Thus, I concentrate on the individual's interpretation of *Working for Patients* with a further aim of establishing whether there is a set of ideas or beliefs which purport to an occupational or group ideology.

As suggested in an earlier chapter, two themes initially emerged when analysing the informants' accounts: those GPs who were seen to be reporting *Working for Patients* as having a minimal impact on their working lives and those who were seen to be reporting the White Paper as having a substantial impact on their lives. This categorisation technique, however, proved to be more problematic than constructive. On closer examination, the individual general practitioners did not account for *Working for Patients* in such a distinct manner. The GPs engaged in what I have called "messy" accounting (see 5.7). I have claimed that the use of "messy" accounting is in part due to the ambiguous and dilemmatic nature of the present health care situation.

Conceptually, it is not my intention to reveal the "underlying attitudes" of the general practitioners. Instead, each GP's account as viewed as varied, inconsistent and changeable. People respond in different ways to the same phenomenon as they evaluate, construct and reconstruct their sense-making rationales. Therefore, the focus is on the discourse itself - how it is used, how it is ordered and how the informants construct a "reality". Following a discourse analysis approach, later referred to as "discursive psychology" (Edwards & Potter, 1992), I view the accounts as *constructions* of "realities" which are presented as being "factual" and "external" to the speaker or author - what Schütz calls "the natural attitude" (cited in Zaner, 1973:35). Also, in line with this approach, I view the accounts as being *functionally* designed in an orderly manner as the speaker or author aims to accomplish a specific task or persuade others to see the world in particular ways (Edwards & Potter, 1992). This orderliness of discourse is "viewed as a product of the orderly *functions* to which the discourse is put" (their italics, Potter & Wetherell, 1987:49). Of course, when people speak there is infrequently just one function of their talk and often informants' narratives can be interpreted in terms of battling with paradox and ambiguity. By focusing on the discourses in this way avoids the problematic task of grouping the entire general practitioners' account. It will become apparent that some GPs draw on two rival discourses: one which is critical of the recent changes and another which supports and upholds the changes. As the function of their argument alters, different discourses are used. In order to understand better the function or purpose of the rhetorical devices drawn on in this study some context of the talk is presented. The

general framework presented in section 5.7 for interpreting and analysing what people say will guide the discussion.

A possible hindrance in focusing on the rhetorical and discursive resources is a lack of space to analyse all of the informants' accounts with equal attention. This restriction raises the question - "can theoretical generalisations be drawn from investigations which follow such an approach?". I argue that such generalisations can be made for two reasons (see also the discussion in 4.1.3). First, it is not my intention to reveal what *all* GPs do, but rather I aim to examine the processes in which GPs involve themselves. In this endeavour it is essential to look at and focus on in some depth the ways in which general practitioners construct and reconstruct their sense-making rationales. Second, I use illustrative excerpts from other interviews to demonstrate the tensions and issues raised here in others' talk.

In the interviews I asked the informants what they thought were the government's intentions by implementing the managed changes. Not surprisingly, there was not a consensus point of view from the GPs and many can be seen to be reporting a confusion in interpreting the Paper. GPs are placed in the centre of the tensions between the principles of work control that we as social scientists claim. I have argued previously that these tensions are in conflict because of the differing interests, commitments and aims of the contesting principles of the work control. What will become apparent in the forthcoming analysis is that the confusion, to some extent, can be understood in terms of the tensions between the market discourse and the managerial discourse drawn on by the government. On the one hand, we have seen the government stating their desire to increase the opportunities for consumers to make choices in the NHS, for the "money to follow the patient" and so on - which can be typified as a market form of control (see 7.2). On the other hand, the government's aim to tighten the lines of command and control through bureaucratic processes by which GPs are required to be more accountable for their actions - which can be typified as an administrative form of work control. I examine how these and other tensions manifest themselves in the talk of the informants as they are seen to be reporting how they deal with the changes introduced. Furthermore, at a structural level I draw from the dilemmas identified by Klein (1989) to aid this exploration. Therefore, the principles of work control and Klein's categories

(the secondary constructs) are used on what the informants said (the primary constructs) to elicit patterns and emerging themes.

The interpretations of *Working for Patients* are categorised two broad sections. To provide a framework for this analysis, I focus on Dr Rudston's account in the first section and Dr Thorpe's account in the second. As stated above, I do not categorically group all the informants' into one section or the other. Instead the focus is on what is said. What will become apparent is that some informants draw from competing and rival discourses in the course of their interview. Dr Cranswick for example features in both of the defined discourses, and other GPs, although presented in just one of the discursive categories, can be seen to be drawing on rival discourses. Dr Rudston and Dr Thorpe provide the framework for this analysis. Their arguments are interpreted in the main as drawing from one of the two identified discursive resources. It is by following and focusing on these two characters' narratives that we can witness some of the processes that they involve themselves in and examine in some depth how they construct what can be viewed as polemic rationales for the health service.

The first narratives explored (in 8.2) are grouped together under the title "curbing costs, privatisation and control discourse". Dr Rudston's account is placed at the centre of this analysis and aspects of others' talk are used where appropriate. Dr Rudston can be typified as an individualistic GP. He suggests that he is sceptical about the appropriateness of both a market system and of management practices being introduced into the NHS. Dr Rudston switches between these two concepts in his discourse therefore it would be misleading to examine one without the other. I suggest that Dr Rudston perceives the introduction of management and a market system as being incongruent with general practice: these principles are in conflict with his beliefs. I conclude my analysis of Dr Rudston's account by typifying him as being "dis-orientated" by the recent changes. The other excerpts which are addressed in this section are also linked by a similar scepticism and a questioning of the effectiveness of *Working for Patients.*

Dr Thorpe's account provides the framework for the second section (8.3). This second discursive resource examined is called a "pragmatic, business and power discourse". This set of linguistically-shaped discourses is grouped by a general acceptance of the government's changes which are said to be congruent with and a continuation of how they practice and think about primary health care. In this section it is inferred from Dr Thorpe's account that he alternates between being indifferent to and being in support of the changes. Also, he does not focus his account on the market or on management in such a distinctive negative manner as Dr Rudston. Dr Thorpe is a first wave fundholder and suggests that the recent changes will not substantially affect the way he practices medicine. I argue that Dr Thorpe construes the government's beliefs and norms to be congruent with his own. It is argued that Dr Thorpe's orientation to work is not threatened by how he interprets the recent legislation. Indeed the White Paper can be interpreted as "orientating" him in his work. Attention is first given to the more sceptical or dismissive discourses which are used when ascribing meaning to the government's actions.

8.2 Curbing Costs, Privatisation and Control Discourse

Those which spoke in what can be called a dismissive way about the changes focused on the role of the market mechanism and on its implications in the health service. I categorise these accounts as drawing from a "curbing costs, privatisation and control discourse". Those which were explicit about these issues spoke of the changes in terms of it being an anomalous situation and as an immediate or future constraint on their lives. It is argued that the discursive resources drawn on here reflect a perceived threat from the changes: the discourses examined here arguably are incongruent with the government's market discourse outlined above. The assumptions, beliefs and expectations for the NHS are accounted for as being incompatible with how the informants interpret the government's intentions. In summary, there are three broad interpretations of the government's aims which are grouped together in this section: the government is attempting to reduce the financial costs of the NHS; the government is

seeking to control the activities of medical practitioners; and the government is laying the foundations for privatising the health service. I start this analysis by interpreting aspects of Dr Rudston's interview.

In chapter 6 I suggested that Dr Rudston wanted to be seen as an assertive and individualistic character. "Doing things his way" is a theme that can be used to categorise his talk. Members of his staff at the Dove practice also were seen to be reporting his actions in a similar manner. Before the more formal interview, for instance, he was seen to be reporting his involvement in a management training programme in the following way:

> "I went on a management training scheme and built towers out of Lego to get us to look at team building or something. I said (pointing at imaginary people), 'Right you have to do this, you have to do that' and we started building straight away. We didn't win because I took over and said this is what you have to do...We [he and his patients] have got out of the in-out rigmarole and I don't need theory to talk and listen... I could bully it [their problem] out of them, which is the management theory bit, or I could go down to their level. It's all to do with communication and personality".

From this statement we can infer that Dr Rudston not only sees himself as an assertive individual, but that he likes being in charge and is critical of management theory and management techniques. He takes pride in his distinctive approach to general practice and believes his way is best for his particular patients. Although Dr Rudston practices with Dr Wansford, he speaks often in singular terms ("I think that..." or "I would say..."). He states that *he* decides what he does, furthermore, he and Dr Wansford state that there are no formal arrangements for decision-making within their practice. Hence, I classify Dr Rudston as relating to a single-handed perspective (as defined by Wilkin, Hallam, Leavey & Metcalfe, 1987). Klein (1989) identified that governments have attempted to manage such individualistic general practitioners since the establishment of the NHS. Previously I stated that the MoH, DHSS and DoH have aimed to encourage individualistic GPs both to work more in teams and take on more administrative responsibilities. In the following passages we can see that Dr Rudston is seen to be reporting a resistance to such drives.

Primarily, Dr Rudston implies that there is a clash between his and the government's ideologies. We can see how Dr Rudston accounts for and makes sense of the changes by drawing from different discursive resources and linguistic devices. He typifies the government's changes as drawing from a

"commercial" ideology and his from a "state service" ideology. (I present a typification of these ideologies in Figure 8.1 later.) The next excerpt is long, however, by presenting this passage of his talk we can see many of the themes which are raised above in action. There are other aspects of this talk that I do not examine here as I intend to retain some focus. I asked him what he thought the government aimed to achieve by implementing *Working for Patients*. He responded in the following way:

> "I would say that the political strategy here is unknown. I don't think that they really know what they are doing. I don't really understand opting out and going independent with self funding hospitals. What are they there for? They're trying to create a competitive role between hospitals so they become more efficient. I don't think that you can put medicine into the commercial market place. I don't think that you can put state hospitals into a commercial situation... We provide a service at the end of the day, what is the product? The happy and contented well person right? There are many illnesses, so many problems that you have to evaluate erm, if you have got a particular chap in your hospital who is brilliant at doing operation X then the local practitioners and colleagues will refer that patient onto him and he can do it. If he is working in the state hospitals and doing some private work, he would get the money from the speciality from which he was an expert in and so on. Now having forced out into the private sector what they cannot do in the state hospital, so the funding has changed. So they are saying the money goes where the patient goes. Is that common sense I don't think that it is. It doesn't do anything. All I am saying is I don't see any strategy, I don't see this commercial situation working within a state situation. There are something's that have to be, by inference, not terribly efficient, not terribly logical because you are dealing with human beings. We are all individuals but yes fit into a formative pattern and the pattern should be observed and checked on. There are lots of things in my mind that are rather silly really. Erm, what effectively are we doing? We are probably creating more side effects than we are benefiting. If you take diabetes, there are lots of illnesses that require on-going therapy which are costly. At some stage this government is going to turn around and say is it really worth the cost? They are looking at it from money. We are living on black gold at the moment and we cannot survive the present industrial state as we are not doing well on the world market. So the government is looking at ways of cutting money. That is the strategy, I am sure".

In this excerpt Dr Rudston is constructing an understanding of the aims of *Working for Patients*. He starts this section of the interview by saying that is unaware of the government's strategy, however, he concludes this passage by stating that is confident with his interpretation of the strategy. By focusing on the variations in his account allows for an important aspect of discourse analytical work to be explored - the situated and functional character of the different versions of "reality". Three themes emerge from this excerpt. The first concerns his stated lack of understanding of the changes, the second focuses what he considers the government's intention to be and the third concerns his views on the workings of the NHS and hence his critique of the proposals. I explore these in turn and consider other accounts that raise similar issues.

Dr Rudston states in the interview that he does not know the purpose of the government's changes (eg. "The strategy is unknown") and that he does not understand the changes (eg. "I don't really understand opting out and going independent with self funding hospitals. What are they there for?"). I suggest that here he is not persuading me that he has little interest in the changes introduced to the NHS or even that he does not understand them. In this excerpt we can see Dr Rudston ascribing various motives and reasons for the government to introduce such changes. He concludes this passage of talk, for instance, by stating that he views the government's motivation is to save money in the NHS. He articulates this view categorically as "that is the strategy, I am sure".

This informant's account can be viewed as an attempt to persuade me (and others) that his rationale and understanding of the workings of NHS are preferable and "superior" to the government's. When such a situation occurs it is argued that any identified differences between viewpoints need to be accounted for (Billig, 1991). According to Pollner (1974, 1975) everyday reasoning assumes that viewpoints which are non-substitutable for each other are perceived as a threat to assumptions of the "reality" of the world. Therefore, I suggest that Dr Rudston is constructing a "superior" counter-argument because he interprets the government's market and managerial model as a threat to his assumptions and construction of the NHS "reality". A possible reason for him reporting an opposition to the changes could be that he perceives them to be a constraint.

Dr Rudston depicts the reasons for government's activities to be a cost cutting exercise. He suggests that the UK economy has financial problems ("living on black gold") and the government needs to find ways in which to save money: "they are looking at it for money" he says. Dr Foston raises a similar point, however he can be seen to be reporting his view with more caution: "I feel very cynical about the Government Paper. I don't know whether the Department of Health wants good quality primary health care or whether it wants cheaper primary health care". Alternatively, Dr Bracken, like Dr Rudston, is more assertive in his argument. He can also be seen to be reporting a recognition that the government is controlling the amount of money spent on the NHS (an argument I raised in an earlier chapter). Moreover, Dr Bracken implies that the government is playing what can be called a "deception game".

According to Dr Bracken, the NHS is susceptible to being used as an economic tool or "buffer" to regulate the economy and as a political tool to win voters support prior to general elections. He said,

> "It [the NHS] costs two per cent of GNP I understand. Now the Chancellor cannot afford to spend over [the amount allocated]. If things get a bit difficult financially then the chance of using the NHS as an economic regulator or as a buffer is great... It is good sometimes when they put more money into it when the election is coming up but they do that anyway, because the opposite [happens] when things are a bit tight and the public [loses out]. There is no morality in this... Prescribing budgets for general practice, the government has told the public again and again and again that GP budgets are not cash limited. A doctor who wants to prescribe won't actually be stopped prescribing any drugs... [after] he has spent his amount. They have promised that and they say that nobody will go short and this is true. But the money that all FHSAs get is cash limited. Now that means that the FHSA has to pick up the tab from another budget. It is cash limited. What the Minister is saying in the Commons is strictly true, but at the same time it is a lie. I sound very paranoid, but I actually know what they are saying and I know what the rules are. Every region has cash prescribing funds we do not get more money. The money that the FHSA get from region is limited. That is cash limiting".

Dr Bracken states that the government is deceiving the public by claiming that the NHS budget is not cash limited. He suggests that the government has gone to great lengths to persuade this to the general public: they have "told the public again and again and again that GP budgets are not cash limited" (his emphasis). Despite what the government says, he suggests that there are financial restrictions on the NHS. If money is spent in one area then this limits the resources available in another. He insinuates that further cuts are imminent which will result in the quality of care being reduced: "We are going to become steadily underfunded. We spend less per population than any other developing country. There cannot be much slack if we are at the bottom of the spending league and we have a reasonably good service. You cannot have a change of service to make it efficient... We are beginning to slip back in the quality of service that we offer". He implies also that this deception is not unique to the issue of cash limits. He is drawing from what can be called a conspiracy theory discursive resource. Dr Bracken acknowledges that he sounds paranoid but justifies his argument by stating "I actually know what they are saying and I know what the rules are" and "I have always voted conservative [but] I am not stupid, I know what they are doing". Primarily he suggests the rules of the game are political: saving money and winning elections. Later on the interview, Dr Bracken reiterates this point:

> "It is not so much the anxiety, in the back of your mind... the system can be more abused for non-medical reasons than before [*Working for Patients* was implemented]... The pressure is there and the changes to the general practitioner contract allow something similar to happen to the us in day-to-day activities [as in the hospital sector]. Medical activities can now be made, it can be made, it can be made

> theoretically on the basis of [an] entirely non-medical priority, like 'how do we win an election' or 'how do we save money'".

However, there seems to be a more subtle message in Dr Bracken's argument. Billig claims that the "conspiracy theorist, in claiming to have discovered the hidden truth about the world, is offering an argument against ordinary, non-conspiratorial interpretations of the world" (1991:115). If this claim can be applied to Dr Bracken's account it can be inferred that his "non-conspiratorial" interpretation of the recent changes, to use Billig's term, is that there are benefits to be gained from increasing the NHS's efficiency (see below). Furthermore, it can be argued that he believes that the government has ulterior motives for their actions. Dr Bracken suggests that the government is increasing central control over the NHS in order to limit the powers that doctors can exert in clinical decision-making. According to his argument these controls will interfere with and disrupt the way in which he practices medicine. Dr Bracken claimed,

> "We have a highly centralised system of financial controls that we have never had before and in some respect it is a very good thing as the NHS was not an effective organisation and no doubt it will become eventually more efficient than it was. This is no bad thing. At the same time it does allow every tight financial control from top to bottom. The people who are allowed to do the control are civil servants at the top and above them are the politicians. Perhaps I am being slightly paranoid, as they are using these powers for slightly less than altruistic reasons".

Also, this rhetoric can be interpreted as battling with paradox. If we use the typifications of work control to understand better this account then we can surmise that Dr Bracken is drawing from, what I term, an administrative discursive resource and a professional discursive resource. In this excerpt Dr Bracken states that he agrees that the NHS needs to be more efficient by tightening the financial controls (drawing from an administrative discourse), yet he states that he disagrees with the government for restricting his activities and controlling costs. Dr Bracken, therefore, implies also that his clinical autonomy is threatened by the increase of governmental controls (drawing from a professional discursive resource). This latter view is reiterated in many ways: "We are being interfered with more..."; "There is still not a lot [of control] but it is getting more, the foundations have been laid with the last contract"; "More and more I am being checked [up on] under the new contract" and; "More and more I am agreeing with someone else's priorities".

Despite the emphasis that Dr Bracken gives to the negative aspects of the changes, his account can be interpreted as a battle with paradox. In chapter 6 I stated that "repair" work is used when a contradiction is recognised by the speaker. The culturally-defined aim of the (western) speaker is to display consistency in an argument (Festinger, 1957). With this in mind, we can infer that by introducing the patient into his argument he can create (consciously or unconsciously) a "satisfactory" conclusion. According to Dr Bracken, the patient's rights and the protection of their confidentiality and trust can be inferred to outweigh the "efficiency" advantages. He refers to his role in this context as being the "patients' advocate". In chapter 6 we saw him drawing from what was termed a legalistic or contractual repertoire to describe his work. I suggested that Dr Bracken asserts that his job is responsible, important and is worthy of acclaim and prestige. The function of his talk has now changed. The function of his argument now is not "what makes him a good GP" but rather it can be understood as "why the NHS changes are detrimental". He said, "The fact remains that with the health promotion and prescribing and having to achieve targets that the FHSA set. When you consult me now you cannot be sure that I am personally and always acting in you interest as my interest may not coincide with your interest". Through focusing on the patient in this way, I suggest, he is drawing on what can be deemed a more "acceptable" argument. His reasoning is more powerful if he is seen to argue for "the general good of society" rather than simply arguing for his own self-interests, such as defending his autonomy. Protecting the patient's interests, in this sense, can be seen as a means to further his own political ends. In support of this claim, he states that in his everyday work, prior to the changes, he personally always acted in patients' interest because he had nothing else to gain. Now, he indicates that other criteria affect his decision-making. This situation, he insinuates, results in patients' needs not always being met, especially if they clash with his own interests. Similarly, in other accounts, such as Dr Rudston's, the "patients' needs and rights" can and will be seen to be rhetorical tools to support personal political ends.

Returning to Dr Rudston's account we can interpret that he also states that the government is attempting to reduce costs under the guise of making the NHS more "efficient" (and by introducing competition between hospitals). However, unlike Dr Bracken, he questions the actual feasibility of this model and argues that the state service and commercial markets are incompatible systems. It is worthy to focus on

how he constructs this argument. He said, "I don't think that you can put medicine into the commercial market place" and "I don't see this commercial situation working within a state situation". Here it can be inferred that Dr Rudston interprets the two models as being incongruous in nature. Because he constructs his sense-making in this way, he implies that the government has a particular reason for combining what he states are two incompatible systems. Throughout the interview and in the time that I spent at the Dove Practice, Dr Rudston implied that he thought the government intended to privatise the NHS. In the more formal interview this opinion was only expressed explicitly as follows: "I think that fundholding is the beginning of private practice. If you get everyone souped-up [*sic*] up to work where you get appropriate things done at the right price, at the right time, then you are in fact negotiating business". In other parts of the interview he focuses on three reasons for why he sees the two systems as incompatible. The first explored here concerns equating health care provisions with commercial products, the second concerns the introduction of financial criteria into health care decisions and the third concerns a shift in power away from clinical practitioners. I suggest that these counter-arguments are discursive means to support and maintain his autonomy at work.

When I asked Dr Rudston why state hospitals cannot be put into a commercial situation he responded by saying, "We provide a service at the end of the day, what is the product? The happy and contented well person, right?". We can infer from what he omits here (what he doesn't say) a view that health care provisions are different to commercial products. In a health care system, Dr Rudston implies, patients seek an indirect service in order to reach a desired end - their health. Leavey, Hallam, Wilkin and Metcalfe (1989) raise a similar point. They say that the commodity sought by patients is not medical care *per se* but a "good" state of health. Also, they state that patients do not necessarily have the knowledge to judge the quality or the appropriateness of the medical care that they receive. In chapter 6 we saw Dr Thorpe making a similar point (see 6.3) and in 7.3 these points are raised when the difficulties with applying a market principle of control typification to the health service are explored.

Furthermore, Dr Rudston implies money can now interfere with the relationship that he has with his patients and with his consultant colleagues. He said, "The emphasis has gone towards something that I

hate in general practice and that is money". According to Dr Rudston "money taints medicine", however, he implies that despite the government's drives, financial criteria do not affect his referral decisions. He maintains that it is the expertise of a particular consultant which influences him. As a reminder he said, "If you have got a particular chap in your hospital who is brilliant at doing operation X then the local practitioners and colleagues will refer that patient onto him and he can do it".

Dr Cranswick, a fundholding practice manager for the Robin practice, echoes a similar point. Dr Cranswick states that if there is a new consultant the area then the doctors want to "try him out", even if this is more costly to the practice. Therefore, it can be inferred that it is the expertise of the consultant which determines whether or not patients will be referred to onto them. He suggests also that the cheapest service does not always determine where a patient is sent. Dr Cranswick commented,

> "We are having to address some issues now [that we have become fundholders]. Two to three months ago a new ENT consultant comes to a local hospital, 'Oh, we will try him out'. Now it is going to cost then £22 more to do that... A classic was on Wednesday, instead of doing a special X-ray of the stomach we are sending people into the ... [local hospital] to have them looked at with a telescope as we found that medically that is a much better investigation that we use. It costs us more, about £30 a test more, but we identified that 24 patients should have the advantage of this".

The new funding arrangements are seen to be reported as creating novel problems: Dr Cranswick states that general practitioners are finding it hard to comprehend the logistics of the financial consequences of their negotiations. He states that because the practice is a partnership, the doctors want to benefit equally from the expenditure. For instance, in response to the negotiation stated above, Dr Cranswick commented jovially that the doctors agreed in all seriousness to refer (an impossible) 2.4 patients each because they each owned ten per cent of the practice!

Dr Rudston continues to state that financial decision-making is destructive and detrimental. He said that the "commercial situation" and the changed funding arrangements have resulted in consultants being "forced out into the private sector" to do the work that they would have done in the state hospital. He said, "Previously it [referrals] have just been based on [when] an individual's needs a service from an expert,... at the end of the day they get it, come what may". Now, the referral arrangements are more complex he claims that it is not just the needs of the patient that determine whether treatment is given.

Each of his patients, he suggests, is an individual with their own unique needs. People are "not terribly logical", he says. Dr Rudston characterises himself as a "holistic" doctor. He defines this as "looking at the whole picture" of every patient. Part of his work he suggests is dealing with social problems. These problems, he claims, cannot be quantified by the (DHA) administrators and therefore are not taken into consideration when deciding which and how many patients are referred onto the hospital sector. His criticism of the administrative procedures is a theme also raised in the coming excerpt. According to Dr Rudston administrators erroneously make their decisions without looking at the individual patients.

Dr Rudston repeatedly draws on the phrase "the needs of the patient". This can be understood to be a "tool" by which he can further his own political ends. I am not saying that his patients are not important to him, indeed their satisfaction is seen to be reported as a priority for him. But rather, I suggest that by drawing from a patient-centred linguistic device enables Dr Rudston to justify and support his argument of sustaining his autonomy at work. For instance, he implies that before the changes, clinical judgement, expertise and personal contacts were respected in the NHS. These are attributes which he claims enhance the quality of care given to the patient and are also accounted for as principal sources of satisfaction for him. Resulting from the government's changes, according to Dr Rudston's account, these facets of his work can now be understood to be under threat. Thus, quality patient care (expressed explicitly) and his sources of work satisfaction (suggested implicitly) are argued to be in curtailed.

The third reason that Dr Rudston identifies to illustrate that incompatibility of the two systems concerns control. He states that there has been a shift in power in the NHS away from the medical practitioners. According to this character the "rules have changed" and the power is now increasingly in the hands of the administrators:

> "The biggest growth area in the health service is the administrative bureaucrats. What I call the 'prats' because unless you are actually a nurse or a medic and you understand, you don't understand what you [the medics and nurses] do... How can you possibly have a professional administrator appointed to tell us how to do a hip operation? Or that this person doesn't need this operation and yes you are allowed to do two knees instead of a hip? How does he know the social effects on everybody else? Does he care about the problems and individuals in the community? No, he doesn't... Now that the doctor-doctor relationship has been destroyed, we do not have the same experts, the same views. I used to ring up somebody and say 'Hi, John can you do such and such?', 'Yeah, sure'. Bang down went the telephone, 'Bye' and that

> individual would have been seen quickly. Because of the interpersonal relationships between the doctors have been destroyed... [by] the bureaucrats... we have got people sending bloody pieces of paper. For God's sake that's not dealing with humans. All we are doing is chucking pieces of paper around, or using the telephone and saying 'has he been operated on this week?', and I get 'Well,... [the DHA] hasn't agreed to pay for it yet'. Well, damn it. That is not the way forward".

This stated shift in power is suggested to be problematic for Dr Rudston. Implicit in this narrative, and in other parts of his talk, is his pride in how he deals with his patients. He states that good doctoring is looking at and assessing the "whole person" and then assessing their needs. This community doctoring, he intimates, is jeopardised by what he calls the administrative "prats" making decisions without the knowledge or understanding that he has as a "holistic doctor". He depicts such administrators as being silly or foolish "prats" because he deems their approach to be naïve. His clinical judgement is suggested to be superior to and threatened by the actions of non-medical decision-makers. Furthermore, he suggests again here his relationships with his colleagues have become more distanced as a result of the bureaucratic "barriers" that have been erected.

Other GPs account for the changes as interfering with the GP-patient relationship. For instance, Dr Skerne draws on a North American health care model to support his argument. Dr Skerne states,

> "There is no reason now for the patients to trust my judgement. They will soon learn that the reason, or start to think that the reason, why I don't send them for an operation will be because I am getting low on my budget and I think that the government has lost a very valuable [asset], the doctor-patient relationship was based on trust. Now, I think that they have sold off that bit. I do. There is no reason now why patients, well a lot less reasons for them to, trust their doctor and if you look at America, American patients don't trust the doctors not one bit. They go along to the doctors and the doctor is no different from the plumber or anybody else... Well, the system we had before was a very efficient system. You had to rely on a professional to make that judgement, but most people for various reasons had a lot of trust in doctors to make the best decisions for them. That was the only thing that was important from the patients' point of view. The doctor may have had, you know, resource implications of decisions, but from the patients' point of view they would accept that that was a good opinion. But they will soon learn that, you know, because there has got to be rationing and if the patients don't trust the rationing you...(throws his hands in the air)".

Sociologically we can interpret Dr Skerne's account here as pertaining to what is called the deprofessionalisation thesis (cf. Rothman, 1984). Dr Skerne suggests that British health care "professions" are comparable to blue-collar occupations, such as plumbers. By implication he suggests that American doctors have lost their autonomy, prestige and are no longer trusted by patients because

budget controls are explicit in their decision-making process. British GPs he implies are becoming devalued in society in a similar way because equivalent processes are occurring here. This, he states, is a result of the government introducing financial criteria into primary health care which he suggests interferes with the traditional patient-doctor trust-relationship.

Additionally, earlier I suggested that Dr Rudston perceived that a detrimental communication barrier was being erected between him and his hospital counterparts. He states that such an obstacle separates primary and secondary health care and is a direct result of the government's changes. Klein identified that governments in the past have attempted to bridge the gap between primary and secondary health care. In the 1940s, for example, it was proposed that GPs be salaried employees in order to encourage closer working relationships between GMP and the hospital and voluntary sectors. Furthermore, in *Working for Patients* it is suggested that by defining primary and secondary care functions more explicitly (the purchaser-provider split) would provide for a more integrated service. Dr Rudston suggests that the opposite has happened. He states that barriers have been erected which threaten an integrated system. Returning to what he said, it can be inferred that a culture-clash is being described between him and hospital consultants: "... the doctor-doctor relationship has been destroyed, we do not have the same experts, the same views". The rationing of health care should be decided by health care "professionals", he claims, not by the administrative "prats". He is drawing on what can be termed an anti-administration rhetoric. He justifies this antagonism as being "bad" for his patients and patients generally. I have claimed above that Dr Rudston can be typified as drawing on a patient-centred orientation. This aspect of his work, he claims, is being thwarted by means beyond his control. He suggests, for instance, that the government is promoting an unequal health care system. He comments, "We are promoting a two tier system for people who are dissatisfied with the NHS, who are in private schemes...". The speculated "two-tier system" was an argument used by the drug companies against the "selected list scheme" (see pp.57-58) and by David Owen, the then Labour Minister for Health, in opposition to the proposed changes. David Owen stated that as a result of the implementation of the government's changes a bipartite system would occur (cf. Currie, 1989). It was argued that the top 40

per cent of the population would be encouraged and enabled to use private health care schemes and the majority would be left with an inadequate cheaper health service.

In short, many of the informants' accounts which I typify in this discourse state that the government is increasing their central control over what GPs. Furthermore, they state that they are more accountable to the state for their actions. Others expressed the increase in control in terms of an increased work load. Dr Wansford comments on this issue: "We do far, far more work than we used to do. The surgery would finish and we would fill in a repeat prescription, and they have increased significantly too, and we would walk out of the surgery and that was it. Now my dining room table is full of papers, my kitchen table is half full of papers and a typewriter". Here we can infer that Elizabeth Wansford feels that here work load has increased and is infringing on her non-working life. This increase is accounted for as a significant change in her world. She suggests that prior to the *Working for Patients* her work remained in her practice, however, more recently she states that she takes her work home with her. An increase in the amount of paper work was a theme raised also in chapter 6 (see 6.4) - where the perceived increase in administrative tasks was identified as a source of frustration and as a constraint in their work.

Parallels can be made between these last narratives and the Murrays' critique of Roy Lilley's remarks (see section 7.1). In the excerpts it is indicated that the existing health services are threatened in some way. We have seen for instance that Dr Rudston implies that the needs of the patient are not a priority for the administrators in the NHS, a theme raised by Elizabeth and Peter Murray. Dr Skerne implies also that financial criteria jeopardise his relationships with his patients. Also, we can again understand these interpretations and constructions to be means to support medical autonomy - what Johnson (1972) calls "collegiate" control (see pp.122-123).

We have seen Dr Rudston indicating that the relationship with his patients and peers, a sense of autonomy in his work and his endorsing of clinical expertise and judgement in medical decision-making are all positive orientations to work for him. Hence, I suggest that Dr Rudston can be typified as

drawing from an "occupational professional" ideology (Elliot, 1972) or what might be called a "traditional professional" perspective. Indicative of this ideology, stresses Elliot appropriately, is the opposition to commercialism and industrialism entering the work domain. Elliot states that this ideology "... incorporated such values as personal service, a dislike of competition, advertising and profit, a belief in the principle of payment in order to work rather than working for pay and in the superiority of the motive of service" (quoted in Watson, 1995b:222).

The implementation of a market and managerial system in the NHS as described by Dr Rudston is expressed in terms of what can be called a constraint. He is seen to be reporting that these systems threaten his relationship with his peers, with his patients and his autonomy. He suggests that the government intends to privatise the NHS and indicates the implementation of business and market systems are signs of their strategy. Dr Skerne uses a similar argument to oppose the changes. Furthermore, like Dr Bracken, Dr Skerne insinuates that the government is deceiving the public by denying such intent. He said,

> "This is what the NHS reforms, in my opinion, are designed to do. They weren't designed to make us more efficient, they were designed to sell us off because that, despite what all of the Tory party people are saying, 'No, no, no, that is not what we are going to do, the NHS is sacred in our hands'. I don't think that that's what the Centre for Policy Studies has in mind. If you look what they have done to all the other industries, to water, to electricity, what they do is cut it up into manageable little blocks and put in local managers who have been there already and they sell it off, and that is exactly what they have done to it".

Next, I look more conceptually at Dr Rudston's dismissive accounting techniques.

Dr Rudston's sense-making rationale of the "state-initiated managed change strategies" can be understood to "dis-orientate" him. Dis-orientation to work, in this sense, is defined as *the constructs that are used by the actor to derive meaning, from their (actual or possible) attachment to an occupational group and their (actual or possible) involvement in organisational activities, are perceived to be in conflict with changing occupational and/or organisational work circumstances*. The changing circumstances, resulting from "state-initiated managed change strategies" are perceived to be in conflict with the individuals' conception of what is "normal", "reasonable" or "acceptable". This perception

potentially confuses or "dis-orientates" the actor when interpreting and acting in relation to their work. Conceptually, we can understand Dr Rudston's account in terms of a conflict between how he construes what I have called the formal and informal structural and cultural aspects of the NHS. In chapter 4, I defined these concepts (see pp.127-128). In Figure 8.1 I present a typification of Dr Rudston's narrative of the changes introduced in the NHS. This typification is not intended to be conclusive where the intricacies of his talk are displayed. Rather, the aim of this typification is to abstract or simplify the essence of what he said (the primary constructs) in order to identify emerging themes (secondary constructs).

	Structure	**Culture**
Formal	**Cost-cutting and privitisation** *Working for Patients* is viewed as a means to cut costs and to privatise the NHS. The use of management and administration techniques are tools to achieve these aims. Competitive and efficient markets are perceived as a guise to increase administrative and managerial controls over medical practitioners.	**Commercial ideology** Health care is seen as a commercial "product". Perceived values include the regard for money and costs, accountability and administration. Doctor-doctor relationships be severed.
Informal	**Clash between the formal and informal** Seen to be reported as a clash between the "commercial" and "state service" ideologies. This clash results in conflicts of interests, priorities and aims.	**State service ideology** Informant's beliefs include individual patient care based on good communication and trust, high degree of autonomy and a support for "professional" medical judgement and expertise. Patients are the priority and stated to be the primary reason for being a GP. Rejection of administrative and managerial practices.

Figure 8.1 A typification of Dr Rudston's construction of the formal and informal aspects of the NHS.

The function of how Dr Rudston describes the changing NHS is suggested to hinder him in his work. Dr Rudston is constructing a rationale to make sense of the government's strategy. I suggest that he constructs the "new NHS reality" in this way because he perceives few personal rewards. We can infer

that he associates the "new" NHS culture and structure as resembling a shift in power and influence. Power and influence, according to Dr Rudston's argument, are now in the hands of the administrators in the hospitals and the DHA. Therefore, the function of his account is interpreted to dismiss and belittle *Working for Patients.*

A linking theme in what I have termed the "curbing costs, privatisation and control discourse" is the dismissive rhetoric used when describing *Working for Patients.* The government's actions, presented in this typification, are constructed as reducing the amount of money allocated to health care provisions, laying the foundation for a privatised health service and increasing central and administrative controls and powers over medical practitioners. Sociologically we can understand that the implementation of the White Paper is perceived to threaten the informants' orientations to work. Furthermore, the government's motives are understood to be withheld from the general public: games, rules and deceptions are topics raised in these excerpts. In the main, the informants state that they understand the rules of the game and that they are angered by such attempts to mislead patients. The "patients' needs and rights" are also a theme raised in this typification. I have argued that by drawing on a patient-centred linguistic device enables general practitioners to justify and support their argument of sustaining autonomy at work. To put it another way, this rhetorical device, I suggest, can be interpreted as a means or as a tool by which personal aims, goals and orientations can be argued for in a more "acceptable" manner. Dr Rudston's account has been used as a skeleton to guide this discussion from which others' accounts stem. Conceptually, Dr Rudston's talk on the recent "state-initiated managed change strategies" has been interpreted as dis-orientating his world view of the heath service. Attention is now given to a contrasting discourse which is drawn upon to support, in the main, the government's health service changes.

8.3 Pragmatic, Business and Power Discourse

The second discourse typification I develop is what I have called the "pragmatic, business and power discourse". I have grouped together those aspects of the informants' talk which draw on "efficiency", "accountability" and "organisation" rhetoric in the interviews. This categorisation device differs from the curbing costs, privatisation and control discourse analysed in the last section. Whereas the accounts above were interpreted to be dismissive, the following accounts are defined as more indifferent to or accepting of the government's changes. Broadly speaking, the excerpts explored here were previously categorised as reporting *Working for Patients* as having a minimal impact on their working lives. Alternatively, we can view these extracts as portraying a view that the informants' orientations to work are not seen to be threatened. Some of the GP informants which featured in the last section are also characterised here. I argued that different discourses are drawn upon as the purpose and function of their talk changes. Contradictory, paradoxical or variant aspects of some of the informants' accounts are highlighted and explored. The majority of what Dr Thorpe said in the interview can be typified as drawing from this discursive resource. Dr Thorpe's account therefore provides a frame or structure for this exploration. I conclude my analysis of Dr Thorpe's account by typifying him as being "orientated" by the "state-initiated managed change strategies". The government's strategy is suggested to be compatible with his beliefs, values and ideas about the future for the NHS. (This is not to say that we cannot find contradictions or ambiguities in his talk.)

The way in which Dr Thorpe, a first wave fundholder, speaks about the changes is different fundamentally to those excerpts presented in the last section. Put simply, Dr Thorpe's interview is interpreted as supporting the government's changes. In the forthcoming analysis it can be seen that Dr Thorpe speaks about the changes introduced in *Working for Patients* in a positive manner. He implies a perception that the government is driving for efficiency and accountability in the health service which, he suggests, aids him in his work. He implies that his personal power as a general practitioner has also increased, a theme which runs throughout his account. He insinuates that the recent changes are

incremental, rather than radical or sudden as some other informants suggested. Dr Thorpe indicates that the strategy advocated in *Working for Patients* concurs with and is in the spirit of current practices at his surgery (the Heron Practice). These aspects of his talk are all explored and looked at in detail. Furthermore, other parts of Dr Thorpe's interview, analysed and presented elsewhere, are reiterated and examined in the light of this discussion. The first aspect I consider here is how he accounts for the changes as having little influence on his work.

Dr Thorpe states that he views the recent changes as incremental, or "evolutionary". He implies that the changes follow the same line of thinking and build on his own practice's strategic rationale. He does claim that some changes have resulted from *Working for Patients* but these changes do not, however, have a significant impact on him or on his practice. When discussing the organisational activities in his practice, he said,

> "I think that, I get the impression that you think that things have changed a lot, they haven't. There has been an evolution of things, I mean the regulations have changed on the first of April or something, but [concerning] the way we organise ourselves nothing has changed...".

Despite his claims and his implication that I had misunderstood the impact of the White Paper, he was keen to talk about this subject. For instance, fifteen minutes into the interview I was aware that out agreed time was coming to an end. "I think that I have time for just one more", I said, to which he responded, "Lets go on a bit longer if you want to, I'm quite enjoying it". (The interview was extended to one hour.) I suggested three areas of his work that I was interested in - his ideas about general practice, how this practice operates and what he called the "evolution" of the changes. "Oh, I think that we ought to talk about the changes 'cause the other things are very dull", he said. Therefore, when I asked him what he thought were the most influential changes that have affected the practice since he had been there, I was surprised that no mention of the White Paper was made. He commented,

> "The Royal College of General Practitioners is erm the professional body which supposedly maintains standards of general practice, and one of the things that they have been doing over the last twenty years is really to improve standards... [They] set [the] standards by means of training GPs and by putting ... [general practice] into an academic framework. So really anyone who is a member of the College of General Practitioners and has the time and inclination will tend to put into practice those things that are a good thing to do by a good GP. So that, if there is any single thing which has changed the nature of the practice here, then it is that. It is simply the influence of the Royal College of General Practitioners".

The changes that have affected the way that he practices medicine, according to this argument, are guided most by his involvement with the RCGP. He states that it is those doctors which want to improve the standards of health care will be rewarded from involving themselves in RCGP training and by taking an academic approach to health care. Hence this excerpt could be interpreted as pertaining to a professional orientation to work. However, I suggest that it is understood better as a rhetorical tool to differentiate him from other doctors. In the following passage, Dr Thorpe speaks about his practice. He states that it is at the "vanguard" of general practice organisation and it is this which distinguishes the Heron practice from the others (later he states also that the middle class population allows the practice to be progressive).

> "The reason that we became a fundholder was because, erm, we, our practice is fairly highly organised, as we say we are in the vanguard of general practice organisation and so take that in line with the fact that we think that fundholding is a very good idea, which has been put into action by the government and the fact that we have got the keenness to do it. That's what we care about".

Although here he does not state his reasons why fundholding is a good idea, it can be inferred that he associates the government's actions in line with how the RCGP promotes "good practice". The fundholding scheme is implied by Dr Thorpe to be at the leading edge of general medical practice as it, he suggests (see below), "is the first step to find[ing] out the most basic things about the costs in the NHS". Furthermore, he states that they have got the "keenness to do it", implying that other practices do not have the same commitment to good practice. In the next excerpt, which is long, the informant's rationale for change in the NHS is presented. In this passage a number of themes identified in other parts of Dr Thorpe's account are returned to and developed. Just before he said the below passage, he commented that the fundholding scheme is best for his patients and best for the NHS. "For what reasons?", I asked. He said,

> "It is best for the NHS because it is an emonstrous [*sic*] organisation which does not get [a lot of] money...In order to decide which bit of the NHS should get more money or less money, assume that everything is not perfect, and we can take it [as that], in order to know which bit of the health service should get a big bit of the cake and which less we need to know how much things actually cost. How much it costs to cover a hysterectomy, or to have Granny in hospital to rest for a fortnight, we need to know how much things cost and we've never know that before. No-one knows yet how much those things cost and we won't for a few years yet. The fundholding initiative is the first step to find out the most basic things about the costs in the NHS. I mean no other organisation in the world must run on the basis of the NHS where people just give it money and the money gets spent and no-one knows what the money gets spent on. You can give a million pounds to a hospital and you don't know what it

> is going to be spent on and it just gets absorbed. What you want to do is say that I'm going to put a million pounds in that hospital because we want to do more hip operations. If you know that you have a hundred hip operations and you want to get those done, you think they would say 'How much does a hip operation cost?', multiply it by a hundred and give it that much money and that gets it done. But nobody knows how much a hip operation costs so you cannot even start to do that. The financial planning that the average housewife would think nothing about, it is quite ridiculous, and the same with general practice, the fact that general practitioners have the blank cheque to spend whatever they want without any restraint or restriction. Every time I, you come to me and say 'I have had a pain in my tummy for a few weeks', and I might say to you, 'Oh well I better get some investigations done, I'll make an appointment for you to see a hospital specialist'. You go up and see the hospital specialist [and they say] 'Erm, perhaps vary your meal a bit I'll give you a letter to give to your GP to prescribe some tablets to you'. That would probably cost the health service the best part of £500 and yet, there has not been any restriction on whether I do that. If I'm having a tired morning I think I cannot get through all of these patients this morning, I am going to have to dispose of them somewhere, and you know the patients love going to hospital. So, Mrs Jones is pleased, I don't have to examine her, only tape a letter for the secretary to type and that's it. The objective is that I can get through my surgery and that's it, £500 gone, bang! I can do that, this practice spends the best part of one million pounds a year on hospital activities and drugs and there is no one to look over our shoulder. It is assumed that GPs are good doctors in general - they are the good guys who behave properly all of the time - and don't take into account the fact that they are human beings overwhelmed with work just finding ways of getting through [their] work".

The first argument drawn upon here can be called an "economic" discourse. According to this argument there needs to be more awareness of the costs in the NHS so that informed decisions can be made. In economic terms, what Dr Thorpe implies relates to principles of supply and demand - a service's or product's market price will govern the level of GP demand. Because the NHS is a large organisation, he implies that an economic rationalisation strategy is essential in distributing resources effectively. Dr Thorpe suggests that the NHS has limited resources and the most effective means of allocating those resources ("the cake") is by knowing how much things cost. This notion of "needing" to know the costs in the NHS is raised in numerous ways including: "We need to know how much things cost", "No-one knows yet how much those things cost" and "No-one knows how much a hip operation costs".

What can we interpret, then, as the function of Edward Thorpe's discourse? He states clearly that costs need to be known in the health service to improve clinical decision-making. He implies also that there are finite resources available to be utilised in the NHS. I argue that Dr Thorpe is attempting, in part, to persuade others to see him as a "realist". Dr Thorpe insinuates that the NHS is an imperfect system and that there are limited resources available. This can be inferred from the above statement, "assume that

everything is not perfect, and it is not". Thus, by implication, he is saying rationing is inevitable. To support this claim further, he draws on a comparison with an "average housewife" who, he implies, plans her finances sensibly in accordance to how much things cost. He states also that other (business) organisations would not proceed without knowing such basic economic information. It is suggested that the same business principle should guide general practitioners in their spending, however, the costs are not known so such planning cannot operate. Dr Beverley also describes his practice in business terms but implies he is uncomfortable with the usage. Dr Beverley said,

> "Well I personally wouldn't like to describe it as a business, but it is. Obviously we are providing a service for people and we are given a sum of money in order to provide that service and we have to account for how we pay our staff. An account in the same way as any business has to and to be able to describe our activities, so in that sense it is a business but I think that we like to think that it was influenced by factors other than business ones. In other words it's what influences us is not, is not profit but, but hopefully patient care, that is what we would like to think".

Returning to Dr Thorpe, in the above passage, he does not speak explicitly about who should decide which health services should get more or fewer resources. For instance, the decision-makers are known only as "they" - "...You would think *they* would say, 'how much does a hip operation cost?'".. Nor does he say who is to benefit from these costs being known. It could be presumed that "they" are the government - the funders of the NHS - and he is arguing that the government should have more control over how general practitioners spend their money. However, I suggest that this is not the crux of his argument. Rather, I maintain that Dr Thorpe draws on an "economic" discursive resource because he perceives that a personal gain is to be attained from financial criteria being introduced into primary health care. Hence, unlike the accounts categorised in the last section where constraints and negative restrictions were interpreted, we can infer that Dr Thorpe interprets the recent government changes in a positive light because he perceives rewards and benefits arising as a result. Some of these rewards are now explored.

In chapter 6 I categorised Dr Thorpe as having a contractual or legalistic orientation to work and as drawing on an "I know best" repertoire. He stressed his importance, credibility and his powerful position because he provides general medical services to his registered population. Furthermore, in

chapter 6, I stated that this informant's account can be understood as battling with paradox and contradiction. His talk was interpreted as juggling between two roles by which a GP can be judged on - medical care (the prescribing and monitoring of disease) and patient care (the quality of the doctor-patient relationship). Although he stated his desire to treat "patients as people" and to meet their individual needs, he said also that he was dissatisfied with his patients judging him by non-medical criteria. I suggested that Dr Thorpe attempted to "repair" or to "resolve" this contradiction by arguing that he has more expertise on clinical decision-making than his patients and, consequently, he is in a better position to decide upon the patient's course of action. In the passage above we can interpret a continuation of this battle between the two identified roles that a GP can adopt. I suggest that the function of drawing on an economic discursive resource is three-fold: one, to support his medical-care approach to practising medicine (what Johnson (1970) calls a "collegiate" form of control); two, to give him a more tangible bench-mark from which he can base his decisions and; three, to have some control mechanism imposed on him, and other general practitioners, to ensure that NHS funds are "correctly" allocated and that the system is not "abused". These inferred functions of talk will now be explored.

First, I look once more into how Dr Thorpe continues to construct an argument which advocates the inappropriateness of what he calls a "customer-relationship" approach to primary health care. Above, Dr Thorpe makes additional assumptions about what patients want. For instance, Edward Thorpe states that patients find enjoyment from being referred onto secondary care - "... You know patients love going to hospital" - and if they are referred he implies that they are then satisfied with him as a doctor. However, although the patient may be happy and content, he questions both the cost effectiveness of the referral and the advice given by hospital consultants. He states that the NHS can spend up to £500 on a specialist who simply suggests minor dietary change and writes a letter directing a GP to prescribe some medication. Therefore, it can be deduced that he is constructing an argument to persuade others that the "customer-relationship" approach is not always the most effective and efficient means of allocating funds or practising medicine. The explicit reason that he states for this is the huge costs and the "waste" involved in referring patients. (He uses another example to reiterate this point later in the interview.) He echoed this point here:

> "We know how much they [drugs] cost <<pointing to his prescription pad>>. We don't know how much we spend on referring patients to hospital. So, if you take those things together, forgetting that I'm mentioning the objective of GPs [is] getting through that number of patients in a day and if the means of doing that are diverse as writing prescriptions which may cost just £5, or just talking to a patient that's nothing except time or referring to a hospital which may cost up to £500 for a simple couple of appointments in that patient. You can see the potential for waste is extremely great particularly when the contract says that I have to provide the best possible medical care for my patients".

The second inferred function of drawing on an economic discursive resource, I suggest, is his want for a gauge or yard-stick to base or support his decision-making. There is an implicit argument in Dr Thorpe's account for a legitimate mechanism to help decide which patients get, say, hospital tests and referrals and which do not. At present, he implies that if patients want to be referred onto hospital he has little choice but to send them because he is obliged contractually to provide the best possible care. This is stated also towards the end of the passage above. Additionally, he states that in medicine that there is always an element of doubt in diagnosing an illness. Therefore, if a patient demands, say, hospital tests, he feels compelled to have them done. He articulates these points in another way:

> "If Mrs Bloggs says, 'I'm sick of you giving me prescriptions all of the time, I think that I should have some tests done'. Because I cannot say, 'Well there is nothing else the matter with you but indigestion', because the nature of medicine [is] as such I cannot be 100 per cent certain that she has not got a stomach ulcer, I have to say, 'Yes, we had better do that then'. That is £500, instead of £5 [for a prescription], if it is an operation that is £1,000 or £1,500. Yeah? So, you see the scale of the costs and the total lack of control".

He implies here that he is obliged to meet Mrs Blogg's demands no matter how medically unfounded. Implicit in Dr Thorpe's account is that this situation, of doing what patients want, has to change. This claim is supported by his assertion that there is a "total lack of control" in clinical decision-making. In his interview he suggests that the government, in *Working for Patients,* is attempting to rectify this situation by increasing accountability and efficiency in the health service. Implicit in this argument is that GP practices are businesses and need to be run as such. This strategy is one that he seems to be endorsing. By knowing the cost of drugs, referrals and treatments is a step in the right direction, according to Dr Thorpe, in making the NHS more controlled and orderly. It could be logical to suggest that Dr Thorpe is arguing that his and other GPs' autonomy should be curtailed for the greater good of the NHS. If he is arguing that controls need to be increased in the NHS then this must include controls over general practitioners too. I argue, however, that this is not the essence of his persuasion. He is

explicit in his statement that doctors, and only doctors, are the best people to make clinical decisions. Therefore, it is reasonable to deduce that there is another outcome to this line of reasoning. Dr Thorpe, I suggest, envisages that his power over patients will be justifiably increased as a result of *Working for Patients*. I argue that the price of a referral or treatment is interpreted by Dr Thorpe as a tangible reason for having more control in the way that he practices medicine. More control over referral rates could also be advocated because he perceives more control over secondary health care sector. When discussing Dr Thorpe's prior orientations to work in chapter 6, it was suggested that before the changes he saw hospital consultants as dismissive of GPs and as holding the most power in the NHS. This hospital-based power, he suggests, is diminishing as a result of the White Paper because hospital doctors have to be responsible to general practitioners and particularly fundholding GPs. Consequently, the use of financial accounting in the NHS can be argued to give Edward Thorpe some external legitimation to refuse some patients' referrals or tests which he does not deem necessary and gain a sense of power over the hospital consultants (a theme raised in chapter 6).

In comparison, Dr Cranswick, also a fundholder, is more dubious about the amount of powers that he has over the secondary sector. However, an increase in power can be seen in the next passage to be of importance to him and the practice's decision to becoming fundholders is implied to be influenced by this - "If we get it right then we can stitch them [the provider units] up". In the last section, I categorised aspects of his talk as utilising what I have called the curbing cost, privatisation and control discourse. Earlier I have argued that actors vary their accounts and draw from different repertoires or discourses to accomplish different tasks. This variability in an actor's talk is a feature of making sense of our everyday lives. Different repertoires or discourses are drawn upon by individuals, in the same interview or even the same sentence, as the function or purpose of their talk changes. This is what Potter and Wetherell refer to as actors varying their "repertoires in interpretation" or as Bahktin (1981) terms different "registers of voice" as used when the function of the talk alters. In chapter 6, Dr Cranswick was typified as having a negative dynamic orientation to work. He is critical and implies his disappointment in the reality of the purchaser-provider relationship. He said,

> "If we get it right then we can stitch them [the provider units] up. In practice, if it is going adrift of what you want then your best idea is to phone somebody up and try

> and put it right, and not say here in the service agreement it says that is not going to get you anywhere. So we are saying that as long as there is nothing in the service agreement that we have to pay for, that is not part of the fundholding, then we will not bother too much about the small print. This is a change in my opinion from the start as I thought that the small print was going to critical and the best practices would be the ones who would get the fine print right. When they took away all measures of challenge, you cannot go to the courts, and you cannot enforce the service agreement....".

Dr Thorpe, however perceives rewards from the situation. The interpreted legitimation from the government to be more frugal in the number of referrals puts the responsibility on the government and hence removes some of the responsible from him in denying patients' needs being met. Or, to put it another way, he finds support in *Working for Patients* and the fundholding scheme for his "expert" or "medical care" approach to primary health care management. Therefore, his approval of the introduction of a mechanism (which he does not describe explicitly) can be understood as a tool for him to overcome the paradoxical or ambiguous nature of his job - he has legitimation to follow the medical care approach rather than the customer-relations approach. Theoretically, we can understand this function of his talk as supporting an occupational principle of work control.

Paradoxically, the third function that I interpret from his drawing on an "economic" discursive resource is his desire for an external control to monitor and check his and other GPs' activities. Returning again to the long excerpt (see p.253), he claimed that because doctors are "human beings overwhelmed with work" it is too easy an option to just refer patients onto the hospital sector. He states that because of the great demands from patients he has to "dispose of them somewhere" and somehow "get through... [his] surgery". To overcome this temptation of referring patients unnecessarily, Dr Thorpe suggests that there needs to be an increase in control over how GPs practice medicine. He implies that GPs have too much autonomy and make unprofessional decisions - "there is no one to look over our shoulder" and there has "not been any restriction [to date] on whether I... [refer patients]". Dr Thorpe states that GPs need to be more accountable and financially responsible for their actions. At present, he claims that he has unlimited access to funds which he implies is unrealistic.

This inference when compared with the last (his implicit desire for a yard-stick or gauge) can be understood as a battle with paradox and ambiguity. The ambiguity in his talk, or his messy accounting, is encountered when we as attempt to apply the principles of work structuring to what he said. This messy accounting is given closer attention. Dr Thorpe can be seen to be drawing on notions from theoretically conflicting perspectives in order to construct a discourse in the interview setting. This process is argued to be a reflection of the confusions that are evident in the NHS. Previously I suggested that tensions identified in the history of the NHS, both prior to and after its establishment, influence informant's understanding and their drawing on contradictory discourses. In the previous interpretation, Dr Thorpe's talk was argued to be supporting an increase in the powers that a GP has over his or her patients. It was claimed that he found legitimation in *Working for Patients* to support his medical-care approach. Using sociological terms, we can view this account as pertaining to an occupational principle of work control perspective. Conversely, Dr Thorpe seems also to be suggesting that there needs to be an increase in the controls in primary health care to curb financial costs in the NHS. The following passage illustrates such a confusion.

> So, I am expected to do everything that I can for the patients and [I am] given a blank cheque to do it with and I am expected to get through all of those patients in one day. How can that fail to be, not necessarily inefficient but non-cost effective anyway. Because there isn't enough money there and we really ought to be deciding whether we send three Mrs Smiths to a hospital for out-patients to investigate indigestion or whether we spend it on Mrs Blogg's hip replacement instead. You cannot balance those two things unless you know the costs.

Here we can witness this GP questioning the effectiveness and efficiency of having open-ended funds available to him. This statement can be seen as following an administrative work structuring perspective. The government's rhetoric can be seen to be drawn upon here. In the last chapter it was suggested that an "internal market" was being introduced to encourage accountability and efficiency in the NHS. Although Edward Thorpe does not talk explicitly about a market system being in operation, it is nevertheless a feature of his account. However, "accountability" and "efficiency" are referred to more specifically and are pinpointed to be essential facets of NHS management. By drawing on these discursive resources I suggest that Dr Thorpe is negotiating an argument where: on the one hand he can be seen not to contravene the government's changes and, on the other he can find support for increasing his personal power. According to Edward Thorpe, costs need to be reduced in the NHS. These controls,

he goes on to insinuate, would discipline him in his referral rates and hence encourage him to use his resources more responsibly. Additionally, he indicates that his responsibilities and powers increase because he is in the best position to decide how resources are allocated. Therefore, his talk can be interpreted and drawing once more from an "I know best" repertoire. This becomes clearer in what he said next.

> "It is in fact a terribly difficult thing to do how on earth do you balance somebody's indigestion that may be cancer against the hip? But, what doctors are saying is that, 'I am not a doctor to make that sort of judgement, that is not a doctor's job, my job is simply to say what we are doing and someone else can worry about the money'. If you take that attitude you have nothing to do with fundholders. If you say that it is a very difficult decision, but who is in the best position to make that kind of judgement? Is it the tax payer? Is it the patient? Or is it the doctor? You know, it is surely the doctor is the most appropriate person to make that judgement. Then, if that is the case, you can't pour that cup away you know, that responsibility is yours. It is the responsibility of doctors to take that responsibility and that's the way that it works".

Earlier we saw Edward Thorpe account interpreted as a tool to differentiate him from other general practitioners. This interpretation can also be inferred from the above excerpt. Although he comments that clinical decision-making is a hard task, he suggests some GPs shy wrongly away from their responsibilities. Furthermore, by omission, he implies that those general practitioners who are not fundholders are not fulfilling their duties and dismisses their actions. He stresses that GPs are in the "best position" to make such judgements and hence, because he has taken this responsibility seriously, he is superior to other (non-fundholding) GPs.

So, can we understand Dr Thorpe's account as pertaining to a occupational or administrative work structuring perspective? I suggest that he is drawing from an economic discourse to find support for his sense-making rationale. However, there is little in Edward Thorpe's account which suggests that he wishes to give up his power for the sake of saving money for the NHS. Moreover, I argue that he is using such a repertoire, which is perceived to be acceptable to the government, to increase his autonomy and influence in the NHS. In this sense, Drucker's (1973) view of a "professional" portrays Dr Thorpe's rationale: "No one can motivate him, he has to motivate himself. No one can direct him, he has to direct himself. Above all, no one can supervise him. He is guardian of his own standards, of his own

performance and of his own objectives. He can be productive only if he is responsible for his job" (1973:34).

Dr Thorpe's sense-making rationale of *Working for Patients* can be understood to "orientate" him. In comparison to Dr Rudston, Edward Thorpe's construction of the changes in the NHS are perceived as matching or complementing his notion of what is "responsible", "acceptable" and "normal" in PHC. As defined in 4.2, I use the term "orientate" in this sense as *the constructs that are used by the actor to derive meaning, from their (actual or possible) attachment to an occupational group and their (actual or possible) involvement in organisational activities, are perceived to be congruent with changing occupational and/or organisational work circumstances.* This perception potentially aids and increases a sense of power for the actor when interpreting and acting in relation to their work. The overall function of how Dr Thorpe articulates the health service changes are beneficial to him. He suggests personal rewards will be gleaned: an increase in power (over patients and consultants) and legitimation in his decision-making are perceived. Consequently, a typification of Dr Thorpe's construction of the formal and informal aspects of the NHS shows little contradiction or conflict between the components. See Figure 8.2 for a typification of his account.

A theme that runs through this rhetorical repertoire is the acceptance of the "state-initiated managed change strategies". We have seen that *Working for Patients* is perceived to be a "realistic" strategy to manage finite resources in an imperfect world. The government's actions are constructed as taking a more responsible attitude to health care management through increased accountability and efficiency and by knowing how much services and products cost. In sociological terms, we can understand that the implementation of the White Paper is not viewed as threatening the informant's orientation to work. They are viewed in a more positive light than in the curbing costs, privatisation and control discourse and enhance the respondents' rewards and complement their ideologies. A medical-care approach to medicine is implied to be supported and the rights and choice that patients have are perceived as diminishing - what Johnson (1972) referred to as "collegiate" control .

<table>
<tr><th></th><th>Structure</th><th>Culture</th></tr>
<tr><td>Formal</td><td>Economic rationalisation

Working for Patients is viewed as an incremental progression on current vanguard and progressive primary health care practices.

Finite resources are perceived to be distributed effectively by the implementation of economic rationalisation strategies.

Furthermore, the devolution of power to individual practices and GPs is viewed as crucial for the successful implementation of the White Paper. Paradoxically, an increase in accountability and efficiency is perceived as encouraging a beneficial increase in controls.</td><td>Economic ideology

The development of a business or economic culture. Cost awareness is an importance criterion in decision-making. Health care is viewed as a commercial "product" where the product's or service's market price determines GPs' work tasks and activities.

Perceived values include regard for money and costs, accountability and administration.

Increase in power to GPs over hospital consultants and patients.</td></tr>
<tr><td>Informal</td><td>Formal and informal cohesion

There is a sense of cohesion between the government's strategies and the best of general medical practice. ie, a focus on organisational unit where fundholders are viewed as the vanguard of primary health care.

Disputes and conflicts arise when managing patient's demands and rising workload.

Professional bodies and medical academic thinking are important in changing and improving current practices. The RCGP is viewed as leading and shaping the nature of general medical practice.

Coherence in NHS resulting from objective financial criterion.</td><td>Formal and informal cohesion

Informant's beliefs include a match between the informal and formal aspects of the NHS.

Increase in work load / administration is compensated by an increase in power.

Typifies two types of GPs: good and bad.

Good GPs

Realists - accept the need for change in the NHS.

Clinical decision-making emphasis .

Commitment to professional standards and professional bodies.

Bad GPs

Resistors or Avoiders - deny the need for change in the NHS

Unrealistic in their approach to modern health care management.

Customer-relations emphasis to PHC.</td></tr>
</table>

Figure 8.2 A typification of Dr Thorpe's construction of the formal and informal aspects of the NHS.

8.4 Rounding Up

In this chapter we have seen a variety of ways in which GPs interpret and make sense of the government's recent changes to general medical practice. It is argued that two broad discourses can be identified which group the interpretations and sense-making rationales. In both of the discourses the

accounts can be viewed as persuasion attempts where their rationales and understandings of the NHS are espoused to be superior to others' viewpoints and understandings.

In the first discourse examined, "curbing costs, privatisation and central control discourse", there is an emphasis on dismissing and opposing the government's intentions and plans. Concerning the perceived aims of the government, three themes arose from the analysis. First, the government is viewed as wanting to reduce the amount of funds allocated to the NHS, second, the level of government controls over the actions of GPs is argued to have risen and third, the government has an ulterior motive to privatise or "sell off" the NHS. The patient's rights and trust in GPs have been argued to be under threat. Put simply, the perceived erosion of the quality and non-commercially-tainted provision of health care given to patients has been interpreted to be a "tool" used by GPs to further their own ends - the freedom to work with few directives or controls. Furthermore, it is argued that Dr Rudston's account in particular implies some disorientation - where his sense-making rationale of a NHS "reality" is perceived to be in conflict with the changing occupational and organisational circumstances.

The second identified discourse, "pragmatic, business and power discourse", differs from the last. Dr Thorpe, a key "user" of this discourse, argues that there are finite resources and unlimited demands for health care and hence the rationing of health care is inevitable. Subsequently, he is viewed as accepting and supporting the government's actions of increasing accountability and efficiency in primary health care. It is claimed that Dr Thorpe is "orientated" by the changes because he interprets the changing occupational and organisational work circumstances as being congruent with his own beliefs, values and sense-making rationale. As stated above, I suggest that Dr Thorpe finds some personal reward in interpreting the NHS "reality" in this manner. The use of an economic or market discourse enables him, it is suggested, to regain a sense of control and power over his patients and hospital counterparts and to have a tangible bench-mark to base his clinical decision-making.

Allen (1994), looking at doctors and their careers, conducted interviews in the autumn of 1991 with doctors who qualified in 1986 and compared this to her previous 1981 study. The 1986 study involved

229 interviews (using questionnaires) with qualified doctors of which 35 per cent worked in general medical practice. Although the methods used in Allen's study and this investigation differ, similar conclusions can be discerned. A small section of her work looks at how doctors perceive the effects of the new GP contract. Allen found that out of 229 doctors interviewed, six percent felt that the new contract had a "beneficial effect", 21 per cent said that it had an "adverse effect", 38 percent reported "no effect" and 35 per cent felt that they could not offer an opinion ("not applicable") (pp. 199-200). On closer examination of these "findings" she found that all those who stated that the new contract had a beneficial effect were GP principals, GP trainees or GP locums. The benefits stated included reduced competition for GP posts, more jobs for women, health promotion opportunities and a new challenge. The latter two benefits mentioned also feature in this analysis. The adverse effects that Allen (1994) found were more far-reaching and again mirror some of the rationales found in this investigation. The main effect described by nearly a quarter of all the GP principals was said to be that it created more administrative work and therefore less time for the patients. The second most common reason that Allen states, which was identified mainly by women GPs, concerns difficulties in gaining part-time employment because of the increase in GPs' work load. Other adverse effects identified by Allen include a reduction in job satisfaction, the fear of a divided "profession", a deterrent from entering general medical practice, fewer financial incentives and a dislike for the business pressures of the new GP contract - all of which feature in this chapter. An example that Allen uses to support this claim is from a male respondents who decided against pursuing a career in general practice. He is reported to have said, "The amount of bureaucracy and form-filling has increased drastically and the government are trying to increase budgetary controls and erode their status as self-employed practitioners. They are also dictating clinical practice..." (1994:199). This could easily be an account typified above in the "cutting costs, privatisation and control" discourse.

The two broad discursive categories presented in this chapter are imposed typifications of how the actors express their priorities, opinions and beliefs. The categories have been introduced to provide some structure and hence clarity to the talk of the GP informants. Within this structure the GPs did not fall readily into one discourse or the other - we have witnessed the GPs using "messy" accounting.

Although themes can be identified which link together aspects of the accounts, it is suggested that the GPs do sometimes draw from opposing repertoires. I have argued previously that the present interpretations reflect the historical context, and because GPs are placed at the centre of the recent tensions, between say control versus autonomy, confusions and ambiguities are interpreted in their interviews. The last chapter was presented in a more abstract form to highlight the tensions that are evident in this chapter.

Links have been made with chapter 6 where the prior and dynamic orientations to work were explored. It has been suggested that connections can be made between how GPs talk about their likes and dislikes about their work and what it means to them to "be" a GP - their dynamic orientation to work - and how they interpret the present health care situation. Both analyses provide for a fuller picture to be gained about individual GPs and their involvement with occupational and organisational activities.

Can a "group ideology" (see p.205 or Watson, 1995b) be identified when we look at responses and reactions to the recent "state-initiated managed change strategies"? Previously I have argued for the value at looking at deviant cases (see 5.5.4). It was suggested that by identifying an actor who draws upon a different world view from the dominant group, whose actions are perceived to be inappropriate or unsuitable, then a dominant world view can be identified which can be compared to the deviant position. The first discourse can be viewed as the dominant group. Certain themes, which have been raised also by Allen (1994), are apparent in these accounts. One linking theme which was also identified in chapter 6 is the importance attached to the GP-patient relationship and the potential for this to be interfered with. Linked with this is the notion of an unequal health service is becoming more apparent. In the "deviant" case, Dr Thorpe is interpreted as wanting the GP-patient relationship to be changed. A second theme from my analysis is the dismay and concern about the government's greater interest in what and how GPs perform their work. Connected to this is an expressed perception that there is an increase in the administrative and business functions which act as a constraint on their activities. This constraint is expressed as a shift in power and influence to the hospital sector and administrators. In Dr Thorpe's case these functions

are not necessarily seen as a constraint. His account has been interpreted to find support for his actions from the government.

One conclusion drawn from this analysis is that how the "state-initiated managed change strategies" introduced in *Working for Patients* are understood is somewhat dependent on whether personal gains or rewards are perceived to arise. In the first discourse, generally speaking, few personal rewards were seen to be reported as a result of the paper. However, Dr Thorpe in the second discourse constructed a rationale which he expressed as enhancing his credibility, his prestige and his power. Therefore, central to the interpretations offered by the informants is the issue of control and who is seen to be in control. This loss of control is viewed as an aspect of the group ideology of general practitioners as it is common to all (except possibly the "deviant" case). This loss of control is viewed as a threat to "professional" autonomy, a theme which has been identified in the historical analysis of general medicine and in chapter 6.

In this chapter I have aimed to develop themes and issues which have been raised in other preceding parts of the thesis. In particular, connections with the arguments developed in the chapter 7 have been made. Therefore, in terms of the principles of work control, there is a recurring issue in the discourses used - the tension between occupational and administrative forms of work control. Interestingly, in both discourses it can be seen that "market" and "economic" notions are drawn upon to describe the government's actions. These actions, however, are seen to be reported in a way that enhances the government's power over GPs rather than supporting or empowering patients. Indeed, according to both sets of accounts, NHS patients are suggested to have on the whole a worse health service which cannot respond to all of their needs as a result of the changes. Not surprisingly, albeit in different forms, we can see arguments for occupational forms of work control in each of the discourse classifications.

It is now, in the concluding chapter, that the emergent themes and issues raised in this investigation are accentuated and clarified. How GPs define and comprehend *Working for Patients* and their work will

be argued to be of great significance to improving our understanding of changes of this kind. Special attention will be given to the structural tensions of work control and GP orientations.

Part IV

Endings and Beginnings

It is good to have an end
to journey towards;
but it is the journey that matters, in the end

U. Le Guin

Chapter Nine

Concluding Inferences, Analyses and Reflections

9.0 Introduction

This investigation has concerned itself with strategic changes in the national health service and particularly in general medical practice since the turn of the century. Central to the discussion is *Working for Patients* which is the most radical government strategy to affect general medical practice since 1948 (Chisholm, 1990; Bryden, 1992). How general practitioners experience, understand and make sense of these changes has been integral to the discussion. To recapitulate, the aims of the study were: to develop theoretical resources for analysing change in small "professional" work contexts, which are also part of a large state-owned bureaucracy; to understand better how "state-initiated managed change strategies" are made sense of by general medical practitioners; to reveal aspects of the researching process and explain the main theoretical and practical choices that have helped shape this investigation.

In this chapter I do not intend to make broad and sweeping generalisations about what all general practitioners do, or about how they all have come to interpret and understand *Working for Patients.* I have endeavoured to elicit themes and patterns which have theoretical importance rather than to generalise the "findings" to a wider population. Generalisations are made but are "theoretical" and not

"empirical" in nature (Yin, 1994). Accordingly, prescriptions of what are "correct" or "right" responses to the changes are not offered. I heed to Wolcott's warning: "Qualitative researchers seem particularly vulnerable to the tendency - and urge - to go beyond reporting *what is* and to use their studies as platforms for making pronouncements of *what ought to be*" (1990:55, his italics). Interpretations and understandings are, in one sense, unique to each individual. However, because of the contextual and detailed nature of this study, actors operating in similar situations may be able to in Bassey's terms "relate" their sense-making processes to those explored here (cited in Bell, 1981).

The overall analysis in this investigation has been guided by a particular epistemological position: people make sense of and understand the world to be "out there" (Schütz, 1962) and beyond the individual. To enable sense-making, our stock of knowledge (unquestioned assumptions) provide a base for categorising and typifying ourselves, others, situations and the world. As Schütz stresses, these stocks of knowledge are not static, but change according to what we deem as relevant and of interest in the world "out there". The following questions then arise. "What shape then do these 'things out there' have?" and "How can they affect the ways in which we operate in our day-to-day lives?". *Working for Patients* has not been viewed as a wholly external "reality" in the sense of being independent of, or separate from general practitioners' own interpretative activities. It cannot be "objectively" studied. Nor, as some in the post-modern tradition might have it, is it solely an internal or subjective experience which is only known to the actor and thus is inaccessible to the researcher. Rather, an internal realist position (cf. Putman, 1989) has been taken where it is argued that "things", like *Working for Patients*, do not have a "hard" ontological status like a house or a river but nevertheless they do have an external "reality". These things, structures or "realities" influence human behaviour, in the same ways as the "hard realities"; they can act as constraints upon human agency or indeed act as opportunities. Therefore, the NHS and *Working for Patients* is "real" in the sense that it creates contingencies on human activities and behaviour. I have argued that the "reality" of *Working for Patients* is beyond or "outside" the individual but exists through the individual, in the social and cultural processes in which they involve themselves. We select information from "out there" and construct meaning for ourselves. These constructs are "emergent", we interact with others and reflect on our

experiences. It is argued that the "state-initiated managed change strategies" are perceived in different ways by different actors; how GPs interpret recent government change strategies is dependent on how they define their work, their orientations and their lives. Indeed how structures are perceived to influence people is subject to their personal circumstances, however, there are "real" structural constraints, such as finite resources, unlimited demand on health care and changes to the GP contract. These processes as they apply to GPs are of central interest to this study.

In line with this epistemological position, a phenomenological approach has been followed in this study. The term was defined loosely to encompass ideas from social constructionism, naturalistic inquiry and interpretative sociology (see 4.1). The individual was placed at the centre of the empirical inquiry in order to access in some detail their sense-making rationales. Moreover, attention was given to *how* GPs, in the semi-structured interviews, account for their actions and interpretations. Through focusing on the language of the informants and the discursive resources drawn upon allowed for continuities and variations in their accounts to be highlighted.

To maintain clarity of focus, primary attention is given to the state's role in and organisation of the NHS and individual orientations. This does not mean however that the occupational dimension is ignored - it inevitably permeates elements of the general practitioners' accounts which relate to the organisational level and those that relate to the individual level. All state intentions occur in a framework recognising the significance of the representational bodies such as the BMA and RCGP. Furthermore, the orientations of every practitioner is in some way influenced by an awareness of belonging to an occupation widely seen to epitomise "professionalism".

Chapter 9 is divided into six parts. The first section (9.1), outlines the central themes and issues which have emerged from this investigation. Next, in section 9.2, in the spirit of reflexivity, I reflect on the processes involved in conducting this investigation. In section 9.3, I comment on the limitations of this study. Fourth (9.4), I suggest potentially useful areas for future research

investigations and in section 9.5 I specify the contribution that this study has made. Finally, the chapter and thesis is rounded off with a last remark (9.6).

9.1 Central Emergent Themes of the Study

General medical practice plays a significant role in the provision of health care in Britain. The role has changed during the course of its development. Whereas before the establishment of the NHS, GPs were isolated from the mainstream of medicine (Klein, 1989), now they are viewed by the government as the "gatekeepers" to the NHS (Secretaries of State for Health, 1989a). These changes can be seen to be the result of compromises and negotiations between medical representative bodies and the government but also to result from actions at a more individual level. Furthermore, how individual GPs interpret and define their work and the government's actions is significant in improving our understanding of such changes.

Attention now is given to the sociological constructions of an NHS "reality" explored in this investigation. Parallels of course can be drawn between these abstract principles and "lay" theories because sociologists and GPs draw from the same culturally-defined discursive resources. However the functions of these theories have different emphases and purposes. This section is concluded with a note on these differences.

Sociologically, it has been argued that the NHS is influenced by the social, economic, political and historical contexts in which it operates. It is unhelpful to look at the NHS as a static, cohesive and homogeneous organisation. In the first three chapters I have indicated the main influences that have helped to shape and form the present health care system. Furthermore, in this analysis I identified different "state-initiated managed change strategies" being adopted for primary and secondary health care sectors. For example, I have argued that general practitioners and hospital consultants each have

been managed a distinctive manner (and often have been played-off against each other by Health Ministers). The history of general medical practice is unique in itself. The development of general medical practice is elaborate and complex. General practitioners since the beginning of the century have had a history of competing interests and concerns with the government and with other medical occupational groups. In addition, compromises, negotiations and oppositions to government proposals in bids to maintain their clinical autonomy are apparent. To put this simply, I suggest that, on the one hand, the government has attempted to increase administrative powers and controls over GPs and, on the other hand GPs, through collective bodies and on an individual basis, have attempted to maintain and increase their clinical freedom. A central argument is this struggle between these two principles of work control (outlined in 4.4.1). The arguments presented in chapters 1, 2 and 3 can now be brought more sharply into focus as follows.

In the run up to the *National Health Insurance Act* (1911), Lloyd George aimed to introduce the availability of primary health care to wage and non-wage earners. This was the first significant measure used by the government in an attempt to change the formal structure of the health service. To achieve this aim the government wanted general practitioners to become state-employees - a theme that continues until the 1970s. With GPs being employed by local authorities the distribution of general practitioners and their activities could be controlled. However, as stated in 2.1, the British Medical Association successfully resisted the implementation of this, and most of the other proposals, and asserted their influence to maintain and enhance their self-government.

The next significant and most radical change came with the introduction of the NHS. Tensions between the two principles again is a useful way of depicting the situation. Government attention was on general practitioners and general medical practice because it was thought that they were the key to accomplishing a "rational and effective" national health service for every man, woman and child. Proposed administrative controls included the establishment of a central control body (the Central Medical Board), the move to state-controlled health centres and for financial incentives to be introduced to entice GPs to participate in the co-ordination of the system. However, a consensus management

approach was followed and "professional perfectionism" (Klein, 1989) was maintained. Few financial restrictions or controls were implemented, the proposal for setting up a Central Medical Board was abandoned and general practitioners were free to chose to operate in the panel system or the local authority owned health centres. GPs retained their independent status and to a large extent their clinical freedom. Moreover, the government has been seen to actively encourage the development of GPs clinical knowledge and skills (see p.32).

During the 1950s the government again tried to exert central control over general practitioners however the "state-initiated managed change strategies" were in the main directed at the hospital sector. Whereas in the hospital sector the government endeavoured to reduced costs by increasing the levels of accountability, costs incurred by GPs were restricted indirectly by imposing prescription charges on (some) patients. Concerning the occupational development, GPs gained status and collective powers as the College of General Practitioners was established and GP splinter groups developed within the BMA. Greater administrative controls were to be seen in the 1960s and especially after the imposition of *The Charter* (1965) (see pp.46-50). The government followed a consensus management approach in the run up to *The Charter* but many of the representational bodies' proposals were ignored. The changes that were introduced, probably the most influential since the establishment of the NHS and until *Working for Patients*, affected GP remuneration, encouraged continuing post-graduate GP training and the "pool" system was abolished for example. At this time there were tensions and conflict within the medical "professions": hospital and general practice doctors were competing for task control. The government is reported as not intervening in this negotiation process but it is argued that their interest in general medical services certainly supported the "professional" status of GPs. Furthermore, GPs were practising more in health centres and grouped practices where they could exert clinical freedom and autonomy away from the hospital services. Separate education provisions supported this distinction. So, although the government increased administrative controls over GPs and fulfilled many of Bevan's ideas about grouped medical practices, GPs also gained occupational controls especially in relation to their hospital counterparts. In sum, GPs gained a "...new lease of life...yet [*The Charter*] is often

overlooked as an impressive example of what can be achieved by administrative will and fiat to steady morale and boost quality of services" (McLaughlin, 1990:131).

In the 1973 *National Health Service Act* the government endeavoured to change the structure of the NHS once more. The purpose of the Act was to increase administrative controls by uniting the administrative procedures of hospitals, AHAs and GPs. It was thought that this unification would ease and enable the effective implementation of financial management and other national policies. If the government's actions are defined in terms of pertaining to an administrative form of work control, then this Act can be seen to strive for structuring health care work on a bureaucratic, administrative or "formal organisation" basis. It was intended for GPs to be controlled and managed under one local unified administration. This was not to be: GPs maintained their independent status and hence did not relinquish their control to administrative pressures. In the main, the "Reorganisation Act" is viewed as supporting GP autonomy and work control because their powers and representation on both area management and regional management committees were increased. GPs' control over work tasks was enhanced by their equal representation with and further separation from hospital doctors, despite governmental attempts to integrate primary and secondary health care sectors.

The 1982 reorganisation was similar in nature to the "Reorganisation Act" as the structure of the NHS (as opposed to the culture) was under scrutiny. AHAs were removed and a flatter organisational hierarchy was operationalised. The only imposed governmental change to affect GPs was the compulsory three year vocational training for all newly qualified GPs. The new NHS administrative structure could not affect or control directly general practitioners' work. Because GPs are independent contractors to the NHS, they consequently avoided the main thrust of these managed change strategies. Alternatively, in 1983 the Griffith's Management Inquiry resulted in the introduction of general management which is suggested to threaten the medical autonomy of hospital doctors (see 1.6).

The "state-initiated managed change strategies" described above concern changes to the administrative structures in the NHS. These strategies affected the hospital doctors much more that general

practitioners and have been argued to enhance, to some extent, the occupational position of GPs. Nevertheless from the mid 1980s onwards, following the government's first comprehensive review of general medical practice services, GP "professional" autonomy came under threat. GP occupational control is argued to be threatened by subsequent state involvement in an attempt to control the rising costs of health care. The state interfered directly with GP clinical autonomy and their relationships with patients (see 2.7 and 2.8). Administrative controls were introduced in the Green and White Papers in 1986 and 1987 to regulate the activities of the family doctor. Constraints include the introduction of a restrictive prescribing "selected list scheme", compulsory retirement age and remuneration changes to a more capitation system. Financial incentives were given to encourage GPs to change their activities and the "patient", "value for money" and "quality of care" were rhetorical devices drawn upon by the government. It is argued that a consumerist ideology replaced the previous paternalistic and consensus management ideologies (Klein, 1989). Moreover, administrative controls were tightened as FPCs were given increased powers and responsibilities.

The 1986 and 1987 "state-initiated managed change strategies" are distinct from the previous changes introduced because of the attempt to alter cultural aspects of primary health care. I have argued that the government wanted GPs to turn their focus away from the treatment of illness, to centre their attention to health promotion and disease prevention (see p.60). These "state-initiated managed change strategies" were challenged by GPs. Therefore, conceptually, the administrative and occupational principles of work control and the apparent tensions between them are useful ways to epitomise the conflicts and negotiations between the state and representative bodies (see 2.7 and 2.8). Clinical autonomy was supported in some respects by the government and compromises were made; for instance the "good practice allowance" opposed by representative medical bodies (Wilkin *et al.*, 1987) was scrapped and the opposed limited drugs list was accepted by GPs (however, the number of drugs on the list increased from 30 to 100). This White Paper takes us up to *Working for Patients* where the tensions between administrative and occupational forms of work control are heightened.

I claim that *Working for Patients* poses the greatest threat yet to the autonomy of GPs (see chapters 1, 3

and 7). I have argued that these recent changes are understood better when framed and guided by its history. The first three chapters were devoted to establishing this reference base. The complex and intricate details of the White Paper have been addressed thoroughly in other parts of the thesis and it would serve little function to repeat the arguments here. However, I have argued that the new GP contract is an attempt to organise the work of general practitioners in a more formal, standardised and bureaucratic manner - ie. on administrative principles. More sharply defined lines of managerial authority, an increase in centralised planning and remuneration changes contribute the rising administrative controls. In my analyses I suggest that these controls clash with the occupational forms of work structuring also apparent in the NHS. In particular these tensions are seen when we apply these principles to the talk of the general practitioners. The informants' accounts were interpreted as drawing from competing culturally-defined discursive resources when explaining and managing their perceptions of the changing NHS and their role within it. Their "messy" accounting, I argue, reflects the ambiguous and paradoxical nature of primary health care and the NHS. I have suggested that individuals are guided by their orientations to work as well as by social processes and structures apparent in the external "reality". Giddens explains this notion, which he calls "structuration", in the following manner "The knowledge of social conventions, of oneself and other human beings, presumed in being able to 'go on' in the diversity of contexts of social life is detailed and dazzling... Structure has no existence independent of the knowledge that agents have about what they do in their day-to-day activity" (1984:26). The point that is being made takes Giddens' notion (1984) one step further. The societal structures and processes help shape individual actions but also individual's actions help shape societal structures and processes. Therefore, to use Watson's words this investigation is "a study of the interrelationships between the individual and the social whose greatest potential lies in examining the processes whereby human initiatives and choices shape and are shaped by patterns of human interactions and power" (1995b:12). A focus on language allowed for this interplay to be explored. That is, *Working for Patients* is beyond or "outside" the individual but operates through the individuals' social, cultural and historical processes in which they are involved. Hence, the function of their talk and how they expressed their role in relation to *Working for Patients* is dependent on whether personal opportunities or constraints are perceived.

Therefore, in the spirit of reflexivity I have not attempted to hide or conceal myself from the investigation. Writing in the first person is viewed as an important aspect of this process. Squire (1990) raises a connected point and states that the use of passive language obscures the activity of the researcher. She said after observing the language used in "traditional" psychological reports:

> "...the authority of the absent investigator lies behind every passive textual construction. It is he or she that decides the hypotheses and methods, and draws conclusions from results. The investigation tries to increase scientific order and truth at the expense of chaos and errors in the field" (1990:40).

In an attempt to remind the reader that this is a subjective account - nevertheless one in which I attempt to persuade the reader that the investigation is credible, plausible and maintains "scientific" rigour - I have used "I" when suggesting, arguing and persuading my point of view.

Not only is the researcher part of the account, they are also a member of the same social, political and economic world as the actors that they are studying: thus is a two-way process. The researcher influences the "data" collection and at the same time the "data" influences the researcher. Correspondingly, I have argued that individuals help shape the worlds of work and work situations (among other events), the worlds of work and work situations influence the individual. This process is what Giddens (1984) calls "structuration" (discussed in chapter 4). Therefore, the researcher cannot analyse and make sense of informants' accounts in isolation of these worlds or from an "objective" viewpoint. In chapter 4 I suggested that following this viewpoint the researcher becomes an invaluable "tool" in the research process. It is the researching "self" that gains the close, in-depth and rich "data". My emotions, observations and experiences have had an invaluable role in the analysing, inferring and interpreting of the phenomena under study. Hence, I have influenced, shaped and guided this investigation. Researchers need not shy away from their impact, but be conscious about their role and attempt to write in a reflexive style: that is "let the audience see the puppet's strings as they watch the puppet show" (Watson, 1994b:78).

Furthermore, I have attempted to consider the "pros and cons" of doing research from this methodological stance and to account for the pragmatic choices that I made. It is not the place here to

The informants in this investigation did not talk in terms of the abstract concepts presented above. This is not to say that GPs are not themselves theorisers. Theorising is not a privilege reserved for academics. Actors constructs sense-making rationales, or "lay" theories, about their lives, their work which tints how they chose to act and behave. The importance of separating and not to confusing these primary constructs with the secondary constructs has been stressed as they are different in nature. "Lay" theories and sociological theories serve different functions: whereas "lay" theories enable people to understand the pragmatics of their everyday lives, sociological theories endeavour to build systematic and rigorous generalisations which do not immediately concern everyday matters (Watson, 1995b). The latter theory is presented above. The theories that GPs construct are of course particular to them and their personal circumstances. Nonetheless themes have been identified which unite the accounts. Chapters 6 and 8 were devoted to these theorising techniques.

9.2 Reflexivity and Reflections

A major feature of this investigation is its reflexive style. Throughout this thesis I have aimed to reveal and reflect on many of the processes that have influenced the study (and myself) and helped shape the final presentation. It is suggested that all researchers make choices (consciously and subconsciously) about the hows, whats, whys, wheres and whens of a research project, whether they are stated explicitly or not. Researchers are inextricably linked to the research process and outcome: "... the investigator is part of the account; to a greater or lesser extent he or she selects, does the looking, listening, points the camera, edits the tape recording, holds the pen. The challenge of subjectivity research is to acknowledge and honour this intermingling" (Fineman, 1993:222). Thus the purposes of this feature are to show to some extent the part that I have played in the study as best as I can and to make explicit the joys and tribulations that researchers may face when carrying out qualitative investigations.

reiterate the detail of these choices other than stating that exploratory research is a challenging task that can sometimes seem to be cumbersome and unmanageable. In this investigation I have immersed myself in and been challenged by making sense of an abundance of complex and rich information. The details of the different approaches that have been taken and abandoned are presented in 5.7. This "talking aloud" style can also be heard through out the thesis and particularly in latter three parts. I have striven to maintain a presence in the writing of this thesis on methodological and rhetorical grounds.

Three texts (Becker, (1986; Wolcott, 1990; Ely *et al.* 1991) have been invaluable resources to this investigation by offering advice on and first-hand examples of researching and writing as well as giving attention to the more emotional aspects of doing an extended piece of academic work.

9.3 Limitations of the Study

The possible limitations of this study can be grouped into three areas. The first concerns the level of "closeness" gained, the second raises a processual issue and the last considers the brief attention given to the contemporary role of "professional" medical bodies and the state.

First, it would be considered by some to be a drawback that I have not been able to access the everyday lived experiences of the GPs beyond the interview setting. Exploring the day-to-day organisational activities was not by and large an option available (see 5.3). Interactions with other GPs or other "professional" workers and staff meetings were not avenues that I could readily explore. My experiences at the Dove practice were an exception to this where non-participant observation was permitted. But even here access here was restricted to the practice manager's office and the surgery's reception. To some extent, this limitation could not have been overcome because of the ethics involved in GP-patient confidentiality and the fact that I am not a qualified doctor myself. These interviews and the non-participant observation however have provided a wealth of material. It has been argued that the

interview material is a bountiful and invaluable resource (see also 5.5.2). I have been able to witness how sense-making rationales are constructed and reconstructed in my presence. And if Clifford's (1980) argument is accepted, then ethnographic studies can only ever be the product of the interaction between the observed and the observer. Still, the limitation remains and access to GPs interacting with others have in the main been inaccessible.

I have suggested that it is vital to examine the processual nature of social existence. According to Pettigrew *et al.* (1992) the present study would not be classified as such because it is not longitudinal in nature. Looking at actions, reactions and interactions of the various interested parties over a period of time would have been fruitful. However, access or the quality of the time available did not permit this to happen. Nevertheless, I suggest that, with a slightly different emphasis, this has been a processual investigation as the meaning and actions of actors are not viewed to be static, but dynamic. "Sense" is constructed and reconstructed as the function or purpose of the talk changes. Furthermore, I believe that I have incorporated the other facets that Pettigrew *et al.* (1992) recommend for researching change (comparative, pluralistic, contextual and historical) in this study. I have endeavoured to supplement the existing literature on the NHS by focusing on these aspects which specifically concern general medial practitioners. It is essential in understanding processes of change to place actors at the centre of the analysis where their constructions, reconstructions and negotiations are explored. Pettigrew *et al.* (1992) recognised this, but nevertheless have been criticised for rarely featuring these accounts in their work (see p.135 or Mangham, 1993).

In chapter 4 I proposed that a framework for examining GPs' orientations to work involved the individual, the organisation and the occupation. Attention to all three constituents has been vital to improving our understanding of GPs' sense-making rationales. However, the first two constituents have been given priority where in part 1 the organisational development of GMP was explored and the individual was given priority in part 3. The occupational aspects underlie much of this analysis, however the role of the "professional" bodies in the recent "state-initiated managed change strategies" have not been a main concern of this investigation. Above (p.271) I claimed that in order to provide

clarity and focus, the government and the individual have been the principal areas of concern. The role and activities of the "professional" representative bodies in relation to Working *for Patients* is a complex and elaborate research issue and one that, in my opinion, is more suited to a different study. Examples of a more political analysis of *Working for Patients* can be found in Butler, 1992 and issues of the *British Medical Journal.*

Instead of looking at the issues raised in this section as limitations, they can be viewed as strengths. If all of these areas were explored fully, one of two things could have resulted. One, the thesis would be exceedingly long and thus would lose its focus. Two, all the issues above could have been explored by diluting the content or analyses, including the empirical exploration. Therefore, a consequence of diverting attention to other aspects would have sacrificed the close examination of the nuances and intricacies of the GPs' talk. Hence, I chose consciously to "do less, more thoroughly" and "funnel" (Hammersley and Atkinson, 1983) the exploration to illuminate the general practitioners' unique and complex accounts and situate these in the contextual and historical setting as described above. Therefore, a trade-off has been made. All projects are restricted in some way or other, be it time or resources: it is held that no project can ever reach that high accolade of being perfect despite our gallant efforts. Atkinson summates such a pragmatic viewpoint:

> "We do not have perfect theoretical and epistemological foundations; we do not have perfect methods for data collection; we do not have perfect or transparent modes of representation. We work in the knowledge of our limited resources. But we do not have to abandon the attempt to produce disciplined accounts of the world that are coherent, methodological, and sensible" (Atkinson, 1992:52).

9.4 Further Research Recommendations

This investigation has looked at the occupational and organisational development of general medical practitioners over the last century and particularly over the last decade. GPs have experienced different

degrees of change and governmental intervention and, as we have seen, interpreted and made sense of these matters in various ways. Consequently, a large number of issues have been touched upon in this investigation which might be pursued in future research projects. For the purposes of this section three main recommendations can be made. The first recommendation concerns coping and managing strategies employed by GPs, the second considers a follow-up study and the third recommends that a comparative and "interprofessional" study be conducted. All these approaches, in my opinion, would contribute to and develop the literature on the health service and the sociology of occupations and organisations.

This thesis has given attention to how informants narrated their interpretations of the White Paper. A logical progression from this analysis would be an exploration of how GPs account for their coping and managing strategies in response to *Working for Patients*. It can be argued that the distinction between these two aspects is blurred: we often engage in a negotiation process between making sense of and responding to complicated phenomena. An assumption, based on the analysis in this investigation, is that the pressures perceived (either opportunities or threats) are dependent on the interpretative processes in which actors engage. Potential contributing facets of this process could be interpretations of the White Paper, orientations to work, beliefs and experiences and so on. A theme identified in chapters 6, 7 and 8 was the issue of control. How GPs manage and cope with this perceived increase or loss in control would be a fruitful starting point for future research investigations. The notion of control and the want to be in control was expressed especially when the GPs were seen to report their dislikes of their work (see 6.2 and 8.2). Others, albeit few in comparison, perceived *Working for Patients* as an opportunity to increase the degree of control (see 8.3). A useful point of departure may be found with Lazarus and Folkman's (1984) coping strategy typifications. Lazarus and Folkman (1984) focus on two types of coping strategies. The first that they identify is problem-focused coping which encompasses individual actions aimed at changing the relationship between the individual and the 'environment'. Coping strategies here include challenging or confronting the 'problem', finding ways to turn the 'problems into solutions' or by creating circumstantial opportunities for themselves: ie, this is a 'pro-active'

response. The second coping style identified by Lazarus and Folkman (1984) is an emotion-focused coping. This involves those actions aimed at managing the distress rather than directly changing or challenging the present situation. The responses that could be categorised here include: distancing or denial, escape-avoidance and accepting responsibility or blame, exercising self-control over the expression of feeling and seeking social support and positive appraisal. These responses can be called 're-active'. Therefore, tentative links can be made with the pro-active and re-active discourses defined when looking at the informants' prior orientations to work. By exploring coping and managing styles would build on the analysis in this investigation and thus expand our knowledge in this area.

The second research recommendation is a follow-up study. The fieldwork for the present study started as *Working for Patients* was being implemented. It was a time of confusion and a time of transition. The internal market, fundholding and indicative prescribing budgets were novel concepts. It has been argued in this investigation that individuals' perceptions and orientations change as the circumstances in which they find themselves alter. It is now five years since *Working for Patients* was first implemented and many of these concepts may well have been operationalised and integrated into the day-to-day lives of the practitioners. For instance, many GPs have become fundholders; 40 per cent of all GPs in 1995 (Kuper & Adonis, 1995) and in 1996 half of the British population is served by fundholding GPs (Brown, 1996). Furthermore, at the time of writing a general election is on the horizon in which the outcome could change the path or direction of the health service once more. In March 1996, if elected into power, the Labour Party said that they would not abolish the fundholding scheme or the internal market straight away, however further recruitment to the fundholding scheme would be prevented (Sherman, 1996). Harriet Harman (Shadow Health Secretary) is reported to have said, when addressing the National Association of Commissioning GPs, "The first stage is to get them talking together with all GPs to look at ways to ensure a smooth transition to GP commissioning" (quoted in Sherman, 1996:1). Harman goes on to state that this will be the "biggest consultation" exercise yet (*ibid.*). Furthermore, the Audit Commission reporting on health care

spending in May 1996 focuses its attention on GP fundholding. A leaked draft document of this report states:

> "There has been a lack of any effective sanctions, short of the rarely exercised removal from the scheme. A call for tougher entry criteria, or more sanctions which health authorities could apply against practices which do not perform well, contradicts with the central drive to expand the number of GPs within the scheme" (Cuff, 1996).

Brown (1996b) reporting on the same leaked document stated that the Audit Commission warned of the fundholding scheme "counteract[ing] years of health authority strategy to rationalise the distribution of services on cost grounds, ensure appropriate specialisation and safety, or make the availability of services as equitably distributed about the district as possible. This could be seen as the dangers of devolution" (p.2).

Thus, in the light of these (potential) developments, this project could be supplemented usefully by a contemporary and comparative analysis of GPs' sense-making rationales and orientations to work and the occupational development of general practitioners. The extent to which the tensions between the principles of work control have been resolved or how the hopes and fears of general practitioners have manifested themselves would be beneficial areas for research in improving the understanding of change processes and the occupational and organisational development of GPs and GMP.

The third recommendation concerns the (potential) changing "interprofessional" relationships between GPs and other health workers within the PHC and in the NHS. I advise that this endeavour should not be to "test" whether or not the GPs in this study are "right" or "wrong" but to gain a fuller understanding of the perceived effects of *Working for Patients* and the changing nature of the NHS. Following Dingwall (1977, 1983), it has been suggested that the social recognition of a "profession" involves defining exclusive claims to specific areas of work and "asserting claims to a certain relationship with other ['professional'] occupations" where mutual respect is maintained (1977:393). For instance, in PHC the relationship between GPs and health visitors and practice nurses are obvious examples where work patterns have altered (see chapter 2). Indeed GPs and nurses have been

encouraged to work with a team-contract where each party defined who does what on a day-to-day basis (DHSS, 1986). This raises a question of how "professional" work boundaries are negotiated in the light of the recent changes. A theme of the interviews was an increasing reliance on practice nurses performing tasks that GPs may once have done. The tasks referred to by the GPs include running health promotion clinics, medical appraisals for new patients and vaccinations. Furthermore, the Royal College of Nursing (1987) is lobbying for nurses to have more clinical responsibilities for such things as prescribing (painkiller) drugs which was also a proposal in Department of Health's (1988) *Health and Medicines Act*. In relation to "professionals" outside PHC, Stephen Dorrell (Minister of Health in 1996) proposed that GPs become more involved in minor accident and emergency services, among other services which have traditionally been provided by the hospital doctors in the secondary sector (Timmins, 1996:2). Hence the boundaries between GP work and, say, the work of practice nurses and hospital doctors is potentially blurred and confused and would be a significant and important area to pursue.

Other questions which provide potential areas of study include the following. How has the 1990 "state-initiated managed change strategies" and affected the relationship between GP and patient and the services available to the patient? How far will the increasing state involvement lead to an improved service? What is and has been the role of the "professional" representational bodies leading up to and following *Working for Patients* (see also 9.3)?

General practitioners as an occupational group and general medical practices as organisations are both areas which have great social significance and have to date been under-researched compared to hospitals. GP are the only "profession" that has contact with two-thirds of the population per annum (BMA GMSC, 1983). Using Calnan and Gabe's words, "Certainly, there are still considerable gaps in our understanding of what are the most significant factors that influence the pattern of care in general practice" (1991:159).

9.5 Contribution of Study

This investigation has focused on the implementation and understanding of a "state-initiated managed change strategy", namely *Working for Patients*. Whereas the Griffiths Report pioneered one of the most influential changes that have affected secondary health care units (Pettigrew *et al.*, 1992), *Working for Patients* is viewed as the most radical change to affect general practitioners and hence there are three significant contributions that I have made to the existing literature on this area. First, a comprehensive structural analysis on the development of general medical practice in England has been presented. Second, how these tensions manifest in the talk of the participant general practitioners, who are involved in these processes of change as they unfold in the 1990s, has been investigated. Hence, the structural sociological analysis is balanced by a more microscopic emphasis on process whereby individual GPs make sense of situations and express in their own personal lives certain tensions and dilemmas. Third, I give an account of the processes that I have undergone whilst producing this study. One aim of this account was to make explicit the obstacles and constraints that researchers are faced when conducting qualitative investigations. These are considered in more depth below.

There is a glut of literature on the National Health Service (eg. Mohan, 1995; Levitt & Wall, 1992; Klein, 1995). However, these works prioritise the hospital sector and its relationship with the government. Tudor Hart (1988) makes a similar observation. He said "[few] are well-informed about developments in British general practice over the past 30 years... For most people, most of the time, above all for most politicians, the NHS has been the hospital service" (1988:xi). General medical practice, it could be said tends, in general, to be treated as an appendage. Calnan and Gabe reflect this point: "It [literature about medicine as a "profession"] has tended to focus mainly on hospital specialist medicine and has neglected other branches, like general practice... (1991:140)". Few studies to date have placed general practitioners at the centre of their examination and explored their beliefs, aspirations, their relationship with the government along with their occupational

development. Recent studies which focus on general practitioners and general medical practice often concern specialist areas, for instance: women in general practice (GMSC, 1994; NHS Management Executive, 1994); inequalities in health and the problems of urban general practice (Wilkin *et al*, 1987); training for general practice (JCPTGP, 1982); and the division between general practitioners and their hospital counterparts (Honigsbaum, 1979). There is a need to look at the individual, historical and structural aspects of general practice alongside the state's involvement in primary health care. Jeffrey (1991) said, when recommending future health research,

> "What is required is a sociological appraisal of the historical development of the interrelationships between the organs of state authority and the providers and utilizers of health care. Only against such a background can contemporary events and trends be seen in their proper perspective" (1991:231).

Furthermore, it has been fruitful to link up these structural themes with the talk of GPs today. What is significant in this study has been the focus on general practitioners in both a structural and micro capacity. Therefore, this investigation bridges the gap observed by writers such as Jeffrey, Calnan and Gabe and Tudor Hart. The general technical, political and policy aspects of recent "state-initiated managed change strategies" in the NHS have not been central concerns for this study. These features, as I said before, have been adequately covered by other works.

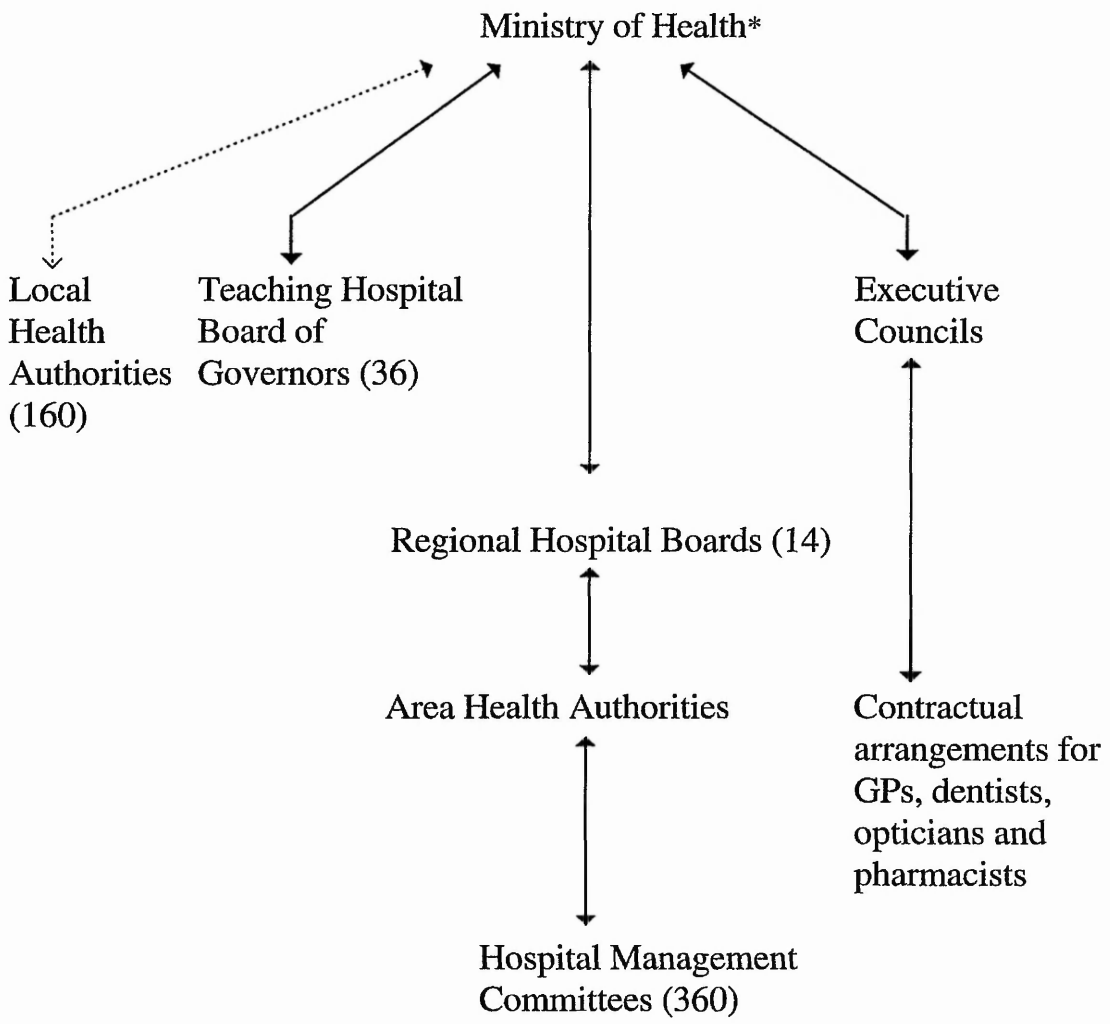
9.6 Rounding Off

"How can I know what I think till I see what I say" (Wallas cited in Weick, 1995:12) is a useful and poignant phrase which captures many of the issues raised in this investigation. Wallas's phrase delineates the constructive and re-constructive processes involved in our ongoing sense-making. Researching and writing this thesis has been a learning experience and has helped me shape my own sense-making on the NHS and ideas about my life. In the same way that GPs have attempted to make sense and continue to make sense of their worlds so do I. One possible reason for this reflection and continuous sense-making process is that "Words [only] approximate the territory; they never map it perfectly. That is why sensemaking never stops" Weick (1995:107). Consequently, if I was to start this

project again, with my added knowledge and more informed viewpoint, the narrative would take a different form. Hence, I give the last word to Charles Darwin, who said when writing to J. D. Hooker:

> "If I lived twenty more years and was able to work, how I should have to modify the O*rigin*, and how much the views on all points will have to be modified! Well it is a beginning, and that is something..." (1869).

NHS in England, 1948-1974



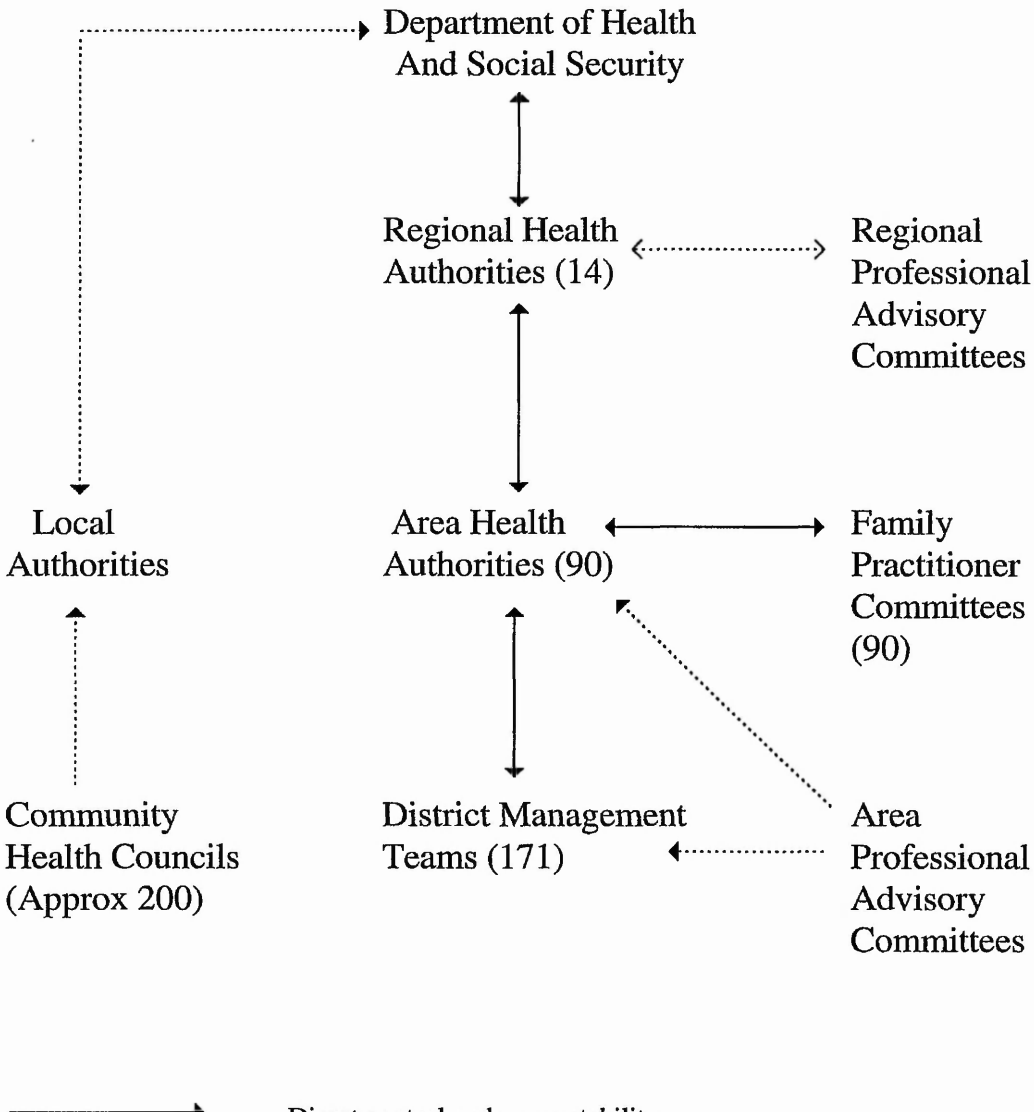
* Became the Department of Health and Social Security (DHSS) in 1968.

——→ Direct control and accountability.

·····→ Advisory and liaison relationship.

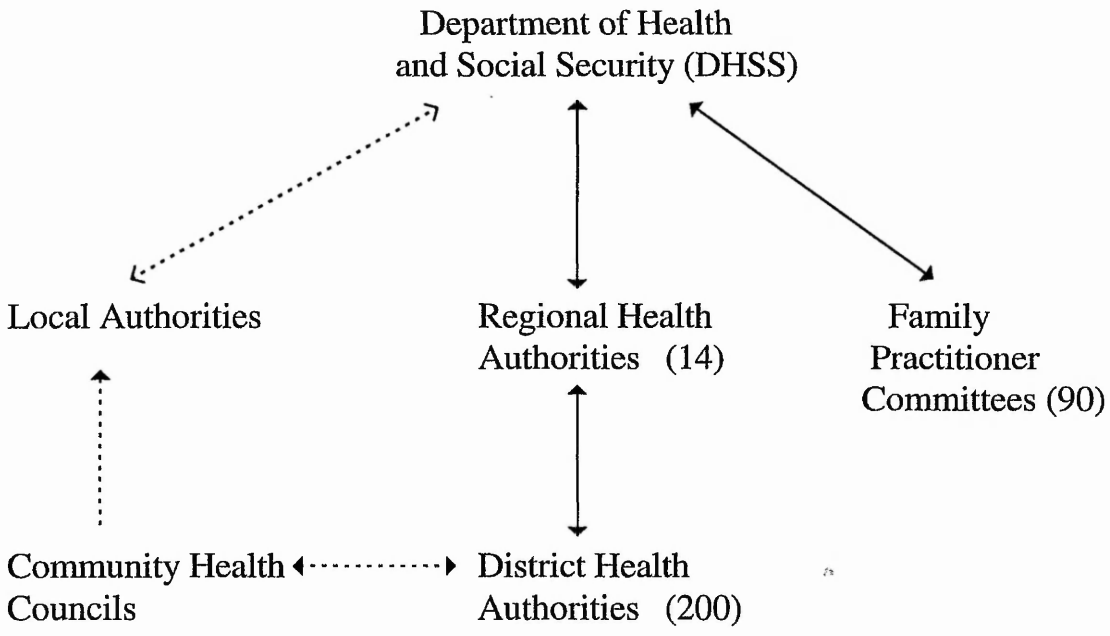
Adapted from R. Klein (1989), *The Politics of the NHS*, second edn., London: Longman.

NHS in England, 1974-1982



Adapted from R.J. Donaldson (1977), *The New Health Service in Britain - its Organisation Outlined*, London: Royal Society of Health.

NHS in England, 1982 - 1989

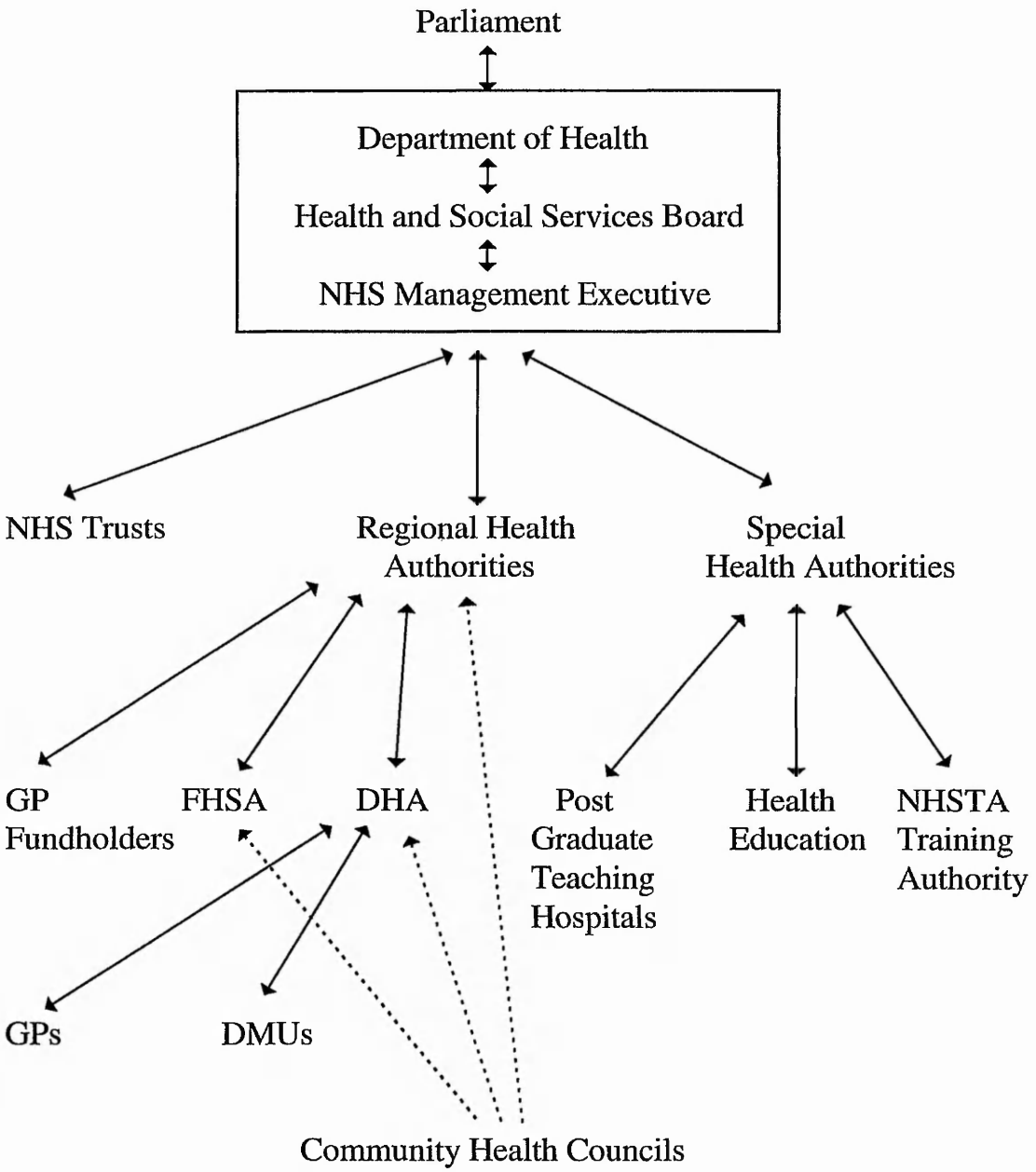


Direct control and accountability.

Advisory and liason relationship.

Adapted from R. Klein (1989), *The Politics of the NHS*, second edn., London: Longman.

NHS in England 1989 - 1991



Adapted from C. Ham (1991), *The New National Health Service*, Oxford: Radcliffe.

Cost of General Medical Services (England and Wales) in Actual and 1948-9 Prices

£ million	1948-49*	1949-50	1950-51	1951-52	1952-53	1953-54
Cost in Actual Prices	44.2	45.7	49.9	50.5	52.0	51.9
Cost in 1948-9 Prices	44.2	46.6	46.7	46.8	47.3	47.1

* Annual rate - interpolated from the 270 days for which the NHS operated.

Adapted from C.W. Guillebaud *et al.* (1956), *Report of the Committee of Enquiry into the Cost of the National Health Service*, Cmd. 9663, London: HMSO.

Earning Capacity of GP with 2000 Patients in England (a Typical non-Deprivation Urban GP)

Income from existing fees and allowances before 1990 (£)		Income from new fees and allowances after 1990 (£)	
Capitation		**Capitation**	
Standard capitation fees	7625	Standard capitation fees	2185
Supplementary capitation fees	1700		
Basic Practice Allowance		**Basic Practice Allowance**	
BPA	8560	BPA	600
Supplementary BPA	1720		
Other fees and allowances		**Other fees and allowances**	
Seniority	5510	Seniority	3810
Group practice	1480	Registration fees[2]	750
Night visit fees	625	Night visit fees[3]	1440
Other payments	4850	Other payments	4850
Total (1)	**42070**	**Total (1)**	**38700**
		PGE allowance	1700
		Minor surgery sessions[4]	480
		Health promotion sessions[5]	540
		Child health surveillance fees [6]	480
		Total (2)	**41900**
Cervical cytology[1]	310	Cervical cytology target[1]	1500
Childhood immunisation[1]	480	Childhood immunisation target[1]	2030
Total (3)	**42855**	**Total (3)**	**45430**

Please see the next page for specific practice details.

[1] Assumes 80% of eligible women on a five year rolling programme are screened, and 90% of children are immunised. Also assumes that GP screens/immunises two out of every three patients in the target population.
[2] Assumes new registrations are 8% of the lists.
[3] Less if GP uses a deputising service.
[4] Assumes one session every month.
[5] Assumes three sessions every two months.
[6] Assumes GP earns fees for all children under the age of five.

Practice Details

This GP practice is fairly busy with a list size which is equivalent to the average in England and Wales. The GP is interested in achieving high levels for cervical cancer screening and childhood immunisation, and is eager to provide a wide range of services. Under the new arrangements, this GP will benefit greatly. The GP could increase his/her income by over £2,500. By contrast if the GP kept his/her workload to the minimum he/she would find that the income would be reduced by over £3,000. This reduction will increase if the deputising service is used as the night visit fee would be lowered.

Adapted from Health Departments of Great Britain (1989), *General Practice in the National Health Service: The 1990 Contract*, London: HMSO.

Initial Research Design

This research design was written eight months after I began the research project at The Nottingham Trent University. Initially, only the accounting firm was being researched. However, with the spot light solely on them and in particular the senior executive, anxiety arose and after much negotiation the following approach was deemed by the firm to be more acceptable. The reason for presenting this early research design here is to indicate that research processes are not static or linear. When this research design is compared to the present aims of this thesis, a shift in focus can be seen. A project can change shape or direction due to changes in circumstances: in this case, the changes made were prompted by access being denied in the accounting firm, but also as a result of the researcher becoming more familiar with their "data", gaining a better understanding of theoretical "tools" available and becoming better informed and more confident about conducting a research project.

Managing Organisational Change: The Case of a National Accounting Firm and the Development of Services for General Medical Practitioners

Aims of the Proposed Investigation

Through the analysis of processes of the management of change, involving an accounting firm and a client group of general medical practitioners, to:

a) further the understanding of the management of change in professional service organisations;

b) further the understanding of organisational change generally;

c) demonstrate the advantages and disadvantages of action-orientated case study research with special reference to the strategy of studying two inter-linked organisations.

Introduction

This study will make a distinctive contribution to the developing case study-based literature on managing change in organisations through examining two linked organisational change processes. Both of the case study organisations being considered are in the service sector of the economy and are dominated by professionally qualified personnel. In each case, changes are occurring which are pushing the organisations into a "market-oriented" direction.

In the general practitioners' case the change is a result of a state-led initiative alleged to "reform" the NHS to "improve the quality of services on offer to patients, to stimulate hospitals to be more responsive to the needs of GPs and their patients and to develop their own practices for the benefit if the patients" (Secretaries of State for Health, 1989a).

In the accounting firm's case the change is perceived as necessary by at least one member of the "dominant coalition" (Cyert and March, 1963) with the intention of gaining "competitive advantage" (Porter, 1980) and long term survival (Goodman *et al.*, 1977).

In both cases the change is not widely taken-for-granted as necessary for those affected. The change is coming from 'above' or 'outside', creating for those implementing the change a substantial task in converting, values, beliefs and priorities - in effect, to change the organisational culture.

Proposed Research Strategy and Methods

The researcher will observe and interpret the change processes in the accounting firm (internal), the facultative interaction in the change process with their client group (external) and the change processes in the GP practices in the light of *Working for Patients* (Secretaries of State for Health, 1989b). The study seeks to investigate the changes by focusing on the point of intersection between the organisations in addition to the independent change processes, allowing for a comparative analysis to be undertaken.

Three literature areas are being reviewed: methods, organisational and cultural change and the NHS recent changes. With regard to methods, the focus is on the concept of action research (Bennis, 1969) in evaluating the processes being studied. In particular, the literature will be used to develop a rationale for a case study approach (Rosen, 1986) will be looked at with an emphasis on participant observation (Foote Whyte, 1984), an ethnographic style of "data" collection and analysis (Atkinson, 1979) and a "grounded theory" approach to theorising (Glaser & Strauss, 1967).

In considering organisational and cultural changes the focus is on organisational models and intervention methods (Schein, 1985), organisational development and action research intervention models (Leavitt, 1964), resistance and the process of change (Schein, 1980) and the use of groups to facilitate change (Kolb, Rubin & McIntyre, 1984).

Concerning the NHS "reforms", the focus is on the concept of change within the health service (Pettigrew, 1988) and the history of health service management approaches. More specifically, attention will be given to the effects of the reforms on GPs in respect of their actions, interpretations and interactions regarding the change.

Access has been gained to the national accounting firm and to suitable GP practices where the empirical research has begun. The range of methods being undertaken includes participant and non-participant observation, formal and informal interviewing, document analysis and work "shadowing" (cf. Lodge, 1988) the key senior executive in the national accounting firm (the central change agent). An important purpose of this process is to understand the intentions, methods and actions of the central studied change agent and the subsequent impact on fellow members within the firm and on members of the clients' organisation.

Following the principles of grounded theory, concepts and hypotheses are expected to emerge as the researcher notes the categories and typifications used by the actors being observed. Additionally, as the study is action research oriented, the effects of academic concepts suggested by the researcher will be recorded along with their subsequent use by the actors.

The final stages of the project will be presented in the form of an account, constructing the researchers' observations of and participation in the processes involved in the case study. The methods of the management of change and meanings given by the actors will be analysed. Moreover, the researcher aspires to provide a conceptual generalisation and a theoretical framework to further the existing stock of knowledge on the processes involved in managing organisational and cultural change.

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Conservation Outline

This telephone conversation outline was used to ensure three things: (1) that I did not omit any information which I felt important; (2) to give me some confidence (I am not very comfortable talking on the 'phone) and; (3) to allow me to concentrate on and be sensitive to what the "gatekeeper" was saying rather than thinking about what I was to say next.

Telephone Conservation Outline

CALLEE: TEL NO: INSTITUTION:

WHO I AM: Sally Riggs I am a Research Officer at Nottingham Business School, Nottingham Polytechnic.

CONTACT NAME:

RESEARCH OUTLINE: My research concerns professional change: The changing role of GPs.

ESSENTIALLY : * An interactive study between:

the GP as an individual,

General Practice as a professional activity &

the changing nature of general practice

AREAS COVERED IN THE INTERVIEW:

* The nature of being a General Practitioner
* The nature of General Practitioner practices
* Views and feelings about changes in general practice

AIMS OF THE RESEARCH:

* Independent study * Towards my Ph.D degree
* To further our understanding of professional change.

NOTES:

DATE OF MEETING:

Explanatory Letter

After an interview time had been arranged, I sent the following details to the interviewee. This is a skeleton letter which was adapted when necessary.

Dear *[interviewee]*

Firstly I would like to thank you for assisting in my research, it is greatly appreciated. I am looking forward to talking with you on *[date]* at *[time]*.

You will find enclosed an outline of my research, stating the aims, methods and what you can expect to gain from an interview. If you do have any queries do not hesitate to contact me (on 0602 418418 ex. 2561).

The interview is informal; it is essentially an exploration of your interests, priorities, and experience concerning general medical practice and takes between 45 minutes to one hour.

I should stress here that the content of our discussion is totally confidential. Anything said in the interview will not be communicated to anyone in a form that can identify you. The research will be written in general terms only, ensuring that individuals or their place of work will not be recognisable.

Thank you again for your time and support, and I look forward to meeting you in the near future.

Yours sincerely

S A Riggs
Research Officer

Research Outline Given to Participants Prior to Interview

After an interview time and date was arranged I sent this research outline to explain the nature of the study.

Managing Professional Change: The Case of General Medical Practitioners

S A Riggs
Research Officer
Business and Management
Nottingham Polytechnic

Introduction

I am a Research Officer at Nottingham Business School, Nottingham Polytechnic. My current research interest concerns the changing role of General Practitioners, in order to further the understanding of the management of change in professional service organisations. This research does not aim to question the rights or wrongs of the recent changes in health care, but to achieve a broader application of the challenging issues facing professionals like General Practitioners at a more individual level. The interview is essentially about the participant as an individual rather than about the technical changes that are happening in the NHS.

I feel that the issues I am addressing are very important ones for people involved in medicine and for the general public alike. Without the help and cooperation of people like yourself this understanding will not be available. Interviews can also provide a useful opportunity for individuals to reflect upon their personal involvement in the changing world of medical care.

Aims of the Research

The aim of the research is to understand how individual practitioners, groups and partnerships, and other bodies in the health service are coping with the considerable challenges in the health sector profession.

At present there is a large amount of literature on management of change that concerns large organisations. One purpose of this research is to look at the relevance of those ideas to the change processes that are occurring in the rather different setting of General Medical Practice.

In the process of doing this it is hoped that light may be thrown on the factors which will enable the proposed changes to be brought about and those that will inhibit successful implementation.

Method of Research

I am presently conducting a series of interviews with General Practitioners and members of inter-related organisations such as the FHSA, and the RHA to achieve this aim.

The interviews are a series of informal open-ended questions that will allow for free expression and flexibility. The line of questioning will follow the responses, interests and priorities of the interviewee.

It is not possible, indeed it would not be right at this stage, to indicate the precise questions to be asked. To do so would prejudice the issues and priorities I wish to explore with practitioners. The nature of these issues and the patterns of change will emerge as similarities and themes develop through the process of the interview programme. I believe that the perspectives of those directly involved in the provision of health care are of utmost importance and should be given priority by the researcher.

This approach permits participants in the research to voice their opinions on and interpretations of the roles and functions of the General Practitioner. This process will further enable the researcher to understand and follow the patterns of responses regarding the changing environment.

The interview will take between 45 minutes to one hour.

What's in it for You?

Participation in this kind of research is frequently found to be personally rewarding, useful, and indeed enjoyable for those interviewed.

Confidentiality

The discussion will be *totally* confidential. Anything said in the interviews will not be communicated to anyone in a form that can identify the participant. The research will be written in general terms only, ensuring that individuals or their place of work will not be recognisable.

Critical Incidents for Practice Managers

Towards the end of my "fieldwork" I compiled these, and other, "critical incidents" (cf. Yukl, 1981) from my observations and analysis. These were later used as teaching material for practice managers on the Advanced Diploma in General Practice Management (run by Nottingham Polytechnic in association with Nottingham FHSA). The practice managers' responses and discussions were particularly useful in refining my understanding of general medical practice.

---

1. Becoming a Practice Manager

You have been working in your practice for a number of years as a secretary. You have a close relationship with the other members of staff, especially with the other receptionists. You are able to share your work and non-work problems. The atmosphere in the practice is friendly, open and supportive. In January 1990, the partners ask you to do other administrative tasks in addition to your secretarial duties. In particular, you are asked to administer the implementation of *Working for Patients*. You are excited and enthusiastic about your new role and feel rewarded by the increase in responsibility.

At the end of April 1990, you are promoted to "practice manager". Nobody else in the practice has been offered this opportunity. A lunch time celebration has been organised by the doctors to announce your new post to the rest of the staff. Only five of your non-clinical colleagues come to the party - four do not turn up. You have been feeling distant from the other members of staff over the last few months. However, you are flourishing in your job as you learn more about your new tasks.

The evening after the celebration you feel a sense of loss and resentment towards the other members of staff. You feel that they no longer want to include you in the social aspects of their lives. You think that they are unjust and unkind as they do not give you the congratulations that you believe you deserve for your achievements. The next morning you attempt to talk to them informally, but they are not willing to listen. They exclude you from their conversations.

Your work now is being affected by the unfriendly atmosphere. You are having to work late some evenings to keep up-to-date with the extra work. The receptionists are beginning to turn up late for work so you have to step-in for them to ensure that, for instance, the telephone is being answered. You talk to each one of the receptionists separately in your office about their lax attitude and warn each of them that if they continue to be late you will deduct their pay.

There is a slight change for the better in their behaviour, but things are not as they were before. You feel isolated, unsupported and tired. You ask the partners for some advice on how to deal with the situation. The senior partner tells you it is your job, as the practice manager, to manage the other members of staff. What do you do?

2. Managing Politics

Your office is situated in the middle of the surgery. When you took the post of practice manager you encouraged the partners and staff to use your office as a "drop-in" room to sort out problems as they arose. After a year and a half in post, you still feel that this is an important function of your room as you are able to witness practice grievances and be involved in the solutions to the problems.

The staff and partners often comment that they like this arrangement as they feel they can relieve the stresses of their job in a room where patients cannot see them. Thus being able to return to the reception or the surgery with a less burdened outlook.

The pressure and work-load of your job is increasing: The FHSA is chasing you for your cervical smear lists. You promise them that it will be in the post by the end of the day. You have also an appointment with a Printer this afternoon to discuss the practice leaflet and you have been asked, by one of the partners, to organise a party for one of the receptionists as she is leaving at the end of the week. Your room is continuing to be used as an "airing-ground".

Much your time is being spent listening to your colleagues' work and non-work problems. Although you are still happy that your room is being used in this way, you are concerned that when you attempt to help solve the problem you are sometimes ignored. However, you feel that you are treated as an equal with the partners and you respect their openness with you.

Dr Patel enters your room and shuts the door behind her. In the past the door has only been closed when a sensitive issue is about to be discussed. Dr Patel is complaining that Dr Smith, another partner at the practice, never listens to her when she is offering him some advice. She feels that the practice is losing out financially, because the doctors have not embarked on a PGE course. She is angry and distressed.

Shortly after this, Dr Smith enters you room and closes the door behind him. Dr Smith goes on to complain, at great length, that Dr Patel has been incompetent in a particular diagnosis. He is angry and distressed. You patiently listen to both of the doctors. You feel that something has to be done. You feel responsible as the practice manager to manage this situation. Quietly, you have a word with each of the doctors and advise them both to talk to each other about their distresses.

After your lunch time break you work on the practice leaflet. Dr Patel comes to talk to you about a patient. Dr Smith shortly follows and listens to the conversation. Dr Smith commends Dr Patel's diagnosis. You are content that the advice that you gave the doctors, before lunch, was of use. You mention to the doctors that you are happy that they have sorted out the problems that they were having. Both doctors look shocked at what you have said. Both of them comment that they are disappointed with you spoke openly about a confidential matter. They turn their anger onto you. You feel a scapegoat and feel used. What can you do to rectify this situation? How can you restore your confidence as a manager?

3. Managing Ethics

An old friend of yours, Jeana, is a patient at your practice. This is not an unusual situation for you as you have lived in the area for a long time. Many of your friends call into to say "hello" after they have attended one of the clinics at the practice. You see this as one of the perks of your job.

Jeana has recently been visiting the practice more frequently, and in surgery times. You have noticed that some of her blood samples have been sent to the lab for tests. Because you have access to the patient files and are concerned for Jeana's welfare, you investigate her condition. You discover that Jeana has an advanced stage of cervical cancer. You are horrified and saddened at this news and are very concerned about Jeana. Dr Snow, Jeana's doctor, discusses the case with you and informs you that there is nothing that he can do for her. (Dr Snow has not told Jeana about the seriousness of her illness as he feels if she knows then the process will be quickened.)

It is Saturday and you meet Jeana for coffee as usual. Jeana is cheery, as always, and is pleased to see you. Despite feeling very sad and distressed by the information that you know about her, you talk about your family and friends as if nothing was wrong. You have talked about your job with her before and in the past have told her informally when she was next due for a routine visit, eg. for a smear.

This Saturday Jeana talks about Dr Snow. Jeana tells you that she is scared of him and feels that she cannot ask him why she has to have so many tests. She comments that she has asked him in the past and he had said that he was not 100% sure of her condition, so he would not tell her anything for fear of being wrong. Jeana pleads with you to look in her medical file and tell her what is wrong with her. You tell her that you cannot. She gets angry with you. She says that she thought that you were her friend and she could rely on you. She breaks into tears and says that she cannot go on not knowing. What do you do?

4. Managing your Authority

The doctors in your practice resent doing patient medical reports for insurance companies. There are two doctors in your practice and neither of them like to do them. There are four or five reports each week to complete. The doctors are paid £20 for each report, however, neither doctor manages to complete them by the allocated time.

The insurance companies contact you when the reports have not been received. They have pressurised you in the past and you promised them that you would try to improve the return time. The reps continue to 'phone every other day until they receive the report. Also a number of your patients have complained to you about the lateness of the reports saying that they feel that the doctors do not care for their well-being. You know that this is not the case. The doctors give up much their free time to spend more time with their patients.

When you confront the doctors they state that they do not have the time to do them ,on top of their other paper work. One doctor comments, "The only time that I can get to do them is at 12 o'clock at night and by that time the last thing that I want to do is another one of those damned reports". How do you manage this situation?

Research Outline Given to Informants in the Interview

On meeting the participant, a summary, based on my conceptual framework, was presented to give a broad structure to the interview.

Managing Professional Change

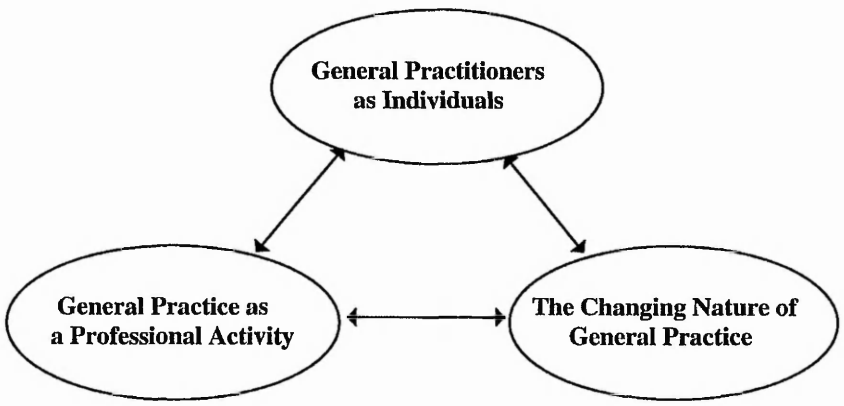
Sally Riggs
Research Officer

* Thank you for agreeing to be interviewed.

* I hope that you will find the experience of the interview worthwhile. I shall give you some personal feedback from the research at a later date.

* Our conversation is totally **CONFIDENTIAL**. Nothing that is said will be passed on to any one in a form that will identify you or your place of work.

* The research project essentially covers three interrelated areas:



* After some brief personal details I would like to explore with you the following categories:

1. **Your perception of the nature of being a general practitioner.**

2. **Your perception of the nature of general practitioner practices.**

3. **Your views and feelings about changes in general practice.**

Thank You Letter

After the interview I sent the participant a thanking letter.

Dear *[interviewee]*

I would like to thank you once more for your help and cooperation when I came to meet you last *[day]*. I found your comments extremely helpful, and beneficial to my research.

If you have any queries concerning the interview, or any other aspect of the study do not hesitate to contact me. It is through the support and cooperation of people like yourself that makes any research a viability. Thank you again.

Yours sincerely,

S A Riggs
Research Officer

Topic Guide

Used as a "prop" to give me confidence and as a resource to structure the discussion when necessary. I would tick-off the topic areas when they had been discussed. The guide became more refined when I became more sensitised to primary health care cultures. In main, the participants steered the disucssion. Questions/prompts were not pursued when deemed inappropriate.

GP QUESTIONS. **NAME:** **DATE:**

* Thank you * Worthwhile * Feedback * Confidential

*** Individual** *** GP as a Professional Activity** *** Changing nature**

A. PERSONAL DETAILS

1 How long here 2 Elsewhere 3 Other jobs 4 Describe job

B. PROFESSION - You as an individual

5 Why GP 6 Where train 7 Useful 8 Other 9 Expectations 10 Likes 11 Dislikes

12 Doctor admire 13 Don't admire 14 Ideal GP 15 Free to practice

---

C. GENERAL PRACTICE - Your practice - how it works

16 Why here 17 Expectations 18 Differ with other job 19 Other practices

20 Colleagues accounts 21 Ideal surgery 22 Who fits in (new partner) 23 (other staff)

24 People able to take risks here 25 How are decisions made here 26 Specific times 27 What issues (ST/LT)

28 Function as a team

D. CHANGING NATURE OF GENERAL PRACTICE - Your views, experience and feelings

i. Change

29 Influential changes 30 What effect here 31 Are things being done differently 32 FH

33 D-M process 34 Why 35 Indicative budgets 36 PM

37 Performance measurement 38 View changes partners 39 View changes staff 40 You 41 Govt reforms being handled here

42 Role changing? 43 DoH view 44 RHA 45 FHSA 46 Patients

ii. Effectiveness

47 Efficient orgns 48 Effective orgns 49 Competition with others 50 Change in future

---

E. FINALLY

51 Future role 52 Priorities 53 How

---

* Add anything * Comments on questions * Style of interview * Contacts * Thanks

Original Question Sheet

These questions were revised after they were piloted. Initailly, I attempted to write the responses on this sheet (larger gaps were left between the questions). This proved ineffective. For the more frequently used topic guide, which is somewhat based on these questions, see appendix O.

Semi-Structured Questions for General Practitioners

A. Personal Details

CAN WE FIRST COVER A FEW PERSONAL DETAILS?

1. [Gender]?
2. How old are you?
3. How long have you been working in this practice?
4. Have you worked in any other practice?
5. What jobs have you done prior to being a GP?
6. Can you briefly describe your job?

B. The Profession - at the Individual level

CAN WE NOW TALK ABOUT THE NATURE OF BEING A GP AND YOUR EXPECTATIONS?

7. Why did you decide to become a General Practitioner?
8. Where did you train [what medical school]?
9. How useful have you found your initial training at medical school?
10. Have you had any other training since medical school?
11. What, if anything, do you read about being a GP [periodicals, journals etc]?
12. What were your expectations of becoming a GP? [What did you think that it would be like?]
13. What do you most like about being a GP in practice?
14. What do you least like about being a GP in practice?
15. What does being a 'professional' mean to you?

C. Organisational Culture

NOW I WOULD LIKE US TO TALK ABOUT MORE ORGANISATIONAL ISSUES OF THE NATURE OF BEING A GP IN A SURGERY SETTING.

[I asked you earlier where you where before you came to this practice. Lets go back to this]

16. What attracted you to work in this practice?
17. Is working / practicing here what you expected it to be like?
18. What have you found different to working here to:
19. i. Previous practices?
20. ii. AND / OR the job that you did before?
21. iii. AND / OR accounts given by other GP colleagues?
22. If you can imagine it, what would you say the ideal surgery would be like?
23. How does this surgery compare to this?
24. What sort of person fits in here? What are you looking for when, say;
25. i. you are looking for a new partner?
26. ii. employing a member of staff here?

27 Can you think of any one doctor whom you particulary admire? What are they like [without mentioning any names]?
28. What about a doctor that you don't admire?
29. How free do you feel to practice medicine as you would like?
30. Generally, do people here feel able to take risks in seeking new ways of doing things? [How are mistakes treated?]
31. Whose advise do you take when you are feeling unwell?

D. Communication

I NOW WOULD LIKE US TO TALK ABOUT HOW THIS SURGERY OPERATES.
32. How do you generally reach decisions here?
33. Do you have a specific time when you all get together to discuss practice matters?
34. How do you think you function as a team?

E. Change

THE NEXT SET OF QUESTIONS ARE ABOUT HOW THE GP PROFESSION IS CHANGING.
35. What are the most influential changes that are, or have affected the way things are done at this practice?
36. In what way has (is) the practice changed (changing)?
37. [If necessary:] Are you becoming a fund holder?
38. How was this decision reached?
40. For what reasons?
41. [If necessary:] What are your feelings about 'indicative budgets'?
42. What is your attitude towards 'practice managment'?
43. How do partners who work here generally view change, do you think?
44. How do you view change?
45. In what way, if any do you feel that your role as a GP is changing?
46. How well do you think that the Government's 'reforms' are being handled in this practice?
47. How do you think the Government views the role of GP's? And in the future?
48. i. The RHA?
49. ii. The FHSA?
50. iii. Your patients / clients?

E. Organisational Effectiveness

THIS SET OF QUESTIONS EXPLORES THE ISSUE OF 'EFFECTIVENESS'.
51. People often talk about organisations as being 'effective' what does this term mean to you?
52. To what extent do you feel that you are competing with other local GP's?
53. Do you think this will change in the future?
54. What does the term 'performance measurement' mean to you?

F. Ideals

AND FINALLY...

55. If you were in a position to decide the future role for GP's, what would your priorities for change be? How would you go about it?

* **Is there anything you would like to add or any comments you would to make on the interview itself?**

* **Thank you very much for talking to me.**

* **Can you suggest any of the GP's that would be willing to take part in my research?**

Transcript Conventions

These conventions have been used in the text of the thesis to provide some clairity.

Bold text	**My questions and comments in the interview.**
Normal text	Respondents replies and comments.
[Addition]	[Additions to respondents' text to give clarification].
...	Some text omitted, either because the tape was inaudible or because the text is not relevant to the quote being analysed in the thesis.
(Speech)	(Speech and interjection descriptions eg. Voice getting quieter)
<<Action >>	Actions in interview that are not mentioned by the informant eg. <<Knock at the door>>.
Word (?)	Not sure of the spoken word being transcribed - there is some doubt about the what was said.
Underlined	Speech is strongly emphasised.

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Managing the Practice

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Abstract

In this paper I will examine the notion of practice management in general medical practice. Practice management is a relatively new concept that affects general practitioners (GPs) in their day-to-day activities and potentially affects their practice survival. The paper examines the model of practice management implicit in the state-initiated managed change strategies for GPs through the 1980's and in the White Paper "Working for Patients". The paper compares and contrasts this to the model implicit in the principles of medical professionalism identified by existing sociological analysis.

Having drawn up two "ideal type" models in this way, the paper turns to the conflict and tensions of the two principles in the reality of general medical practice. It is argued that there is a trend towards state control of medical practice at the expense of professional autonomy. Empirical illustrations are used to exemplify this trend from research carried out in the Midlands.

Introduction

It has been suggested that in the development of societal patterns of work organisation in recent centuries there are two particular and rival principles that can be discerned (Watson, 1987). The first principle is where the division of labour occurs on the basis of distinctive occupations with a significant degree of control of the work being in the hands of occupational members. The second principle is the administrative / employment principle where work is controlled by corporate owners or state employers using "managers" as agents. These potentially conflicting principles are explored in relation to the recent state-initiated "managed change strategies" introduced in the UK in April 1990.

The occupational and administrative principles of work organisation

In order to make sense of the world of work, sociologists have categorised the control of occupations in two ways: the occupational principle and the administrative principle. Traditionally, we locate people through their occupation, for example, "he is a blacksmith, she is a farmer or he is a merchant". However, as work organisation has become more bureaucratised and formalised (Goldman & Van Houten, 1980), it is argued that peoples' work is controlled more by the organisation within which they work rather than by the occupational grouping to which they belong.

It can be argued that there are two exceptions to this trend: first, where the work task is seen as deviant such as in prostitution; and second where the work task is controlled by the members of the occupational group rather than by the state or by another employing agency (Watson, 1987). The latter form of occupational grouping is often recognised as a "profession". In these two instances there tends to be a concentration on the occupational principle.

The occupation of general medical practice, often referred to as a "profession", can be seen as a form of work organisation in which its own members traditionally control and define the tasks that they perform. The actions of these occupational groups affect the social, economic and political climate of society. There has been a strong sociological interest in occupations known as "professions" as they have resisted outside control and commercialism.

Leaders and representatives of the so-called medical professions, have sought to regulate and structure the market through limiting and controlling the number of its members. This process is known as market closure or "monopolisation" (Collins, 1990). Market closure is a characteristic of capitalist societies as people come together and establish regulations and acquire political enforcement as a legally privileged group. Members of the privileged group, or "status group", share a felt identity, ideas and standards within the division of labour (Weber, 1978). The groups have to change and adapt in order to survive as competition will drive them out. Parkin (1972) suggests that the most important determinant of the rewards received by an occupational group is their "marketable expertise".

The attributes that an occupational group has are better understood in terms of the extent to which it exhibits the characteristics of "professionalization" (Hughes, 1960). This indicates that a professional occupation needs to be understood in relation to the market and on through an analysis of professional power. It is useful to understand the professions as a process where the

degree of their success is determined by proportion of market closure gained. Following this notion, Berlant (1975) sees professionalization as a process of monopolisation, whereas Larson (1977) sees it as a process of market control and constitution in order to promote upward occupational mobility. Becker comments,

> "professions as commonly conceived, are occupations which possess a monopoly of some esoteric and different body of knowledge. Further this knowledge is considered to be necessary for the continuing functioning of society" (1970:94).

In the context of medicine, Parry and Parry (1976) argue that the Medical Registration Act (1858) provided a foundation for market closure as the profession sought to control medical training, education and qualifications.

Central to Freidson's work (1970) is the notion of legitimate power given to professions by the state. He argues that a profession was different from non-profession as the leaders of a profession were given the ability to define and control their work through professional autonomy. Non-professions do not have this opportunity. Freidson states that specialised knowledge and altruism are not essential characteristics of a profession. The professionalization process, which is constantly changing and being negotiated, is seen as essentially political. Power and influence are more important than knowledge, education and work in gaining and maintaining professional prestige.

Johnson (1972) also focused on power as an essential characteristic of professionalism. Johnson essentially looked at the professional-client relationship. He pointed that the greater the distance between the provider and the user of the service, the greater the degree of uncertainty. Therefore, the greater the authority of the provider and the greater the dependence of the user. For example, Johnson claims that medicine is traditionally a form of collegiate control. The doctor defines the needs of the patient and the ways those needs are met. Johnson states that a profession is not an occupation in itself, but a means of controlling one.

It is believed by some, for example Freidson (1973), that the occupational principle of work control is increasing to the detriment of the administrative principle. The increase in the number of work occupations known as "professions" has come to be understood by social scientists as a defining feature of industrialised societies. As Goode (1960) commented, "an industrialising society is a professionalizing society".

As societies become more industrialised with a greater need for the division of labour the more power the professions have as the need for specialised knowledge becomes apparent. In this way, certain occupational groups have avoided the administrative influence as they have, through strategies of professionalisation, been able to define and control their own work.

Contrary to the "professionalisation thesis", some writers, for example Oppenheimer (1973), believe that there is a trend whereby professional work is becoming devalued and subordinated as the labour process is continually being fragmented. Work is not controlled by the professionals, but by state employers or corporate owners. Managers act as the controlling agents. It is felt that professional experts are more under administrative control and thus are treated as other non-professional occupational groups. Navarro illustrates,

> "the health professionals have shifted from being independent entrepreneurs to becoming employees of private medical corporations (as in the US) or employees of the state (as in the majority of European capitalist countries). In both cases, that process of proletarianization is stimulated by the state, with the assistance and stimulus of the corporate segments of the capitalist class" (1977:284).

McKinley and Stoeckle (1988) define the process of proletarianization as

> "the process by which an occupational category is divested of control over certain prerogatives relating to the location, content and essentiality of its task activities, thereby subordinating it to the broader requirements of production under advanced capitalism".

They argued that, with greater specialisation and deskilling resulting from recent state management policies, other health workers are now performing some of the once-professional functions (cited in Calnan & Gabe, 1991).

The occupational and the administrative principle of work control are "ideal types" (in the Weberian sense). That is, taken in their "pure" form, the control of work could be seen as one or the other. However, in reality such neat divisions rarely exist. More likely, there is a combination of the two principles. Johnson (1977) stated that both processes (the application of occupational and administrative principles) can occur at the same time. It is not inevitable that the medical profession in totality will be going through a process of proletarianization or alternatively increasing professional autonomy. Which way the profession of medicine goes is, among other things, dependent upon the nature of the work under question; whether it can be routinised and

fragmented or whether the tasks performed can be done by machines. Alternatively, there are tasks that cannot be routinised without affecting the contribution they make to the "global functions" of capital (Watson, 1987).

A recent context in which we can see the tensions operating is that of the changes occurring to general medical practice in the UK. This paper will now outline some of the features of the "state-initiated managed change strategies" and some of the findings emerging from a study of primary health care centres in the Midlands.

The case of general medical practitioners

Historically, the state was seen to respect professional autonomy in general medical practice. The National Insurance Act of 1911 freed general practitioners from the control of private patient referrals giving them some economic security. In the 1946 NHS Bill (operationalised in 1948) permitted GPs to maintain their independence as they contracted their services to the NHS through executive councils. As a result GPs gained an increase in income and achieved more job security. Thus, it can be argued that the state supported the occupational principle and did not threaten GPs autonomy. It is unclear if this was an active state intention or an act of indifference (Calnan & Gabe, 1991).

However, another feature of the 1946 Bill encouraged a divide within the medical profession. Hospital doctors were awarded a salary and the freedom to work in private practice. Consequently the hospital doctor was less dependent on the GP for their income through the referral of patients. This produced a conflict within the profession.

The Bevan philosophy of the NHS, the foundation for this legislation, was to have a centrally planned organisation to deliver the health needs of Britain whilst retaining a significant level of autonomy. There was a struggle between the two principles of work control. Those in the Ministry of Health responsible for finding the funds to pay for the service clashed with those responsible for spending the funds. Sir Cyril Jones, when looking at the finance of the NHS commented on the "fundamental incompatibility between central control and local autonomy" (Public Records Office, 1950). Jones advocated cost control should be a non-medical management decision as medical professions have a self-interest in the practice of medicine. Jones's recommendations were rejected by Bevan at the time. However, we see the same theme of state control being introduced to control costs in the 1980's and 1990's.

There has been an extensive amount of legislation and state activity affecting primary health care since the 1980's. Primary health care is central to the changes affecting the NHS as they are viewed as the gatekeepers to expensive hospital treatments. Further, GPs can provide a preventative service which is understood to be less expensive than curative medicine. Primary health care is defined as "those first line services administered by two statutory authorities, the family practitioner committees [now the family health service authority] and the district health authorities" (Morley et al, 1991:3).

The changes that have affected general medical practice can be summarised as follows: In 1985, under the Health and Social Security Act, Family Practitioner Committees (FPCs) were established as independent health authorities. Previously, the FPCs role was largely an administrative one: paying practitioners and offering general advice to GPs and patients. As a result of the 1985 Act, FPCs took on a more managerial role: planning services for the population in their authority, ensuring health care was available to all and inspecting in addition to overseeing GPs premises and the deputising service. In 1986, the Green Paper "Primary Health Care: An Agenda for Discussion", sought to review primary health care comprehensively for the first time in forty years. The outcome of the discussion formed six objectives:

1. To make services more responsive to the customer;
2. to raise the standards of care;
3. to promote health and prevention;
4. to give patients the widest range of choice in obtaining high quality primary health care services;
5. to improve value for money;
6. and to enable clearer priorities to be set for the FPCs in relation to the rest of the health service.

The recent White Paper "Working for Patients" (Department of Health, 1989) is based on these objectives. Underlying the state-initiated managed change is the necessity for FHSAs (previously known as FPCs) and GPs to be accountable for their expenditure and the encouragement for value for money. The state proposed a series of measures to increase resources in primary care, to monitor performance closely and to introduce financial incentives to improve performance and quality in general practice. Day & Klein see the state as having three objectives:

> "to tighten up the management structure in order to ensure central control over the NHS's policies and priorities, to raise efficiency through competition, and to increase consumer choice" (1989:3).

The belief that a competitive environment encourages efficiency and consumer (patient) choice has been a theme of the state over the last decade. The rationale underlying the new health care market is that competition provides both an incentive structure for improving efficiency and a transmission devise for triggering efficiency in other parts of the service.

It is advocated by the state that the development of a stronger managerial framework will increase freedom for the patient to chose the service most appropriate to their needs. The main thrust of the White Paper is "to give patients, wherever they live in the UK, better health care and greater choice of the services available..." (Department of Health, 1989:3).

Contrary to this belief, surveys show that convenience and tradition, rather than an evaluation of available alternatives, largely determine patient choice of a general practitioner (Ritchie, Jacoby & Bone, 1981). In the same survey it was found that people only change doctors when their circumstances force them to do so, for example, moving out of the area. The health care market is believed to be more advance in America. We could expect to see the consumer choice there as being more prevalent. A recent study shows that less than 40% of patients sought information, exercised independent judgement and exhibited a readiness to make comparisons between doctors (Hibbard & Weeks, 1987). Leavy, Wilkin and Metcalfe (1989) argue that the market mechanism in the UK is unlikely to improve quality of care or efficiency in general practice in this way. Mechanisms for enhancing consumer choice through Community Health Councils or by increased representation of the public on FHSAs have not been introduced. However, Leavy et al do point to other features in the White Paper, such as medical audit, which enhance improvements in efficiency and effectiveness of general practice - a form of administrative control. Hence, it can be argued that the "market principle of control" is a guise for threatening professional autonomy as it is used as a tool to control and regulate the tasks performed by GPs.

The state can be seen to threaten professional autonomy in the following ways: First, the White Paper makes it clear that if GPs do not monitor their performance then the state will do it for them. That is, if GPs choose not to manage their own indicative prescribing budgets within a defined limit, then the FHSAs will manage them by monitoring and controlling their performance for them. A GP comments,

> "We got held over the coals a little bit over our prescribing budgets, we are way over what we should be. That is because, I think, we have got quite a lot of patients that have expensive drugs. We don't throw things around. We have so much allocated that we can use on our patients for prescribing, then if we go over that we have to justify it. We had to have a visit from the FHSA to analyse our

prescribing... They sort of said, if you use that instead of this [drug] then it would be an awful lot cheaper".

In this sense, GPs are being managed by the FHSA. The attitude behind this is reflected in a comment by a general manager of an FHSA discussing health screening,

> "There is a level of resistance from some GPs to perform health checks. We have to accept that there are some things in life that we don't like, we have to get on and do them as a requirement of the law or as part of the contract that we have to do. You can either accept them as part of your job and do it, or you get out and do something else".

Second, the increase in the number of practice nurses can be understood as a mechanism to restrict professional autonomy. Practice nurses now often perform the health screenings of patients and it is felt that they will eventually prescribe certain medicines (Calnan & Gabe, 1991). One doctor, reluctant to delegate her work to the practice nurse, states,

> "I would like to do all of the health screenings myself as I feel that it is important to see the patient on every visit. They [the patient] feel cheated if they only get to see the nurse. I cannot do it any more. I have to let the nurse do it and then she tells me if anything abnormal comes out. I have so much work to do, for example, the paper work. I have to keep on top of it otherwise I will not get paid. I don't like it or the way things are going. I am a doctor not an administrator".

GPs are encouraged to work in teams and have larger practices as a result of the White Paper. A general manager at a FHSA comments,

> "GPs have to fulfil the contract and find the best way of doing that. Practice nurses are seen to be competent at health checks and are value for money for the GP. These changes have forced people to reconsider the needs of the team. We have to manage the change using those resources effectively".

Third, as we have seen with the discussion above, the health care market is said to increase consumer choice and an encouragement of self-responsibility of the patient. If this were to be realised, as patients saw the extent to which GPs are dependent on them for their income (through the renumeration system), it opens up the possibility for deprofessionalisation, if not proletarianization.

Fourth, further to the potential increase in consumer sovereignty, it can be argued that the state is negotiating on behalf of the patient. A GP remarks

> "I feel a bit insecure with the changes because, I think, the core commitment at the top [the state] is not geared towards good general practice, but towards cutting costs and making the public think that they [the state] are getting them a good public service".

In Johnson's terms, there is a shift from the collegiate form of control to a mediative form of control. The state has intervened in the relationship between the practitioner and the patient and defined (some of) the needs and the manner in which they are catered for (Johnson, 1972). For this to be upheld, there is the need for supervision and management to ensure the state's policies are implemented. Thus, Johnson comments

> "...elements of the bureaucratic role become interweaved with the occupational role in service organisations, the result being a general dilemma stemming from the problem of balancing administrative and consumer needs. Such differentiation may destroy colleague relationships and neutralise the controls which an autonomous profession imposes on its members" (1972:79-80).

To capture the perceived threat to professional medical autonomy, a GP, when discussing the implementation of the 1989 White Paper, gives the following account,

> "Imposed change is an attack on our professionalism, treating us as if people are not professionals. They [the state] say, "this is the way that you should actually run your show". They think they know [that] what they are doing is good. Well it is not. For example, there is no evidence to show that it is worthwhile to screen the over 75s... [a feature of the new contract]. It seems to me that the way the contract was imposed on us should be an amazing lesson how not to bring change anywhere and maybe we can learn form that".

Conclusion

In summary then, we can argue that there is a trend where the occupational principle of control is being opposed by an administrative principle in general medical practice as professional autonomy is being diminished. The state is encouraging a freedom for GPs to meet the needs of their health population or "market". The scope in which this can be achieved however, is being defined by the state more now than ever before. So, the seeming support for professional medical autonomy through a "market principle of control" is a guise for an administrative form of work control. A supporting factor of this notion is the belief that the state is acting only on behalf of the patient rather than increasing the patients' actual power and effect in the provision of primary health care.

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PARTICIPANT OBSERVATION RESEARCH AND MANAGERIAL WORK:

how not to be the academic berk in the garbage can.

A paper for the British Academy of Management Conference 1991, University of Bath.
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Abstract The paper first considers the nature of participant observation research and the methodological implications of its use. Second, it suggests various advantages of participant observation in research on management and, third, it looks at the challenges and difficulties of using the method in practice, drawing on the authors' use and varied experiences of the method.

Introduction

> *All modern science is rooted in observation and, as every scientist knows, observations at first hand are the most satisfactory. In practice, however, our knowledge of the world is built up principally of other people's observations, and not of our own. It is inevitable that we should admit second-hand knowledge, but we must recognise that in doing so we accept not only other investigators' careful observations, but also a whole mass of careless and casual popular impressions and legends whose reliability we have generally no means of checking.*

John Madge used these words in his classic research methods text *The Tools of Social Science* (1953) to stress "the importance of first-hand observation". There is an old fashioned tone to the statement and an implicit adherence to a positivistic conception of social science - one which sees a close correspondence between social science and the natural sciences. At the same time, however, there is an attractive common-sense tone to the statement. It is suggested that if you want to know about something, do not readily accept what others tell you but go and look at it for yourself.

Because of the difficulties of academics getting close to managerial practice they can easily become dependent on the kind of second-hand reading of the research of others referred to by Madge. They are also in danger of being influenced by what he calls the "mass of careless and casual popular impressions and legends" .

Managers may be variously portrayed by academic writers and teachers as, for example, disinterested and objective decision-makers `who spend their time rationally collecting and considering "data". Alternatively, they may be seen as the reward-seeking manipulators of labour whose effective rationale is one of serving the interests of "capital". Yet again, they may be thought of as less distinguished versions of the heroes and heroines whose best-selling biographies and autobiographies recount how they built a great business or "turned around" a large company. At other times they may come across as the faceless role-players who somehow link the organisational contingencies of technology, size and environment to organisational structures to bring about organisational effectiveness.

All these images have some connection to the realities of managerial work. But how far do they go towards giving us a full and sensitive understanding of what it is to be a manager in a modern organisation? The virtues of first-hand observation of managerial work in this respect have already been demonstrated by such people as Carlson (1951), Dalton (1959), Mintzberg (1973) and Pettigrew (1973) and Kotter (1982). The observations of these researchers have helped dent the classic image of the manager as the cool and detached apolitical data analyst and rationalistic decision-maker, for example. This work can valuably be built upon to further enhance the effectiveness of academic teachers and researchers through the use of participant observation, we suggest, especially if the method is associated with the kind of interpretive methodological framework into which it most naturally fits.

Participant observation is not an easy or straightforward research method to apply, however, as we will show later. But, first, we need to establish just what participant observation as a practice involves and to explain what we see as its virtues in the field of management research.

What does participant observation involve?

One of the most quoted definitions of participant observation is that of Becker (1958:652):

> *The participant observer gathers data by participating in the daily life of the group or organisation he studies. He [/she] watches the people he [/she] is studying to see what situations they ordinarily meet and how they behave in them. He [/she] enters into conversations with some or all of the participants in these situations and discovers their interpretations of the events he [/she] has observed.*

The method appears nearly always to be used in association with other methods - so much so that another popular definition, that of McCall & Simmons (1969:1), refers to "a characteristic blend or combination of methods and techniques" which

> *involves some amount of genuine social interaction in the field with the subjects of the study, some direct observation of relevant events, some formal and a great deal of informal interviewing, some systematic counting, some collection of documents and artifacts and open-endedness in the direction the study takes.*

The tendency for participant observation to be associated with other techniques is one reason for the preference of some writers for the terms "field research" or "ethnography" (Bryman 1982:142).

What is unclear from many of the definitions of participant observation is the nature of "participation". Does participant observation of managerial work, for instance, necessarily involve the researcher in undertaking managerial tasks? McCall & Simmons - writing about the method in general terms - refer only to "genuine social interaction [with subjects] in the field", for example, whilst Dodge & Bogdan (1989) refer to "close contact with subjects within settings in which they normally spend their time". Bryman (1989:142), in his characterisation of the approach, refers to"the fairly prolonged immersion of the researcher in the context that is to be studied".

The variability of the extent of participation within participant observation is typically dealt with in research texts by the use of continua such as that of Gold (1958) who locates field research positions on a continuum ranging from complete participant (where the management researcher, for example, would become a manager), through participant-as-observer and observer-as-participant to complete observer. This approach is rejected by Collins (1984), however, who, instead, provides us with the valuable distinction between unobtrusive observation, where the researcher tries to be the "fly on the wall", only participating in activities when there is no alternative, and participant comprehension where the research sets out to participate in activities to the extent of achieving the "attainment of native competence".

"Unobtrusive observation" amounts to the "strong version" of the participant observation strategy and has considerable potential for management research where there is advantage in getting really "close" to the managerial experience. In the same way that Collins became a member of the scientific research team he was studying (a team investigating "spoonbenders") so the participant observer in management might valuably take a role in the organisation's managerial process.

There are various advantages to the "strong version" of participant observation in which, in Madge's (op cit) words "the heart of the observer is made to beat as the heart of any other member of the group under observation, rather than as that of a detached emissary from some distant laboratory" so that he or she "will learn to think almost as they [the subjects] think". Collins was concerned to achieve this in his spoonbending research and he points to a considerable practical advantage of the approach: the reduced need to be constantly taking field notes! The research involves "internalising a way of life" and can do this to the extent that the researcher observes themselves (as a "native member") as readily as other subjects. This makes possible "participant introspection".

For the management researcher to be interested in such an approach clearly presupposes a basic interest in the subjective aspects of social and organisational life. And this suggests a broader methodological stance than simply one of adopting a specific research technique. As Archer points out, "our views about how a piece of research may best be conducted presupposes philosophical positions (explicit or not) about the nature of 'knowledge' and 'reality'" (1988:270). This implies, as Bryman puts it (1989:27), that participant observation is not just a different approach to data collection but is a "different way of 'knowing'" in which "people's understandings of the nature of their social environment form the focus of attention". This is in contrast to positivist or quantitative research which "treats facets of the environment" like organisation structures "as pre-existing 'objects' akin to the physical or biological matter on which natural scientists work".

To see the greatest value in participant observation one has to have a particular view of the social world and a related conception of the role of the researcher. Both of these are implied in the notion of an "interpretive" methodological stance. As Burgess (1984:78) points out:

> *such a perspective suggests that the social world is not objective but involves subjective meanings and experiences that are constructed by participants in social situations. Accordingly, it is the task of the social scientist to interpret the meanings and experiences of social actors, a task that can only be achieved through participation with the individuals involved.*

Participative observation in management: why do we need it?

From what has been said so far, it will be apparent that we see virtue in improving the general understanding of the subjective and experiential aspects of managerial work. As managerial roles are central to the functioning of organisations it follows that the broad understanding of organisational processes can be enhanced through the use of participant observation in management research.

The extent to which this argument will prevail is necessarily dependent on the extent to which one sees organisations in "processual" terms. The view of organisations which is taken here is a processual one and is summarised in Watson (1986:21):

organisations. . . . . are managed in order to achieve certain goals and policies which are articulated by those who are at the top or are 'in charge'. But these goals, as well as the procedures and arrangements which are associated with them are as much the outcomes of the conflicts, negotiations and indeed confusions existing among the various individuals and groups which make up the organisation as they are pregiven elements into which people fit. The organisation, then, is an association of people with often widely differing and indeed conflicting interests, preferences and purposes who are willing, within rather tightly defined limits, to carry out tasks which help meet the requirements of those in charge.

The implication of this view of the work organisation is that if we wish to understand the processes which occur within it then we need to look closely at the purposes and interests of the individuals and groups who make up the organisation. We have to look at how power is wielded and experienced; the forms which personal and group conflicts take; the sources and nature of confusions and ambiguities; the negotiations which occur between parties and the values, meanings and interpretations which inform individual behaviour. To understand all these things, we need to "get close to the action". And to understand managerial work - the work of "steering" the ungainly vessel of the work organisation - we need participative observation in management settings as a key tool.

The richness, depth and detail of the material that can be gathered by participant observation derives from five characteristics of the method: *closeness to people; contextualisation; process analysis; flexibility and openness; and credibility.*

Closeness to people arises from the researchers' working with the people they are studying and forms the link between the methodological centrality of individual meanings in interpretive social science and the form of activity undertaken in the application of participant observation as a method. Through close association with subjects, the researcher, as Bryman (1989:25) puts it, "seeks to elicit what is important to individuals as well as their interpretations of the environments in which they work". This knowledge is necessary to an understanding of organisational processes because such processes are seen as outcomes of people's values and meanings rather than as objective "things" (cf Silverman & Jones, 1976).

Stewart (1989) in her consideration of "the ways forward" for the study of managerial work calls, among things, for work which concentrates "on the interaction between the individual and the job" and that we might look at "how individual managers think about their work and their jobs". Participant observation's quality of "closeness to people" is very relevant here - especially when combined with its potential for setting specific actions in their context.

Contextualisation is made possible by the researcher's closeness to events and managerial situations. The interconnections and interplay between individual factors or "variables" in a situation can be seen and analyzed. Thus, for example, one might see how departmental political factors, individual career interests, structural constraints, environmental influences all play a part in a particular managerial decision. The closeness of the researcher both to events and to people enables the researcher to consider the multiple perspectives on offer and, through listening to the accounts of a range of actors, paints a relatively full and rich picture of events and processes. The accounts of individuals can be "situated" by the researcher and varying stories cross-checked.

By participating themselves in the life of the organisation which their subjects manage, the participant observer is more capable than most researchers on managerial behaviour of "interpreting managers' behaviour and its relation to managerial tasks" (Hales 1986:104). The importance of this is stressed by Hales in his critical review of research on "what managers do": he points to a

reluctance on the part of many of the studies to locate managerial work practices carefully within the broader context of the function of management in work organisations (Ibid: 104).

Process analysis is implicit in both of the above two characteristics of participant observation research. Through being located within the research setting the researcher is not confined to the "snapshot" picture with which the survey or single interview researcher has to be satisfied. They can follow the unfolding of events and thus appreciate the ways in which the complex human interactions which make up a work organisation take constantly shifting shapes. The central and persisting role which change plays in the lives of managers can therefore be better appreciated. Stewart (op cit) concludes her review of ways forward in management research by arguing that one of the most potentially valuable ways we can do research which will help managers to be "more effective" will be "to try to improve our understanding of the action and thoughts of managers over time".

Flexibility and openness means that the researcher is not constrained or blinkered by too tight a research plan, fixed list of informants or interview schedule. Researchers may vary in the extent to which they bring prior assumptions to their investigation and indeed none of them is likely to be a *tabula rasa*. Nevertheless, the logic of this type of research does mean that there is a greater likelihood of unexpected insights, information and concepts than in the style of research that sets out to test a hypothesis derived from an existing set of concepts and propositions. Dalton, probably the most significant participant observer of managerial life, stresses the "freedom of movement" which enables one to pursue "the best-informed informants" and the ability one has to build rapport before asking "disturbing questions" (1964:75).

Credibility is a factor which is considered here not so much as something internal to the research process (that aspect will be considered later) as something which is pertinent to the process of dissemination. The point being made may be more relevant to management researchers as teachers than as writers but we would claim that teachers in business schools are more likely to be listened to by their students (managerial and prospectively managerial) if they can demonstrate first-hand experience of managerial work than if they cannot. This point should not be overdone (and such experience could be gained by non-research-related secondments) but anything which helps bridge the gap between theory and practice, as reported in informal conversations with numerous business school students, must be welcome. Participant observation is a way of doing research and gaining direct managerial experience at the same time.

Participant observation and bargaining in the garbage can

The view of organisations which we are taking and which was set out above sees the goals, procedures and arrangements which constitute "the organisation" partly as "outcomes" of confusions, conflicts and negotiations between people. Whilst people do cooperate to carry out tasks that cooperation "is limited by the fact that the cooperators all have their own private interests to pursue or defend" (Watson 1986:22). This view corresponds in part to the vivid image of organisational situations as garbage cans (Cohen, March & Olsen, 1972). The organisational settings into which a participant observer would dive can be seen as a dustbin into which has been thrown a whole series of particular circumstances: problems which happen to about and are in need of solutions; solutions which are about and need problems to be attached to them; people who happen to be about and who happen to have particular interests and have certain amounts of time available.

The participant observer has to become a member of the organisation they are studying and survive in this dustbin full of people, problems and circumstances. To research managerial aspects of organisational life they will have to hold their own within organisational conflicts and managerial politics as well as - given the basic exchange nexus which characterises employing organisations - contributing something to the organisation or to particular interests within it. The basic position of the researcher in the organisation is one of a trader: offering various things to various parties, formally and informally, in order to be provided with the access, information and experiences which the research requires.

The participant observer is continuously making and remaking bargains with individuals and groups, carefully establishing and re-establishing their credibility. They have to build and maintain networks of informants, using all the interpersonal skills they can muster to enable them to be accepted as insiders whilst, at the same time, they maintain sufficient of the outsider about their conduct to give legitimacy to their raising and putting of questions.

All of this suggests that participant observation is neither easy to set up nor straightforward to operate. We will now look at some of the factors which are pertinent to the likely success, or otherwise, of participant observation in research on management. In doing this we make use of our personal experiences in two British organisations: a telecommunications manufacturing company (UTComs) and an accounting firm (ACC). In the first case the method has been applied relatively successfully whilst, in the second case, it had to be abandoned.

In UTComs, Tony Watson has spent a year working within the management team on the developing of the human resource strategy. His research focuses on the orientations and experiences of managers in a context of change. In ACC, Noel Fook and Sally Riggs were working within the marketing function and researching, respectively, marketing orientation and the use of niche marketing in the accounting firm. In the light of deteriorating access opportunities within ACC, Fook and Riggs have moved the focus of their research outside the accounting firm into, respectively, educational and health organisations, at the same time as maintaining links with the firm.

UTComs is a manufacturer of telecommunications equipment and systems which has gone through some major ownership and partnership changes. It is in the process of adjusting to a more liberalised British telecommunications process at the same time as coping with an aggressively competitive world market context and the ravages of economic recession. ACC is a medium-sized accounting firm with branches across the UK. It too suffered from the economic recession and , like UTComs, made employees redundant during the period of research.

The basic trade

It is normal in social research for the researcher to offer some kind of inducement to those whose time and attention are being sought. As Bryman (1988:15) notes, organisational researchers frequently report that they felt it necessary to provide feedback to respondents - in the form of a copy of the research report, for example. Additionally, one is often able to suggest to interviewees that the interview experience itself should be worthwhile and rewarding. All three of us made much of this in the interviews which were integrated into our participant observation work in UTComs and ACC. We found it a helpful tactic and it was not untypical to be told by individuals, as Riggs was

> *I like it when you come with me places. You ask me questions that no-one else asks. You make me think about what I am doing.*

These two types of "return", however, are unlikely to be sufficient to balance what the researcher is seeking when they look for a participant observation opportunity in a managerial context. There will be costs to the organisation in terms of such things as accommodation, managers' time and the provision of learning opportunities. But, at least as significant as these, will be the potential threats to both individuals and the organisation. The researcher is going to come across personal, departmental and corporate secrets and develop a position where they may, potentially, not only give away secrets but sit in judgement on managers. The researcher's presence is potentially threatening. Riggs and Fook were told about one reluctant informant, for example, "he takes things very personally, and he fears that this will backfire on him".

A lot, then, has to be offered, to balance these costs and threats before one can gain access. And firm commitments on confidentiality have to be given - commitments which will give respondents confidence in the researcher's discretion without precluding their publishing of interesting material.

In ACC and UTComs confidentiality was promised in similar terms. At the individual level, it was stated that nothing in interviews or personal conversations would be passed on to anyone else in a form which would identify the individual. And at the organisational level, a commitment was given that nothing would be published in written or spoken form which would compromise or publicly embarrass the organisation. Throughout the research work, this commitment was reiterated in conversations with individuals.

No problems arose, consequently, in UTComs but in ACC access to individuals became increasingly difficult as an atmosphere of low trust and defensiveness within the organisation generally grew and grew (for reasons not directly connected to the research we must stress). This happened to the extent that there was a reluctance for people to talk to anybody they did not know really well. All the promises of confidentiality in the world could not break through what looked to the researchers like a state of "organisational paranoia". The participant observation work within ACC was eventually ended as gatekeepers closed doors to Fook and Riggs with words such as "you would open a can of worms if you went in there" or "the partners are very sensitive about that area".

Once the basic conditions of confidentiality are agreed in establishing the research project, perhaps the most significant thing the participant observer has to trade with is their knowledge and skills: those things which the researcher can bring to organisational tasks. UTComs was developing a series of "progressive" human resource management initiatives (a culture change programme, harmonisation of employment conditions, teamworking, personal development, performance related pay, management competencies and so on) and needed any "extra professional help" it could find. Watson was able to present himself as a former engineering industry employee relations manager who could bring extra insights to the change management process through having seen "a lot of other companies through his research and consultancy work" (the words are those of the initial key "gatekeeper"). He was able to reinforce his claim that the company "needed" him through the warnings he gave of some "dangerous inconsistencies" which he "thought there might be between certain progressive and certain old fashioned human resource practices". His experience of helping manage a major redundancy in the past was also noted and became very relevant as UTComs found itself having to make significant numbers of people redundant. The basic deal was neatly summarised in the words of one manager; "you need us and we need you". UTComs was getting an extra pair of "expert" managerial hands and Watson was getting an opportunity to do research and "update his managerial experience".

Fook and Riggs had no difficulty in gaining initial access: their projects were negotiated for them by a professor whose chair was sponsored by ACC. Fook was able undertake tasks in the marketing function using her business experience in Hong Kong and her knowledge of marketing thinking developed in her MBA studies. Riggs did not have direct marketing expertise to offer ACC but her skills acquired in her studies in the social sciences were offered as helpful in the collection of information about specific niche markets and in some market research work. This suggests a valuable general point to encourage those without previous management experience wishing to do participant observation research in management: the skills which qualify them to be academic researchers can be very relevant to certain managerial tasks. What may be most important is the way these skills are presented to gatekeepers and potential patrons.

Gatekeepers, patrons and supervisors

Gatekeepers are "those individuals in an organisation that have the power to grant or withhold access to people or situations for the purposes of research" (Burgess 1984:48). The initial gatekeepers are important because it is with them that the researcher establishes the "basic trade" and hence gets "through the front door" of the organisation. But our experiences indicate that one endlessly confronts further gatekeepers as one seeks access to new departments, other branches, extra forms of information (especially documents) or indeed to further levels in the organisation.

It is very useful, as we all found, to have particular patrons - people with power and influence - who can open doors for one and make introductions. But this is by no means straightforward. As Punch (1986:22) observes, researchers "may suffer by being seen continually as extensions of their political sponsors within the setting despite their denials to the contrary". The handling of what Dalton calls "obstructive allegiances" can also involve one at times distancing oneself from a group or a department in which is formally located. Klein (1976) in her account of working as a social scientist in industry discusses how her location in the employee relations function disadvantaged her and Watson had often to distance himself from the personnel function in UTComs (a function widely seen as over powerful) whilst Riggs and Fook had to cope with their identification with the marketing department in ACC (it tended to be seen by many as peripheral in an accountant-do. .inated firm).

For more junior researchers, the academic supervisor can be both an enabler and a hindrance. Riggs and Fook had to manage carefully the tensions which arose between their key sponsor and their academic supervisor - men with severely contrasting personal styles and priorities. Watson, correspondingly, had to manage tensions between his initial sponsor and other gatekeepers, some of whom objected strongly to this individual's forceful and, at times combative, style.

In all these matters the researcher has to work constantly on establishing and maintaining personal credibility: showing that, in spite of being associated with particular people, departments or academic institutions, one is still one's "own person" and worth talking to.

Researcher credibility
a) handling anti-academic prejudice

The mutual suspicion that exists between the academic and industrial worlds much of the time was effectively illustrated by David Lodge in his novel *Nice Work* (1988). An academic is sent to "shadow" the manager of a foundry whose initial reaction is

> *I don't want some academic berk following me about all day (1988:88).*

On the other side of the academic/ industrial divide, Lodge's fictional vice chancellor observes that "there is a widespread feeling in the country that universities are 'ivory tower' institutions, whose staff are ignorant of the realities of the modern commercial world" (Ibid:85).

The participant observer going into management has to handle these prejudices. Watson had, for example, to cope with a series of comments of the type "You're not one of those professor guru types who tell us all how we should do it without ever really having to get their hands dirty, are you?". And Fooks and Riggs had to establish that they were not "student types avoiding earning a real living". We all used jokes to handle this; quips such as "you know I am just an absent-minded academic". Alternatively one could make carefully judged outbursts: "talk about academics never getting anything done: you lot are even worse than academics in holding meeting after meeting and never deciding on any actions". Basically, however, one had to establish that one could "deliver" on tasks undertaken or otherwise show that one's ideas were "useful".

Researcher credibility b) knowledge, experience and status

Riggs, Fook and Watson had varying degrees of managerial knowledge and experience and there was considerable difference in the formal status of the two research assistants on the one hand and the professor on the other.

Our experience suggests that the degree of status and experience one has can be either an advantage or a disadvantage. To be a professor who has also been a manager could suggest considerable credibility. Alternatively it could suggest someone who became a teacher because they were not good enough as a manager. Or, yet again, it could suggest a "know-it-all" to be kept at arm's length. Being a research assistant with limited or no managerial experience is a similarly double-edged sword. It suggests that, on the one hand, you have little to trade by way of knowledge or experience. But on the other hand it means that you unlikely to be seen as a threat. Your credibility is very dependent on how you present yourself to organisational members.

Researcher credibility c) personal style

Fundamental to participant observation research is the need for the researcher to be perceived as someone that people are happy to have around and find it worthwhile talking to. This inevitably means that one's perceived personality is a crucial factor in the success or otherwise of the method. As Lipson (1989:65) says of those being studied,

> *At first, they may judge the researcher in terms of such external characteristics as cultural background, age, gender, and perhaps, professional background. As relationships deepen, the personality and culture of the researcher has more impact than 'externally obvious' characteristics.*

The basic exchange relationship which underpins the method is more than a matter of doing useful tasks for people; it involves bringing "interest" to situations, bringing amusement to conversations and being accepted as, as one of us was described (in transatlantic tones), "a regular guy". Fook and Riggs were aware that being young women working in a largely male organisation created an initial level of interest in their presence but, also, meant that they had to cope with the dangers typically noted by women field workers who, as Warren (1988:37) notes, experience

> *several dimensions of male dominance: not only sexual hustling, but also assignment to traditional female roles and tasks such as mascot, go-fer, audience, butt of sexual or gender joking, or 'cheerleader'.*

The woman researcher has to develop a style which allows her to handle what Scott (1984:177) calls "subtle and not so subtle sexism" of research situations without reacting in a way which will create hostility and therefore non-cooperation on the part of male informants. Fook and Riggs became practised at not reacting to such events as a partner in ACC winking at them and saying "What can I do for you two girls?". And, as tensions and sensitivity grew in ACC, there was an implication that even these apparently "harmless girls" might be a threat. Riggs was introduced by one partner to another with the words

> *Watch her. She's not one of those normal women. She'll ask you trick questions. She's got a brain.*

Participant observation is dependent on one building up a network of key informants - people like the centrally significant "Doc" in Whyte's classic *Street Corner Society*. This not only involves developing friendships and alliances but doing favours for individuals. Dalton in building his network of what he calls "intimates" says he "gave every legitimate service and possible courtesy and went beyond what was normal in giving personal aid" (1964:65). Watson found himself on various occasions being consulted by managers on how to handle both difficult employees and difficult bosses, for example, and Fook was able to draw on her own marketing business experience to advise colleagues on how better to do their job. Whilst none of us found ourselves, like Dalton, assisting someone with their marital ambitions we all found ourselves discussing career issues with organisational friends and intimates - especially when both ACC and UTComs were making people redundant. One cannot afford to be seen as an "academic berk" but, equally, one cannot pretend not to be naive in certain respects. Without revealing naivety one would be unable to ask so many of the questions which are vital to the research. One's personal style has to involve *controlled naivety:* a style which suggests one is a basically wise but unpretentious person who doesn't yet know why things are like they are. You are ignorant of certain details but will soon understand once your informant puts you in the picture.

The form which one's controlled naivety takes will vary - especially with one's personal experience and knowledge. Ethnicity may also be relevant, as Fook discovered in finding her Hong Kong Chinese identity useful when needing to ask a respondent to explain matters of organisational life in more detail.

Conclusion To engage in participant observation research on managerial work is clearly very challenging. The researcher is going to have to use every personal, social and political skill that they possess to achieve access, to establish credibility, to develop a network of guides and informants. Their knowledge, experience, status, gender, age, ethnicity and personality are all resources to be used in the basic exchange relationship they will need to establish with managers and others.

To enhance our knowledge about and understanding of managerial work in the way argued for here, researchers have to dive head first into the organisational "garbage can". They will inevitably get bruised and will get their hands dirty. Complete success can never be guaranteed - as Fook and Riggs found when political tensions grew so large in ACC that data became simply too difficult to get at. But, for the academic teacher and writer who can get into and stay in the garbage can long enough, there is gold to be found. And for the business school teacher there is the added bonus that they can say to their managerial students "I've been there!".

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