Redefining Professional Roles in Healthcare – the Business of Dentistry

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by

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Abstract

In the latter decades of the 20th century there were considerable changes in government policy and public attitudes in the UK towards those we regard as professionals. Changes in a wide societal context led to the traditional role and definition of a 'professional' being brought into question, through raised public expectations and the development of a more consumerist approach to service delivery, especially in the public sector.

This thesis sets out to explore the social construct of 'a profession' in contemporary society and to investigate the responses of the professions to change. A review of the relevant literature across a wide range of subject areas, including sociology, history, psychology, and management, allowed the development of a deeper understanding of the social construct, and of its derivation from the three learned professions of the clergy, law and medicine in the UK. The characteristics of altruism, expert knowledge, and high standards of conduct have developed to afford the professions a distinct social status, linked to the power of their established communities, their strong collective and individual identities, and the autonomy granted to them through a social contract dependent on an understanding of trust and accountability. The professionalisation process through which the traditional and newer professions have developed demonstrates the importance of contextual elements to the continued survival of the professions, as well as characteristics and responses of the professions themselves.

Healthcare now encompasses a range of professions in the UK, from the traditional profession of medicine and the 'semi-profession' of nursing, to the newly established Allied Health Professions, all of which have been subjected to radical change through the implementation of the NHS Plan in the last decade (DH 2000). The main policy changes affecting these groups of professionals are reviewed, in terms particularly of the impact of increased rationalisation, and their influence on professional relationships with their inherent elements of autonomy and control, as well as perceptions of trust and fairness with regard to policy decisions and contracting arrangements.

Adopting a social constructionist epistemology in a qualitative approach intended to deepen understanding of the relevant issues, an initial investigative study was undertaken using a semi-ethnographic methodology of observation and participation at relevant events across the health professions from 2005 to 2008. This identified a number of key issues for these professional communities in terms of decreasing levels of autonomy, changing inter-professional relationships, and developing professional roles. The dental profession was identified as being at a unique point in its continued development as a profession by virtue of government policy which imposed a new NHS contract for dental services from April 2006. Dentistry thus became the focus for the main phase of the study, which comprised 40 semi-structured interviews with leaders and frontline workers in the profession from 2008 to 2009.

The findings of the study indicated that the social construct of 'a profession' remains relevant to the professionals themselves in contemporary society, and still incorporates the traditional elements of altruism, expert knowledge and strong professional values and standards. In addition, the contemporary construct incorporates elements of innovation and entrepreneurship, and a move towards a more independent commercially-minded professional in the 21st century, despite higher levels of societal control. The response of the profession to challenge reflects the responses of both individual members and the collective professional community, and a balance of interests is identified that each individual professional considers in determing their own response. The importance of the successful renegotiation of a professional identity is discussed in terms of the identity theories developed by Stryker and Burke (2000) and others, and the renegotiation of professional boundaries is considered through the work of Fournier (2000).

It is concluded that the continued success of the professions to defend their position and status in society is dependent on a 'magic mix' of elements as demonstrated by the dental profession at the present time. There is no evidence of deprofessionalisation of this profession, but proletarianisation is seen in the controlled degradation of its professional services. The overall conclusion is that government policy is aimed at undermining power in the professions, and in medicine in particular, by redefining existing professional roles, and the introduction of new 'professions' which are skills-based rather than knowledge-based.

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"The best augury of a man's success in his profession is that he thinks it the finest in the world."
George Eliot (1819-1880)

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TABLE OF CONTENTS

TABLE OF FIGURES

TABLE OF TABLES

Glossary

AHP	Allied Health Professions
BDA	British Dental Association
BMA	British Medical Association
CDO	Chief Dental Officer
DCP	Dental Care Professional
DH	Department of Health
GDC	General Dental Council
GDP	General Dental Practitioner
GMC	General Medical Council
GP	General (Medical) Practitioner
NHS	National Health Service
NPM	New Public Management
PCT	Primary Care Trust
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
VT	Vocational Trainee (also known as a VDP Vocational Dental Practitioner)

Chapter 1: Introduction

Chapter 1 Introduction

1.1 Introduction

The purpose of this thesis is to further our understanding of the professions and their development into the 21st century, and to examine in particular the healthcare professions and their response to the changes they are experiencing in the current political, social and economic environment in the UK. During the course of this research it became apparent that policy changes affecting the Dental profession presented a unique opportunity to study the changing nature of a profession at the present time, and this profession thus became the focus for the fieldwork and analysis undertaken during the course of the research. In the latter decades of the 20th century there were considerable changes in government policy and public attitudes towards those we regard as professionals. Changes in a wide societal context led to the traditional role and definition of a 'professional' being brought into question, through raised public expectations and the development of a more consumerist approach to service delivery, especially in the public sector. Whilst many of the core elements associated with professionalism such as autonomy, expert knowledge, responsibility and ethical values undoubtedly remained key to the concept of a profession (Ellis 2004), the balance between these elements had shifted with increasing calls for more transparency and accountability. Much of this has come about in the light of prominent media attention to cases of misconduct, and increased client knowledge, involvement and expectations.

Defining the concept of 'a professional' has proved to be a challenge for academics who have striven throughout the 20th century to determine their characteristics, study their behaviour and define the ways in which they interact with society. A categorical definition still proves to be elusive, as would be expected of a social construct which continues to change as society continues to develop and evolve, with changes in economic and political trends influencing the overall context in which the concept is interpreted. There can be no doubt that the original historical concept of a profession has evolved into a new contemporary form, even during the directly observed period of one's own lifetime, and that there may be distinct differences between countries and cultures in this socially constructed phenomenon.

The construct of 'a professional' in the UK is widely believed to have originated from the three learned professions of the clergy, law and medicine. The construct has become more complex with the development of a series of 'new model' professions since the 19th century, primarily encompassing the male-dominated communities of

scientists and engineers of the industrial era, and the caring and more feminised professions of teaching and nursing. More recently the concept of 'a profession' becomes more difficult to define with the formation of a wider range of new professions in information technology, management and health, subscribing to the general ethos of 'professionalism' and publicly promoting an image of trustworthiness and quality standards. We must thus conclude that to be deemed 'professional' is still desirable for both the professionals concerned and their client base.

This extension of the common usage of the term is likely to have altered the contemporary social construct, and consequently affected society's attitude and behaviour towards professionals, with a reported loss of trust and respect (Rosen and Dewar 2004; RCP 2005). It might also be asked whether this change is experienced solely in terms of professionals, or whether it is part of a wider change in societal behaviours and expectations. It is difficult to determine the degree to which this change in attitude is due to individual experiences or wider societal changes and pressures. Some of the change in the construct may be due to actual change in the professions themselves, in response to external pressures and challenge from society and government, or as a consequence of an internal strategic shift; hence the dynamic nature of the construct. Should it be assumed that policy changes, social trends, technological innovation and the media have all played a part in this change process?

An interest in the subject of this study was kindled by a personal involvement in the work of the healthcare professionsand the changes to which they have been subjected in the past two decades. The rationalisation of the NHS through the introduction of the New Public Management (NPM) by Thatcher's government of the 1980s, the re-modelling and fundholding of the 1990s to meet the requirement for patient-centred services set out in John Major's Patients' Charter (DoH 1991) and the restructuring and renegotiation of NHS contracts since the introduction of The NHS Plan (DH 2000) under Tony Blair and New Labour in the last decade, have driven extensive change through imposed government policy, designed to break down the control structures of the medical profession in particular, and bring healthcare into a heavily controlled and monitored bureaucracy. A review of the relevant literature and a preliminary investigation to determine the pertinent issues led to a particular interest in the way in which professionals perceive themselves as professionals, the changes which they have experienced in their professional careers, and the ways in which this has influenced their subsequent actions and behaviour to accommodate and adapt to the changes. It also brought to light the current changes in the dental profession which set it aside from the the majority of healthcare professions in its apparent freedom to

operate outside of the state funded systems, allowing more scope for independent enterprise in its further development as a profession.

Clearly there is no shortage of questions to be posed and potentially answered in relation to this field of enquiry. Given the contentious nature of the concept of a professional, the starting point for this present study has been to gain a deeper understanding of the construct of 'a professional', to determine what constitutes a profession, and the process by which a profession has come to exist as a social construct with relevance in modern society. This inevitably leads to an insight into the means by which professions change over time, and the implications of this continued development or evolution in terms of the changing perceptions of those within the profession and of the public it serves, as well as others with whom it engages in professional relationships.

This area is examined in more depth through the dental profession, which is used as a case study to determine the professionals' own perceptions of recent change and their reactions to it. A profession's strength lies in its established identity both at the individual and collective level, and the perceptions of those within the profession play a key part in the establishment of these identities through social interaction and verification. Thus the professionals' own perceptions of change play an integral part in the change process and the professions' subsequent responses.

1.2 Aims and scope of the research

Aim 1: To explore the social construct of 'a profession' in contemporary society.

Aim 2: To explore the responses of the professions to change.

Implicit in these aims are a number of assumptions:

- that the social construct of a profession exists in contemporary society.
- that the professions have experienced change.
- that these changes have been significant enough to elicit a perceived response from the professions.

In order to carry out this particular research it is deemed necessary to fully understand the complex concept of 'a profession', not only in the form of its present social construct, but also in terms of its inception and previous development by which means its current meaning has been derived. Thus this thesis starts from the broad foundation of a study of the way in which the concept of 'a profession' came into being in the UK, and the historical development of the three learned professions, through which their

early responses to challenge can be determined. This allows a deeper understanding of the nature of the professions, and the way in which they have become associated with such distinct characteristics as altruism and expert knowledge. This offers some insight into the development of their close association with elevated social status, apparently linked with elements of power, autonomy and control.

Contemporary interests focus much of the current attention in this field towards the healthcare professions in the UK, being highly visible in the public arena, closely linked with government policy and spending, and having been subject to radical and repeated change in the past two decades. This differentiates the public sector professions from the legal profession and others which operate primarily in the private sector. Healthcare now encompasses a range of professions, from the traditional profession of medicine and the 'semi-profession' of nursing, to the newly established Allied Health Professions, all of which have been subjected to radical change through the implementation of the NHS Plan in the last decade (DH 2000).

Having established an understanding of the social construct of a profession, an initial investigation was undertaken across a range of healthcare professions to establish their experiences of current change in the period 2005-2008, and their reactions to the changes. This revealed a deep-seated distrust of government and management by the professions, high levels of uncertainty regarding the future, ambiguity over newly created roles, and tensions in inter-professional relationships. The dental profession appeared to be at a unique point in its development with the imminent imposition of a radical new contract for NHS services in April 2006, and the freedom to choose between the realistic options of practice in the state- and privately-funded sectors, or a combination of the two, potentially raising issues of conflict between altruism and commercialism. The new NHS contract was to be much more restrictive, and the dental profession had previously been shown to value their independence highly (Dancer and Taylor 2007). The dental profession was thus selected as a casestudy for the main fieldwork in this thesis.

1.3 Research Process and Questions

The research for this thesis has been undertaken through three phases using an iterative method, so that each stage informed the next. It is based on a qualitative approach designed to deepen understanding, and adopts a social constructivist epistemology based on an interpretivist theoretical perspective as discussed in Chapter 5.

The main phases of the research comprised:

a. **Literature review:** a wide range of literature from sociology, history, health and management was reviewed in order:
    - To gain a full understanding of the origins and development of the social construct of 'a profession' through an historical study of their development, placing them in their current social, economic and political context.
    - To gauge the past responses of the professions to change, in order to preserve their status and retain their positions of power and control, together with their changing professional relationships and identities.
    - To study contemporary literature which places the healthcare professions in their current context, and to further explore the issues of autonomy and control, and 'fairness', the latter in terms of the psychological contract.

b. **Preliminary investigation:** an initial phase of ethnographic observational fieldwork was conducted across the healthcare professions in the period 2005-2008, in order to address the research question:

R1. What has been the perceived impact of recent change on UK health professionals?

c. **Main fieldwork:** the main phase of fieldwork was undertaken focusing on the dental profession as a casestudy, comprising 10 interviews with leaders and policy makers within the profession, and 30 interviews with frontline workers in the form of General Dental Practitioners (GDPs) in order to address the research questions:

R2. What does it mean to members of the dental profession to be 'a professional'?

R3. How has the dental profession responded to recent change?

R4. Has the dental profession been deprofessionalised or proletarianised by these changes?

Analysis of the data for the two groups showed that the social construct of 'a profession' is still relevant in contemporary society from the perspective of the professionals, and that altruism and high professional standards remain key elements of this construct.

The profession's response to change has demonstrated their desire to retain their autonomy and control over their work, while they have lost elements of control over their field of practice, and are subject to increasing levels of control from society. At the present time the dental profession appears to possess a unique mix of elements contributing to its current success: the dental profession's ability to adapt rapidly to change by virtue of its relative freedom, particularly in choice of contracting relationships; its entrepreneurial ability to remake and extend its boundaries to absorb new fields of practice; its retention of the role of diagnostician at the head of a clinical team, ensuring its continued legal monopoly status; the increased levels of demand for its services; and its close association with high levels of specialisation, practical skills and, most particularly, advanced technology. It has little interest in increasing its power within society, but has a strong sense of fairness which has impacted heavily on its responses to challenge.

While there is some evidence of proletarianisation of the profession, which might be viewed as controlled degradation (Abbott 1988), there is no evidence of de-professionalisation, and this profession appears to be at the peak of its professionalisation process, which sets it apart from other healthcare professions that are subject to tight state control.

These findings are discussed in the broader context of the professions across the UK, and their implications for the future development and management of these occupational communities. It is concluded that existing models of autonomy and control may need extending or amending in light of these findings, and that further work is indicated to explore the balance of interests that individual professionals need to consider in deciding upon their response to challenge. It is also suggested that work on the psychological contract should be extended to those who are in restricted contracting situations, who are consequently able to exhibit a wider range of unrestricted violation behaviours.

The full scope of the research conducted for this thesis, its findings, and implications, are presented in the following section as a synopsis of the chapters contained within it.

1.4 Synopsis of Chapters

Chapter 2 The social construction of the professions

This chapter seeks to define the elements that have contributed to the social construct of a profession in order that we might fully understand the concept and the means by which it has become part of our reality (Berger and Luckman 1967; Bruce 1999). The

development of the construct in its historical context then allows consideration of the professions' responses in the past to challenges to their status in society. It is argued that it is only with a full understanding of this contextual background that a meaningful analysis of the contemporary situation can be undertaken.

The social construct of a profession is seen to have originated in England from the Church in mediaeval times (Carr-Saunders and Wilson 1933), with early associations of altruism and vocational calling (O'Day 1987). Through analysis of a contemporary definition by Cruess et al (2002) and a broad range of sociological literature in this field, including that of the trait theorists (Hickson and Thomas, 1969) and functionalists (Parsons 1951), it is identified that both expert knowledge (Jackson 1970; Corfield 1995; Fournier 2000) and autonomy (Elston 1991; Ferlie et al 1996) have been strong features of the professions from early times. They had grown up in close association with the universities (Jackson 1970) and the acquisition of a specialist body of knowledge (Freidson 1986), the application of which in practice for the public good appears to set them apart from other occupations (Ackroyd 1996). The self-regulation traditionally enjoyed by professions has arisen from the high levels of trust placed in them by the public, who grant them autonomy through a social contract which demands accountability in return.

It is evident that the professions have developed a position of status in society (Prest 1987a) through a range of strategies aimed at furthering their positions, largely driven by poor public perception (Corfield 1995). A closer historical analysis of the establishment and development of the three learned professions, through the accounts of Holmes (1982), O'Day (1987), Prest (1987b), Corfield (1995) and others, reveals more detail of their responses to past challenge, and of the differences between them which appear to have affected their success. In particular the inflexibility of the structures which bound the clergy, and their consequent slow response to change, as well as their close dependence on the state, afforded them little flexibility to adapt to changing social circumstances and the introduction of competition. The lawyers and medics however managed to maintain and strengthen their powerful status in society through strategies which enhanced their monopoly status (Larson 1977) and safeguarded or extended the boundaries of their professional fields (Fournier 2000). Their strengths appeared to lie in the successful unification of their internal divisions (Corfield 1995), their close collegiality fostered by the establishment of their respective professional bodies (Carr-Saunders and Wilson 1933; Turner and Hodge 1970), and their continued avowal to shared values, reflecting high standards of both morals and conduct (Johnson 1972).

The continued success of the professions has been closely linked to the period of industrialisation, and this may be due to urbanisation (Pelling 1987), social restructuring and the rise of the middle classes (Holmes 1982), the increased demand for their services (Corfield 1995), or a combination of all of these factors. Their own strategies for continued historical survival could not have succeeded without conducive contextual conditions. Improvements in science and technology contributed to the rise of the medical profession in the 19th century (Prest 1987b), together with the establishment of a range of new model professions (Ackroyd, 1996), perpetuating and modifying the social construct to encompass a broader range of professional occupations, The continued successful development of the professions into the 20th century appears dependent in part on the strength of their professional identity and their strong institutional organization (Carr-Saunders and Wilson 1933), both of which have allowed them to maintain a position of power in the relationships through which they engage with society. The most recent challenge to their professional autonomy has come with increased demands for transparency and accountability consequent to a number of high profile misconduct cases especially in healthcare, and this area is of particular contemporary interest in terms of the professionals' response to challenge and change.

Chapter 3 Professional identities and relationships

This chapter seeks to examine the continued responses of the professions to change in the 20th century, especially with regard to the preservation of autonomy and control, and the relationships of the professions with society. Collins (1990a) suggested that Wilensky's work in 1964 stood at a divide between earlier work that sought to establish the altruistic nature of the professions, and subsequent work which sought to undermine the power of the professions, concentrating on issues of power and control and the strategies through which the professions defended their monopoly status. A later post-revisionist movement concentrated on the historical comparison of professions across a range of contexts (Collins 1990a).

Having acknowledged the complex mix of issues pertaining to the professions, the decision was made to concentrate the current study on the ways in which professions assert themselves in society and respond to challenges to their status. The professionalisation process is regarded as a demonstration of the success of their past responses to change, and the professions are recognised as going through waves of strength and weakness throughout their development (Prest 1987a). It could be argued that medicine might be in a period of decline at the present time. The clergy is

recognised as the original profession on which others are based (Carr-Saunders and Wilson 1933), with a subsequent rise in the legal profession in the 17th century, followed by the growth of the entrepreneurs and new model professions (Ackroyd 1996) together with medicine in the 19th century. This growth can be linked to the industrial era, and this success is discussed through Johnson's (1972) argument for positive and negative aspects of the growth of the professions. There is no doubt that the success of the professions was due to increased demand and could not be dependent purely on the strategies of the professions themselves in isolation from the demands of society. Larson (1977) felt that the establishment of professional monopolies was key to their success, although Corfield (1995) considered this to be part of the move for all businesses to capture competitive advantage at this time. Olesen and Whittaker (1970) describe the occupations being swept along by external forces dependent on prevailing cultural and economic norms. While altruism became apparently less important, specialist knowledge remained as a strongly defining characteristic of the professions.

A strength of the professions lies in their identity, linked to the professionalisation of the individual which may occur through enculturation (when the individual is influenced by the surrounding group) or by acculturation (where two groups affect each other) (Olesen and Whittaker 1970). The strong identity developed at both individual and collective levels appears to be an important factor in the retention of status by the professions in our society. The identity theory of Mead (1934), relating to the emergence of 'self' experiencing the 'otherhood' of generalised others, has been extended through the work of Stryker and Burke (2000), who have worked respectively on the external linkages of social structures to identity, and the internal processes of self verification. The implications of this work are discussed in terms of the establishment and violation of a professional identity, and it is argued that aspects of the present responses of the professions can be explained in terms of mismatches in the self-verification process and the conflict of roles experienced, for example, between commercial and professional values, and the consequent stimulus for sensemaking (Weick 1976). Dent and Whitehead (2002) endorse this lack of verification and acknowledge a new identity formation for healthcare professionals in recent years.

The work on identity is extended through Berger and Luckman's (1967) work on the formation of institutions in the construction of social realities, discussing their treatise with respect to the establishment of professional associations, considered to be of paramount importance in the establishment of the professions (Carr-Saunders and Wilson 1933; Turner and Hodge 1970). Again, the importance of a body of transmitted

knowledge is endorsed, to provide the rules of conduct and roles within the profession which can be reaffirmed to successive generations through language and symbols, strengthening the collective identity which is continuously remade and challenged (Barry et al 2003). Further discussion of the role of professional associations highlights their importance in learning, validation, regulation, reinforcement of monopoly status, boundary-setting, training, setting and maintaining standards, working as a unified group (Bucher and Strauss 1961) and establishing a group consciousness (Johnson 1972). Importantly, they were seen to act effectively in countering government policy and the rise of managerialism.

The power relationships entered into by the profession with society thus become a further focus for this thesis, and it is noted that Johnson (1972) considered professionalism to be a form of occupational control, necessary for the successful establishment of the professions in society where levels of uncertainty existed between professionals and clients. Autonomy is directly linked to perceived value in society and a conferred sole right of judgement, with its inherent levels of social control. The conflict between the professions and authority has been well documented (Turner and Hodge 1970; Olesen and Whittaker 1970, Dent and Whitehead 2002 and others). Professionals' relationships are discussed in the light of Johnson's typology of the relationships through which control may be exercised by the professions, in the forms of patronage, collegiality and mediation. It is noted that relationships formerly based on trust are now placed in the hands of auditors and managers, and the profession appear to be under attack from this group of 'organisational professionals' (Reed 1996).

Two further points are raised for discussion; firstly, the changing nature of autonomy for professionals; and secondly, the ways in which the undermining of trust can affect professional relationships. Autonomy implies self-determination and the freedom from control, with lack of coercion in professional practice (Kasher 2005). While it is recognised that professional autonomy is not absolute, and dependent on social and economic limits, constraints in the public sector (Dent and Whitehead 2002) through the welfare state (Clarke 2005) and the New Public Management (Ferlie et al 1996) are seen as a breakdown of trust (Reed 1996) and as damaging to professional pride, morale and integrity (O'Neill 2002). The concept of 'responsible autonomy' (Freidman 1977) embodies the antithesis of management control and its present applications in industry show limitations in its boundaries. The model proposed by Dent (2003) of the balances between autonomy and control in European hospitals is discussed, in terms of its limitations in failing to recognise the increasing degree to which the professions

are subject to additional external controls imposed through regulation and legislation arising directly from the state and EU.

Although a proportion of professionals are now employed directly by private and public sector organisations, many retain their independent, self-employed status while exhibiting a strong collective identity. This complicates their contracting relationships, which are dominated by their strong expectations of fairness, linked to their strong moral and ethical standards. This is explored further through the literature pertaining to the psychological contract, which has developed the work of Rousseau in the 1990s to the CIPD version of 2005, in which trust and freedom are central elements of the relationship based on mutual obligation and trust (Kickul 2001; Van der Heuval and Schalk 2009). The relevance of this concept is discussed further through studies based in the NHS (Kickul and Lester 2001; Cortvriend 2004) and the resistance to change recently exhibited in the studies by Van der Heuval and Schalk (2009). In view of the importance of effective management by appropriately trained managers in this respect, it is argued that the concepts of the psychological contract should be extended to incorporate the restricted contracting relationships of professionals, particularly in the NHS, so that changes in these relationships might be managed more effectively.

The decision was made to restrict the area of study to the healthcare professions as they exhibit a diverse range of professional groups, and have been subjected to extensive change through well-documented government policy, as well as social and economic trends. This has especially been the case in terms of the policy challenges affecting the medical profession which have gathered pace under the New Labour Government during the last 10 years, with radical restructuring, the creation of new professional roles, and increased rationalisation. These changes, and the professionals' responses to them, thus become the focus of the following chapter.

Chapter 4 Challenges to the Healthcare Professions

The changes to which the NHS health professions have been subjected over the past two decades are considered in this chapter. The professions themselves comprise the medical profession, nursing, and the newly created Allied Health Professions (AHPs). In addition, the profession of dentistry is considered worthy of attention, given its annual budget exceeding £1.6 billion and its membership exceeding 30,000 practitioners. The general trend towards multiprofessional team working in the NHS is seen to be altering levels of autonomy in the professional groups, and the interprofessional relationships across healthcare. While doctors were previously considered to be the powerful elite (Pelling 1987; Corfield 1995), they were in the past

regarded as being pompous and taking advantage of patients (Carr-Saunders and Wilson 1933). Their superiority appears to arise from their strong attachment to intuitive diagnosis and implicit knowledge. Nursing has risen from semi-profession status (Etzioni 1969; Ackroyd 1996) by virtue of a professionalisation project apparently driven by the state (Dent 2003). The AHPs are derived from a very diverse group of semi-professions, and both nurses and AHPs have been granted increased status and power through new roles which are seen to have increased ambiguity and tensions between professional groups (Fitzgerald and Teal 2003).

The original NHS was based on a medical model of care delivery, centred around the doctor supported by other clinical staff. This persisted until the Griffiths Report (DHSS 1983), which resulted in the appointment of non-clinical managers to replace former administrators. The quasi-market conditions and fundholding of the 1990s brought the NHS into a more commercially-orientated era. The 1991 Patients' Charter was designed to realign services with patient need, increasing levels of technocracy and friction at the clinician/manager interface. The NHS Plan (DH 2000) resulted in major restructuring and together with 'Agenda for Change' introduced new contracts for all NHS staff in a 6 year period. Increased governance was accompanied by increased accountability, and loss of the right to self regulation.

Increasing management control over the medical profession (Harrison and Lim 2003) and increased public involvement in medical services (Rosen and Dewar 2004) continued to challenge the profession, together with increasing conflict between medical and managerial roles for those in dual positions (Thompson 1997). Further loss of control over training by the profession resulted from the European Working Time Directives and the Modernising Medical Careers initiative. Other factors are discussed, including the effects of genderisation and the difficulties women historically encountered in entering the profession in the past (Witz 1992; Perrott 2002; Corfield 1995). The increased involvement of patients through public representative bodies (Harrison and McDonald 2002), the increased availability of specialised knowledge through the internet, and an increasingly consumerist approach by patients, all add further weight to the challenges facing the healthcare professions.

Deprofessionalisation of the professions has been alleged as a result of policy measures and social trends (Gabe and Kelleher 1994; Potter and Morgan 1997; Fournier 2000), although Abbott (1988) described a process of 'degradation' in which work is downgraded and allocated to subordinate groups, potentially creating a specialist elite. Harrison and Macdonald (2003) discuss the implications of the shift

from substantive to formal rationality in the health service, which they felt to be based on an underlying distrust of the medical profession. Fournier (2000) described the corruption of professional practice by its shift towards commercial rather than public interests, requiring the redefinition of its boundaries. A number of publications have arisen directly from the concerns of the medical profession in its changing professional role and apparent loss of public trust (Rosen and Dewar 2004; RCP 2005).

A preliminary study was undertaken from 2005 to 2008 in order to address the first research question relating to the perceived impact of recent change on the UK health professions. This initial phase of fieldwork informed the direction of the main study, and comprised semi-ethnographic observation sessions (participant and non-participant) at 12 workshops and other events relating to the subject area. A number of the sessions arose as a consequence of other associated research projects (Harris et al 2007; Dancer and Taylor 2007; Dancer 2008; Harris et al 2008; Harris et al 2010). The events covered areas including professionalism, trust, leadership, the business aspects of professional practice, and the future of the healthcare professions. Fieldnotes were thematically analysed and a number of issues emerged: there were concerns that levels of clinical autonomy were diminishing; new roles were proving to be ambiguous; there was a perceived lack of effective leadership in medicine; there was a generalised distrust of government and local management; there was a high level of generalised uncertainty, especially over new roles and contracting in dentistry; there was low regard for other professions in social services; there were substantial changes in inter-professional relationships through new roles and teamworking; and there was perceived conflict between healthcare and commercial services.

It became evident that dentistry was affected by a distinct set of issues related to contracting and social change at this time, as well as being a profession that highly valued its autonomy and freedoms, and that enjoyed high levels of independence with a more business-orientated approach than most others in healthcare. This profession was thus chosen as a casestudy for the main fieldwork of the research. The development of dentistry has been somewhat different to that of the other health professions, originating from a Guild and remaining unrestricted in its practice until the Dentists Act of 1921 with the requirement for formal qualification. It has benefited substantially in terms of status from its association with medicine through the GMC and the Royal College of Surgeons, but it was still reported to have a poor reputation in the 1930s (Carr-Saunders and Wilson 1933). After the formation of the NHS, dentists remained as independent contractors working in an item of service system, essentially running their own businesses.

The Dentists Act 1984 set out the scope of practice as 'the Business of Dentistry', and once patient charges were introduced in the 1990s, dentistry became much more business orientated (Newsome 2003). Dentists have enjoyed high levels of autonomy, and it has been reported that individuals entering the dental (rather than medical) profession were more committed to personal and financial gain, status and independence (Crossley and Mubarik 2002; Brand et al 1996; Kulick et al 1998). Calnan et al (2000) demonstrated an increased entrepreneurial and innovative tendency amongst those who entered private practice, and government intrusions were seen as major 'dissatisfiers' which threatened the dentists' core need for control (Chambers 2001). Dentistry had been placed at a unique point in its professionalisation process by the imposition of a new contract for NHS dentistry in April 2006, which effectively brought NHS dentistry under tight contracting arrangements controlled locally by Primary Care Trusts (PCTs) in which strict targets and payment levels would be negotiated on an individual basis. This potentially changed the professions' relationships with clients from a collegiate relationship to a state-mediated arrangement with immediate effect for NHS treatments.

These changes in contracting arrangements can be interpreted in terms of Johnson' (1972) typology of relationships, where it might be anticipated that this pseudo-nationalisation of the profession by controlling its NHS activities might lead to localism, potentially dividing the profession's loyalties and leading to an increased trade union role for the BDA. Dentists however now enjoy the freedom to move to the private sector, or of mixing their practice between private and state-funded systems. Social changes have also affected the profession significantly in terms of increased demand for lifestyle and cosmetic services. In terms of the psychological contract, this means that exit from the NHS-mediated system is a viable violation action (Kickul and Lester 2001). There are clear implications in terms of shifting autonomy (Dent and Burtney 1993), the conflict of business and professional values (Welie, 2004a), the inexperience of NHS managers in managing the change process (Cortvriend 2004) and the commitment of professionals to work which offers rewards other than of a financial nature (Fielden and Whiting 2007; Harris et al 2007).

It would appear that, after a period of relative parity, the medical and dental professions might now be defining their professional models along divergent lines. Thus allegations of deprofessionalisation and proletarianisation in the medical profession may not be relevant in dentistry. There is scant literature in this area, but growing concern that the GDC intend measuring 'professionalism' in its revised revalidation measures to be

instituted in 2010. Recent legislation has also established a new range of Dental Care Professionals (DCPs) who are able to undertake some of the practices previously restricted to the dentists. As a result, a small number of opinion pieces have appeared in recent dental journals. Cottingham and Toy (2009) voiced concerns over industrialisation of the dental profession, while Trathen and Gallagher (2009) attempted to redefine professionalism in dentistry as being dependent on its economic sources, but no empirical work has been reported in this field to date.

This critical point for the dental profession affords a unique opportunity to study its responses to the changes which have been implemented through government policy, and its ability to cope with the challenges presented by the social and economic climate. The main fieldwork set out to address the three main research questions from the perspective of the professionals themselves in order to gauge their perceptions of the social construct of a profession, their responses to change, and of the potential for de-professionalisation or proletarianisation of the dental profession.

Chapter 5 Methods and Methodology

Crotty (1998) outlined a framework comprising the four elements of Methods, Methodology, Theoretical Perspective, and the Epistemology that informs it. This framework forms the basis of this chapter which discusses each element in turn.

In the initial phase of fieldwork reported in Chapter 4, ethnographic methods of data collection were utilised through participant/non-participant observation, the findings from which led to the selection of dentistry as the focus for the main study. In the main phase of fieldwork, data was collected by semi-structured interviews with members of the profession. Group A comprised 10 leaders and policy-makers, while Group B comprised 30 frontline General Dental Practitioners (GDPs). All data was collected and transcribed by the researcher, helping to immerse them in the data and its analysis (Denscombe 1998). The approach was iterative and the interview schedule modified as a result of the analysis of previous data collected, allowing emergent issues to be tested against further participants' perceptions. Analysis was undertaken by the open coding of transcriptions and fieldnotes (Miles and Huberman 1994). Appropriate ethical approval had been granted through COREC in conjunction with an associated research project.

A qualitative methodology was deemed appropriate in order to deepen insight into meanings and understandings of the sample group, with data collection on a personal level. The approach in this study was both ethnographic and iterative, using a

modification described by Layder (1993) of the grounded theory approach (Glaser and Strauss 1967) in which empirical work was used as a starting point, analysis was based on fieldwork, explanations were developed that were recognisable by the participants, local explanations were based on the evidence produced, and with an emergent design in which the focus was developed during the study. This allows for a richness of detail from the 'thick descriptions' obtained through qualitative methods, with the influence of 'self' acknowledged on both the generation and interpretation of the data.

Leaders can be unduly influenced by their organisations (Becker 1967) but have useful privileged access to knowledge (Flyvberg 2001) and high level involvement in the subject area. Bias may be reduced if the perceptions of such a super-ordinate group are taken with those of a subordinate group also (Becker 1967). Interviews were undertaken until a theoretical saturation point was reached (Strauss 1987) where no further insight was offered through further interviews. The influence of 'self' in an ethnographic approach is based on issues around the researcher's values, identity and beliefs which become incorporated into the research process (Ball 1990), although Becker (1967) argued that it was impossible for a researcher to completely divorce themselves from their interest in a situation. The interpretation of the findings is thus presented as a construction based on self-awareness rather than on description (Denscombe, 1998), and as a version of reality (Hammersley 1992). The positive contribution of the researcher must also be acknowledged (Miles and Huberman 1994) especially in terms of immersion of self in the subject area, access, and the establishment of mutual trust and respect with participants in this present study. A reflexive account of the researcher as a qualified dentist working in a field outside of general practice is given, to establish interests, perspectives and acknowledge a degree of absorption into the area of study.

The advantages of data collection in an undisclosed situation are discussed in terms of the richness and validity of data from an undisturbed natural setting (Becker and Greer 1957) and must be weighed against the low reliability of data and the strong influence of self on the data and its interpretation (Denscombe 1998). Reliability of data can be tested in further interviews in a series, and by means of a clear audit trail (Lincoln and Guba 1985) throughout the research. The validity of qualitative data is difficult to establish given its uniqueness, and the limitations on generalising from its findings are acknowledged.

The theoretical approach to this study describes the context of the work and the basis for the logic within it, while its epistemology is the theory of knowledge which underpins that theoretical perspective – our understanding of 'how we know what we know' (Crotty 1998). Constructionism is an epistemology described in terms of meanings which are constructed rather than discovered, embracing a relativist approach (which recognises that 'the way things are' equates to 'the sense we make of them') (Crotty 1998) and a realist approach (where socially constructed reality is 'real') (Berger and Luckman 1967). Constructionism therefore takes objects to be meaningless until we interact with them, in order to construct a meaning that is historically and culturally influenced by symbols and rules already in existence in society (Crotty 1998). Constructivism offers an alternative where conventional norms and meanings are dropped, allowing individual reinterpretation without preconceptions (Heron 1992). There is a need to adopt a critical perspective in order to avoid reifying the sense we make of things into an objective truth, and interpretation is thus required, which in turn is influenced by our social behaviours.

We live in a complex world which determines how we behave and feel, and the symbolic interactionism described by George Herbert Mead (1934) and already discussed in section 3.3 describes how every person is a social construction which comes into being as a consequence of its interactions, and is highly relevant in an ethnographic approach. A theoretical approach based on interpretivism is aimed at providing understanding rather than explanation, and does not seek to uncover universal laws. The double hermeneutics described by Giddens must be taken into account in the interpretations of both participant and researcher. It is thus intended in the current study to adopt a critical constructivist approach in examining the responses of the professions, themselves a socially constructed phenomenon and a product of history, culture and society.

Chapter 6 Findings

The findings are derived from content and thematic analysis of the data from the main phase of fieldwork in the dental profession. The interview data is reported from two groups: Group A, the 10 leaders and policy makers, and Group B, the 30 frontline GDPs. As would be anticipated there were marked similarities in their responses, demonstrating the strength of unification in a profession that is however acknowledged as comprising many distinct individuals. Differences in the perceptions of the groups appeared to arise from the rather detached views of some participants of Group A who tended to adopt their 'spokesperson' rhetoric, in addition to expressing their personal views. Group B participants were much more direct in their responses, which were

based on their own experiences rather than on a politically correct 'soundbite' or holistic overview. Both groups however were perceived to be highly engaged with the research, and open and honest in their participation.

Five main themes emerged from analysis of data from Group A: Values, Standards, Independence and Autonomy, Challenge, and the Future. It was thought imperative for a professional to have a set of appropriate values, which were to a degree inherent and certainly formed from an early age, espousing the principles of putting others first and always doing your best. It was felt to be essential that a profession set and maintained high standards, relating to all areas of conduct and practice. The drive to constantly learn and update in order to practise to such high standards was thought to be self-motivated, and the implicit trust in professional relationships was based on the maintenance of high professional standards. It was evident that independence and autonomy were extremely important in this profession, which strongly resisted enforced control of its day-to-day practice. There was a strong distrust of government and obvious violation behaviours in circumstances which were perceived as being unfair, with practitioners leaving the state-funded systems to retain independence in the private sector.

Most participants viewed the recent policy changes as a challenge to the profession, in which many new opportunities were offered for further development. However, there were perceptions of threat and attack, with an undercurrent of conspiracy related to the distrust of government and a feeling of being let down by the General Dental Council (GDC), which was no longer regarded as part of the profession but as a government body. Membership of the profession was by virtue of being on the GDC Register, and no other professional membership was deemed necessary. A degree of nostalgia was evident, although there was acknowledgment that change was necessary in some respects. The close association of the profession's practice with technology and science was appreciated as a key driver of it's continued success, together with social trends which had led to increased demands for care, and an opportunity to extend the boundaries of the professional domain. The future of the profession was thus seen to be secure, with optimistic views of younger professionals who faced a future in which independent privately-funded practice would play a larger part, and in which the dentists became more specialised as the leader of a team of Dental Care Professionals (DCPs) to provide a wider range of care.

The conflicts of interest that a professional faces in making decisions to advance their practice became evident from this data set, and it is proposed that in taking such

decisions the individual professional has to consider the balance of interests between self, their business, their patients, the profession and the wider public. This proposed balance of interests was supported by the responses from Group B, which were very much in accord with Group A. However, the frontline practitioners gave a much more pragmatic view centred on their own personal experiences, and a much more complex picture emerged of the inter-relations of personal and professional standards and values, and the practical problems of balancing the conflicting demands of healthcare and commercial practice, in attempting to run a successful business in the healthcare sector. The main themes which emerged from this group were based around high standards, which were perceived to be the bedrock on which the profession was based and currently under attack by recent government policy. There was a universal avowal to doing good. Autonomy and independence were linked with the emotive concept of freedom, and there was a strong sense of injustice and indignation at the way in which the profession had been treated by government. This revealed a deep and inherent sense of fairness, and an expectation of mutual respect and trust in professional relationships. This was the area in which the professionals felt most disappointed in the recent contract changes.

The overall view of the profession was optimistic, in the recognition that dentistry had been allowed the opportunity to find its own way to thrive outside of the state-funded systems. It was also recognised that dentists are a very intelligent group of highly motivated and entrepreneurial professionals who would find a way of making any system work, however flawed. The future of the profession was viewed by the vast majority as being full of opportunity. It was thought that the profession might split into two groups, with no consensus as to the means of division, which might be between NHS and private funding, or between routine basic care and advanced specialist practice. The funding of services, and hence the government's involvement through the NHS, was seen to be intricately linked with the further development of the profession, but it was universally accepted that the professionalism of an individual practitioner is a property of the individual, and is not affected by the funding of the services they provide. While Group B brought to light many issues of conflict, disappointment and injustice, their overall feeling was that dentistry was a good profession with many positive aspects, and with a very promising future.

The overall findings demonstrate the strength of feeling in terms of freedom and fairness of these professionals, who are extremely independent and essentially unconnected except through their shared values, professional codes and standards. They appear to have a very clear idea of what constitutes 'a professional', through their

own experiences and socialisation, and the unwritten traditions of the profession. They present as an entrepreneurial group who by virtue of their small size can readily adapt, and adopt (sometimes begrudgingly) new strategies to make the most of any situation, welcoming new technology and the opportunity to expand their professional domain. However, they maintain a strong sense of independence and autonomy, resisting control. They appreciate the limit of their power base and thus present little threat to government outside of their own specialist field. Their high professional standards appear to contribute to their highly developed sense of justice, and their consequent concerns over fairness, not only for themselves but for their patients and society. In these professionals' minds, the future of the dental profession appears to be full of opportunity, and although it will be different to what has gone before, there may be many positive aspects to inevitable future change.

Chapter 7 Discussion

The limitations of the extrapolation of the findings are acknowledged in view of the qualitative nature of the work, but this does not preclude discussion of the findings in the wider healthcare context and in terms of the published literature. It is argued that the construct of 'a profession' is still relevant in contemporary society in agreement with Burrage (1990), Ackroyd (1996) and others. It is also proposed that the professions have developed in distinct groups over the past five centuries, and recent government policy and social changes have redistributed those groups, bringing them all towards a more commercial model of practice in the 21st century. While Larson (1977) thought the concept of professionalism was of no practical application, it is argued that this study of dentistry shows the opposite, and that dentistry at present appears to have a 'magic mix' of elements which are contributing to its continued success as a profession, identified as:

- the continuing relevance of the social construct of a profession.
- the ability of the profession to adapt quickly to change due to its small size and relative freedom from state control.
- its entrepreneurial capabilities in remaking and extending its boundaries and field of practice.
- its retention of the diagnostic role in its field, with continued legal monopoly status.
- increased demand for its services.
- its close association with high levels of specialisation and advanced technology.

It is postulated that the dominance of the institutionalised professionals of the 20th century will now recede, allow the freestanding professionals to rise again.

The construct of a profession described by the professionals in this study demonstrated the persistence of a strong degree of altruism in a complex mix of elements, with high levels of diversity within the profession which also contributed to its success. Only recently has this profession been challenged by the imposition of managerialism and 'culture of performativity' described by Dent and Whitehead (2002), and it appears to have responded through new identity formation (Barry et al 2002) as a provider not only of healthcare, but of other valued services to society. The literature relating to identity would indicate that the profession needs to be inculcated in discourses relevant to the present, so that the professional's construct will match with that of society and the rest of the professional community, in order to unify the profession and engage with the dominant truths in society (Stryker and Burke 2000). A mismatch will result in failure to verify self, evoking an emotional response and stimulating sensemaking activity (Weick 1976). The loss of traditional symbols and rituals can make it more difficult to distinguish between professionals and non-professionals, and increased controls impact on the verification of identity by restricting the ability to adapt and seek a client group where mutual identities are verified (Weick 1976).

It is recognised that codes of behaviour and standards are becoming more explicit with stronger rationalisation and societal control, while increased transparency might be beneficial in affording the opportunity to publicly demonstrate high professional standards. However, the 'guilty till proven innocent' implications of newly introduced revalidation perpetuates the undercurrent of distrust between the profession, the government and the public.

The high barriers of entry to the dental profession afforded by tight legal regulation, high levels of practical skill and expensive specialised equipment are seen to counter the increased availability of public knowledge, which in reality leads to increased demand for specialist services, as suggested by Fournier (2000). The perceived threat from DCPs is low, given their lack of degree level education and holistic theoretical overview of the field of practice. This is quite different to the situation between the medical professional and the AHPs, who are university educated and have a range of diagnostic roles in the field of medicine. This situation can be viewed in terms of the shifting boundaries of practice between professions (Fournier 2000) and the development of interdependent professions which develop in relation to one another as described by Abbott (1988).

Changes in recruitment strategies in Dentistry at undergraduate level to take account of professional values are aimed at strengthening the profession at its core. The control of postgraduate qualifications from within the profession through the Royal Colleges and the retention of research and generation of new knowledge from within the profession in the clinical setting, both seek to reinforce the profession's powerbase and maintain its status. Connectedness in the profession is purely through legal registration, and membership of a professional association (Carr-Saunders and Wilson 1933) does not appear necessary. There is a strong sense of a shared value system, with antipathy for those who fail to uphold the profession's standards and thereby bring the profession into disrepute. There is also nostalgic regret at the loss from the profession of the GDC and the Chief Dental Officer (CDO) role, both of which are now viewed as under government control. The dentists' lack of concern over leadership does not mirror the situation in medicine, perhaps due to the more networked and less hierarchical nature of the smaller dental profession.

The observed responses of the dental profession to change shed some further light on the professionalisation process, and the balance of interests which influence individual decisions during the change process are considered in this context. Autonomy is regarded as equating to freedom (Mele 1995) and this allows entrepreneurial and innovative activity which is stifled by bureaucratic control. The dental profession is placed in the matrix of autonomy and control proposed by Dent (2003) and this is extended through the addition of a third dimension of societal control, taking into account increasing regulation through legislation in areas such as cross infection, health and safety, and employment. The effect of these three areas of control is shown to be different in services funded through different means, affecting the independence of the professional concerned. Consideration is given to whether professional conduct is directly influenced by the funding of the services provided (Trathen and Gallagher 2009).

The reasons behind the government's decision to allow the dental profession a unique degree of freedom in their contracting are discussed, in terms of the benefits to the state of a higher proportion of care funded privately and the relatively low levels of power in society wielded by the dental profession. The role of the professions in systems of governmentality is discussed in terms of the papers by Reed (1996) and Davies (2006). The changing relationships of the professions are considered in terms of Johnson's (1972) typology of relationships, with a clear indication that dentistry has resisted the move towards patronage and mediated relationships with the state, and chosen to remain partly if not entirely in a collegiate relationship with its patients. The

increasing role of corporates is discussed in terms of their tightly controlled patronage type of contracting arrangements, proving to be of concern within the profession.

The boundary work of the profession which had become evident is discussed in terms of Fournier's (2000) framework of four elements: firstly, the renegotiated boundaries with the lay public, including the influences of the media and advertising; secondly, the boundaries between professional groups, in terms of the roles of the DCPs and the controlled degradation (Abbott 1988) of work in the professional field; thirdly, the expansion of the field of practice to include lifestyle treatments and to meet increased demand, with the potential for accusations of being tainted by money and commercialism (Reed 1996); and lastly, the flexibility of boundaries, which is possible in dentistry by virtue of its freedom to operate outside of NHS controls. The perceived value of dental services is currently increasing as judged by increasing client demand, and this, together with the freedom of the profession, has enabled its current apparent success. However, this has not been an easy transformation for many in the profession, and their perceptions of the change process are in many cases of unfair treatment at the hands of the government and its agencies.

This leads to a consideration of the psychological contract and how this might be applied to professionals who are engaged in restricted contracting relationships, rather than employed directly by the state. The issues raised by Cortvriend (2004), Van der Heuval and Schalk (2009) and others all appear to be relevant in this context, in terms of loss of trust, high levels of uncertainty and poor perceptions of management. This particular group allows study of violation behaviours unhindered by tight employment contracts, and without losing from the study those who exit from the contracting arrangement, as they remain part of the profession which comprises the study group. In terms of Kickul and Lester's (2001) work on the reactions of 'entitleds' and 'benevolents' to breaches in the psychological contract, the dental profession appears to encompass both viewpoints and might thus be classed as 'equity sensitives'.

The final section of the discussion considers the findings in light of the allegations of de-professionalisation and proletarianisation of the professions. The controlled degradation with delegation of routine work to a lower subordinate group in dentistry is controlled by the profession, where in medicine it is not, and the DCPs do not share the equivalent status or theoretical knowledge base of the dentists, so any proletarianisation at present appears to be controlled. Abbott (1988) warned that others will invade a field of practice if demand cannot be met, and this appears to be the situation with regard to the entry of the corporates into the dental marketplace. The

industrialisation of the dental profession alleged by Cottingham and Toy (2009) appears inappropriate, and Fournier's (2000) 'labour of division' appears to be more relevant in allowing the profession to offload mundane work and develop a more specialised leadership role. The issue of funding appears to be an unavoidable consideration when considering the future of the healthcare professions, and there is no doubt that the economic downturn will continue to have an effect on all the professions.

De-professionalisation is discussed further through a set of issues identified by Fournier (2000). She considered that a profession might be deprofessionalised firstly through corruption of its professional practice by commercialism (Reed 1996), which is countered in view of historical evidence that the professions have always been involved in commercial transactions, and are seemingly returning to that model. Secondly, it is argued that a profession may become deprofessionalised through the codification of professional knowledge and the rationalisation of services, both of which have been effectively resisted by the dental profession. Lastly, there is the potential for deprofessionalisation by the erosion of monopoly power through the dissemination of knowledge to the public, and it has been seen that in dentistry this has infact led to increased demands for treatment due to improved awareness. It is thus argued that the dental profession does not show evidence of deprofessionalisation at the present time. Ackroyd (1996) thought the professions were becoming more systematised and institutionalized, and again the dental profession has shown a different tendency, to adapt to the logic of the market and adopt independent and entrepreneurial practices. Murphy (1990) described degrees of proletarianisation in terms of loss of control of professional goals and ideology, and loss of control of technical aspects of work. If it is clear that specialisation does not equate to de-skilling, then dentistry has retained high levels of technical autonomy and seeks to retain its ideological autonomy, although this is threatened through increasing bureaucratisation in the NHS. The potential future deskilling of one element of the profession to provide a basic core service would indicate that this group may become a subset of the profession, but it seems likely that this work will be devolved to DCPs if the profession is able to retain its control over the degradation process.

Chapter 8 Conclusions

In view of the findings presented and in terms of the key research questions it is concluded that:

R1. What has been the perceived impact of recent change on UK health professionals?

- The preliminary study across the healthcare professions showed that the implementation of the NHS Plan had led to concerns that clinical autonomy was diminishing in the medical and dental professions, with increasing generalised bureaucracy and distrust across healthcare of government and local management. The new roles brought in as a consequence of the NHS Plan were proving to be ambiguous and not necessarily empowering, with high levels of generalised uncertainty over the future. The unsettling and threatening nature of the changes had led to a move towards a militant stance and regrouping in the medical and dental professions, who perceive their autonomy to be directly challenged by government policy, with confusion over the potential conflict between healthcare and commercial services for some who had always practised in the NHS. The dental profession alone has been allowed a freedom of choice in its contracting arrangements, due it is assumed to its relatively unpowerful position in society and the financial benefits to the state of privately-funded treatments.

R2. What does it mean to members of the dental profession to be 'a professional'?

- The social construct of 'a profession' remains relevant in contemporary society and is applied in daily practice rather than existing as a theoretical construct. It has changed as the professions have had to evolve and respond to challenge in a changing social context. Altruism and high standards remain at the heart of the dental profession, and there is still a strong feeling of 'something within you' in relation to personal and shared values. The implications of renegotiated new identities for the profession, in terms of verification and the avoidance of emotional response to a mismatch, make this an important area in which the profession needs to engage the public and its members to ensure unity and successful verification of new roles. The strength of collective identity is likely to allow more successful maintenance of the social construct and retention of the profession's status in society.

R3. How has the dental profession responded to recent change?

- The success of the dental profession's response to change has been tempered by the 'magic mix' of factors identified, namely its small size, its entrepreneurial ability to adapt, its individual members' freedom to choose their contracting arrangements, its association with high levels of technological advancement, and high levels of demand for its services. It is acknowledged that not all of

these are under the direct control of the profession and its success is ultimately dependent on its client base.

- The profession has become more commercial but this appears to be a general tend across the UK professions, and perhaps marks a return to the privately-funded systems of professional services in the past.
- The professions are increasingly affected by controls through rationalisation, especially through increasing societal control and regulation. This appears to be particularly prevalent in healthcare due to the risky nature of the work.
- Individual members of the profession are required to make their own personal decisions relating to their future practice after consideration of the balance of interests between self, their business, the profession, their patients and society. The collective response thus depends upon these individual choices, which in part will be influenced by the leaders and policymakers in the profession.
- The responses of a profession to challenge will be heavily influenced by the strength of their professional identity, at both individual and collective levels, and by their perceptions of fairness in their professional relationships, particularly in contracting agreements and negotiations.

R4. Has the dental profession been deprofessionalised or proletarianised by these changes?

- In the dental profession there is evidence of proletarianisation through the potential development of a sub-set of the profession which carries out only basic care. This might however be viewed as controlled degradation if it remains under the direct control of the profession, such that routine work can be appropriately devolved to other professionals such as DCPs, allowing increased specialisation of members of the dental profession itself.
- There is no evidence of deprofessionalisation in the dental profession, which remains in a strong position relative to other healthcare professions by virtue of its relative freedom from bureaucracy, rationalisation and state control.

1.5 Contribution to knowledge

The dental profession does not appear to have been studied in this way before and recent literature comprises opinion pieces rather than empirical studies. The study has provided evidence to show that Dentistry is different to all other professions, and does not fit into existing models of the traditional, semi- or new professions. This implies that existing theoretical models need to be modified and extended, and adds weight to the arguments that the professionalisation process is unique to each profession and heavily contextually dependent. It also highlights the need to extend current models of

professionalisation and research studies to include the newly created professions in healthcare which have arisen as a consequence of the NHS Plan (DH 2000).

The unique context during the timeframe of this study has provided a novel insight into the reactions of a profession subjected to change. The distinct character of the profession and its freedoms from the state-funded system has provided a deeper understanding of the way in which professionals may act when unfettered by strict government bureaucracy. The semi-ethnographic nature of the research has provided a rich source of data for analysis, with frank expression of feelings, fears, and violation behaviours.

The thesis has extended work in the areas of autonomy and control, most of which has previously been based in an organisational context. The addition of societal controls to existing models of control is proposed, to reflect the increasing levels of control imposed upon professionals.

The findings of this study also extend the concept of the psychological contract to include restricted contracting relationships as well as direct employment in organizations, with particular relevance to professionals who have such high personal standards and values, and thus expectations of others with whom they relate. This will provide policy-makers and management with further insight as to how professionals react to change and how best to manage change processes.

The findings provide clear evidence that the professionalisation process for the healthcare professions continues in the 21st century, as demonstrated by a group who are relatively unconstrained by rationalisation, who have been allowed the freedom to adapt and respond to challenge at both individual and collective levels.

The social construct of a profession is evidently still viable in a contemporary society, from the perspective of the professionals who have negotiated a new identity in the past 4 years. In the 21st century, the elements of entrepreneurship, innovation, and commercialism appear to be incorporated into the contemporary construct of a profession.

The identification of the 'magic mix' of success factors brought to light through this work which have contributed to the dental profession's apparent strength at the present time may be used to assist this and other professions in developing future strategies for

their further successful development. It must be recognised that public demand for services is an essential element of success.

1.6 Recommendations for further research:

A number of areas are identified as worthy of further research as a consequence of the present study:

- Public perceptions of the professions.
- Leadership in a collegial community.
- The psychological contract in contracting relationships, particularly in professional groups with high expectations and autonomy.
- Further exploration of the balance of interests which an individual professional considers in making their personal decisions.
- The continued development of the dental profession in relation to the DCPs.

1.7 Summary

This chapter has provided a detailed overview of this thesis, demonstrating the scope of the research undertaken, the reasons behind it, the methods employed and their justification, the findings which are discussed in the context of the existing literature, and the conclusions which are drawn, with their implications in terms of adding to theory and improving practice.

In the following chapter a detailed study of the literature will provide the historical context which provides a deeper understanding of the social construct of 'a profession', its derivation and development, together with an insight into the reactions of the professions to challenge during their early development, highlighting the importance of status, power and control to these communities.

Chapter 2: The origins of the Professions

Chapter 2 The Origins of the Professions

2.1 Introduction

It is considered that any study of the professions requires a solid understanding of the relevant social construct, in order that further related research and analysis can be meaningfully undertaken. This initial chapter is thus aimed at gaining a deeper understanding of what a profession is and how it has come about, the important elements that constitute a profession, and how these might affect its response to change. In other words, what makes a profession special and worthy of our consideration? A broad range of literature relevant to the social construct of 'a profession' is presented and discussed, to demonstrate the origins of the three learned professions of the clergy, the law and medicine in particular, and how the characteristics we commonly associate with the concept of a profession have arisen from their subsequent development. It is acknowledged that the social construct of a profession is by definition a dynamic concept which will change over time, and is dependent on the prevailing social, economic and political context.

An initial consideration of the sociological trait theorists' work identifies that altruism, expertise and autonomy have all become associated with the professions, together with the development of shared values which incorporate high standards and codes of conduct. Professional autonomy in particular is strongly linked to accountability and public trust, and directly relevant to the challenges facing the professions in the 21st century in terms of their rights to self-governance. It becomes evident that the three learned professions have engaged in strategies to establish and maintain their status in society, allowing them to retain their positions of power and control. A detailed examination of the histories of these three communities sheds further light on the means by which they have already reacted to change in the past, highlighting both the differences and similarities between them.

The success of the professions in terms of their continued growth, both in numbers and types, during the 19th and 20th centuries is discussed with particular regard to the establishment of the 'new' professions, leading to the supposition that the professions' success has been due not only to their distinct combination of characteristics and skills deemed of value to society, and the particular social, economic and political contexts in which they operated, but also the unique strength of their identity in the wider community which appears to have allowed them to maintain the privilege of their position in society and effectively deal with the conflicts and challenges that have arisen.

2.2 What is 'a profession'?

'A profession' is a social construct which, as Bruce (1999) reminds us, arises from the culture (that is, the people) engaged in a particular social context. That construct only becomes viable as a reality of 'how things are' through shared meaning (Berger and Luckman 1967). By this means a construct such as 'a profession' can become reified through typifications which become progressively modified by successive interactions, building up the relevant social structure. A 'reality' then is recognised as having a being independent to our own volition, in that we cannot wish it away. Much of our world in terms of the social institutions to which we relate preceded our arrival, and becomes modified by society during our lifetimes and beyond. Due to this socially embedded and often long-term process of development, powerful socially constructed institutions may prove persistent:

> *"Social institutions can have enormous power, and simply 'de-constructing' them by showing their human origins (especially by showing that some groups benefit more than others from particular institutions) will not make them vanish."* *(Bruce, 1999:30)*

Those who participate in a social reality do not 'act' in it, but live their part in a social order that is constantly fluid. Our world is thus made up of a complex process of repeated social constructions, influenced by judgement and decisions at many different levels.

Much of our world is not experienced first hand, but language allows us to express meanings and experience beyond the scope of 'here and now', allowing them to transcend time and be preserved through generations (Berger and Luckman 1967). The contemporary social construct of 'a profession' thus arises as a reified product of culture, through a process of repeated social interaction and construction, to produce a typification which is passed to the next generation through language and personal experience for further modification. It has thus been created by people, institutionalised, and passed on as a form of tradition.

The derivation of this dynamic construct from previous generations suggests that much can be learned from an examination of the origins of the construct and the way in which it has been modified by successive generations, an approach adopted by the post-revisionists described by Collins (1990a). The present form of the construct will be studied through contemporary definitions of the term 'profession', demonstrating the characteristics recently associated with the construct. This will form the basis of an historical study of the origins of the traditional professions and

their early development, in an effort to determine how the current social construct has evolved.

There have been many attempts to distil the notion of a 'profession' into a succinct definition, and understandably no consensus view is agreed which is applicable across the range of commonly recognised established and developing professions. Freidson (1986) warned against the concept of a 'profession' being treated as a generic rather than as a changing historic concept. The term 'profession' was initially used interchangeably to denote any occupation or main source of employment, and originated from the clergy who 'professed' a public affirmation when taking their vows of commitment to a religious life; a profession (or confession) of faith thus indicated commitment to a particular calling (O'Day 1987; Corfield 1995).

The occupations that we currently label as 'professions' have not always been regarded in that light. In the 13th century all 'professional' services, such as teaching, legal and medical services, were provided by the clergy. In a time when members of all occupations were banding together into exclusive societies, the universities arose from a Guild of Learning, awarding degrees which enabled the bearer to teach. The universities soon came under ecclesiastical domination themselves, and all students and teachers took holy orders, with all writing undertaken in Latin, effectively excluding the uneducated laymen from entering into their discourse:

> *"To the great mass of the younger students the university was simply the door to the church; and the door to the church at that time meant the door to professional life".* *(Rashdall 1895:696)*

Entry into the professions was thus guarded by the church[1]. However, by the 15th century the secular Inns of Court were becoming firmly established in London dealing with common law, and occupying a position part-way between the universities and the guilds. The surgeons, apothecaries, scriveners and notaries also had their origins outside of the church in the trade and craft guilds, and consequently did not enjoy equivalent status to the 'gentlemen's professions' at this time.

After the Reformation in England the term acquired a range of secular applications, but still encompassing elements of public commitment. A 'professor' thus became a public teacher in the time of Henry VIII. From the 16th century the word became

[1] The civil service originated entirely from ecclesiastic organisation, while early legal services were established through the canon lawyers.

more closely linked to negative characteristics such as insincerity and failing to perform to expected standards (Freidson 1986). By the 17th century, the term came to refer to the set of "skilled service occupations that entailed a professional training in specialist knowledge to be applied in the service of others" (Corfield 1995:19).

Traditionally the origin of the professions has been discussed in terms of the growth and evolution of the three learned professions, the Clergy, Law and Medicine, though Goode (1969) later added university teachers to this trilogy. Carr-Saunders and Wilson (1933) considered that the emergence or 'segregation out' of professions began in early medieval times from either the church or the craft guilds[2], followed by the establishment of a handful of occupations in the 18th century which were suited as 'gentlemen's occupations', often for the second or third sons of the landed gentry who were not in line to inherit (Johnson 1972; Corfield 1995). Industrialisation resulted in an apparently exponential growth in the numbers of professionals, together with their structural organisations, and the development of systematic methods for the establishment and maintenance of training standards (Carr-Saunders and Wilson 1933; Prest 1987a).

In the 1755 edition of Dr Johnson's Dictionary, the term 'profession' was defined as a calling, vocation or known employment, and this sense of an 'occupation' continues to some extent in modern usage. However, by Johnson's 4th edition in 1773, the term 'profession' accorded a narrower usage and was associated particularly with 'divinity, physick and law', which were historically viewed as vocations associated with a dedication to their way of life (Corfield 1995). Each of these dignified and high-status occupations was regarded as being established around a specialist body of knowledge, which was often set out in specialist tomes in an attempt to both buttress professional authority and to impress the wider public. This development was closely linked with the universities who issued the degrees which served as licences to teach and practice (or 'profess') in the disciplines of theology, physic and law (Prest 1987a).

The following contemporary definition of a profession is a modified version offered by Cruess et al (2002) of the Oxford English Dictionary definition:

> ***"An occupation whose core element is work based upon the*** *mastery of a complex body of knowledge and skills.* ***It is a*** *vocation* ***in which knowledge of some department of science or learning or the practice of an art founded upon it is*** *used in the service of others.* ***Its*** *members profess a commitment to*

[2] The differences between a craft or trade guild and a profession have been much debated by Ackroyd (1996) and others.

competence, integrity and morality, altruism ***and the*** *promotion of the public good within their domain.* ***These commitments form the basis of*** *a social contract between a profession and society,* ***which in return grants the profession the right to*** *autonomy in practice* ***and*** *the privilege of self-regulation.* ***Professions and their members are*** *accountable to those served and society."* *(Emphasis not in the original: Cruess et al 2002)*

This somewhat lengthy definition appears warranted by the complexity of the unique status attributed to a profession in our society, and the significance of the many characteristics and connotations which are associated with membership of such a community. The commonly agreed characteristics generally associate a profession with a complex body of expert knowledge over which control and a monopoly of practice is exercised. The concept of mysticism in relation to the professions' 'mastery' of a monopolistic area of expertise is associated with the arcane and esoteric knowledge relating to the practice of the profession. This is often safeguarded by the use of closed language or jargon which excludes non-members from participating in discussion. The idea that the work carried out has an altruistic foundation, based on 'doing good' and 'putting others before self' appears to be a key element of professional practice, setting the issues of trust and accountability as paramount in the relations between a professional and their client in the social contract through which services are rendered. There is an implicit expectation of high quality standards, as well as control over recruitment and training, with a degree of autonomy being granted to and exercised by individuals within the profession, who relate to each other on a collegial basis.

Corfield (1995) agreed with these general features of a profession in proposing that:

"The professions may be taken as all skilled tertiary-sector occupations that are organised around a formal corpus of specialist knowledge with both a practical and theoretical bearing....with a distinctive ethos that focuses upon service...indicating that professionals are ...centred upon the provision of expertise. Other correlates include: a high social prestige; a formalised process of training and qualification; and some degree of regulation or control of entry into the business." (Corfield 1995:26)

It appears that the practical application of high-level theoretical knowledge sets the professions apart from other occupational groups, and perhaps bestows them with high social prestige.

2.3 Professions and professionals

The changing notion of 'a profession', and of what it means to be 'a professional' (in the sense of being a member of a profession), is thus heavily dependent on historical and social context (Johnson 1972; Dent 2003). In a contemporary context, the term 'professional' may also be used to denote behaviour worthy of a

professional by an individual who is not actually a member of a profession. Wilensky (1964) noted the increasing trend for many occupations to become professionalized, a phenomenon reiterated by Dent and Whitehead (2002). Alternatively, the term 'professional' may indicate paid as opposed to amateur (unpaid) status (Freidson 1986), with both positive and negative connotations. To avoid confusion, throughout this thesis 'a professional' will be used to denote a member of an established profession.

The essence of the individual 'professional' and collective 'profession' are inextricably linked. Welie (2004a) and others have stressed the importance of a professional providing their services as a member of a profession and not as an independent practitioner, with the profession and its recognised standing in society adding weight to the relationship of trust which a patient or client may place in the individual practitioner concerned, and in the legitimacy of their practice (Dent and Whitehead 2002).

Early research on the professions was concentrated on the development of 'Trait theories', attempting to identify the key distinguishing features of an 'ideal type' profession, and heavily based on medicine and law (Johnson 1972). Common defining features included:

- Expertise
- Power
- Collegiality
- Autonomy
- Self-regulation
- Standards and training
- Professional associations

This type of approach sought to distinguish the professions from other occupational groups, and Hickson and Thomas (1969) found that the older traditional professions scored highly on those factors taken to characterise a profession. O'Day (1987) questioned the value of comparative studies based on features or traits which the modern professions might share, and thought it inappropriate to apply a system of measurement based upon these traits in order to gauge 'profession-ness' through attempting to produce a tangible measure of the intangible factors involved. In an interactionist approach the professions were viewed as part of a wider social classification of occupations, with differences of degree rather than kind (for example, Abbott 1988), while in the functionalist approach adopted by Parsons

(1951) and others, an attempt was made to relate behaviour to the functional relevance of the professions for society, in an effort to produce more socially relevant theory (Johnson 1972).

There appears to be a consensus view that each profession emerges and subsequently recedes at certain points in its development, and it could thus be argued that perhaps the distinction between an occupation and a profession might also shift with time. This would seem pertinent in the currently observed situation where new professions are being 'created' through legal changes, registration and the formation of new professional bodies, for example in healthcare and accountancy. The established professions are being challenged through the creation of these new professional groups, and there are clear implications for the development of and changes to the relationships between the individuals and groups concerned. Jackson (1970) discussed at some length the question of whether a profession might be a particular type of occupational group with characteristics not shared by others, especially in the context of the rapid growth in the range and number of professions in the 19th and 20th centuries[3]. Jackson felt that assumptions had been based on our limited knowledge and experience of the professions in western society and their rise since the industrial revolution. This had been closely associated with the rise of the universities as 'institutions of the intellectual' that were in a position to legitimise authority and competence (Jackson 1970:4)[4]. While professionals were originally set apart by their gentlemanly status, from the 19th century it was their scientific knowledge and qualifications that distinguished them from the rest of society. Fournier (2000) felt that a professional service should be 'rendered' rather than sold, with professionals set apart from managers by their commitment to the public good rather than to the good of the organisation.

The professions are thus held to be distinct by virtue of their services being of interest and relevance to all humankind through their universal need for wellbeing (Ackroyd 1996), an argument which is particularly pertinent in healthcare. Etzioni (1969) perceived a close association between professionals and serious life and death matters. Corfield (1995) indicated that in the 19th century "the professions

[3] In the UK and Western Europe, the terms 'occupation' and 'profession' were used interchangeably until the 19th century (Corfield, 1995), and in Eastern Europe this continued until the 1960s.

[4] Jackson (1970) likened the issue of occupation versus profession to the case of cult versus established religion in terms of the degree to which an occupation might be considered a profession, and suggested that we should not be asking if an occupation is a profession, but to what extent it exhibits characteristics of professionalisation, whilst also recognising that this will vary in time and circumstance. He felt that it was important to acknowledge the way in which the role is perceived in the generalised systems of knowledge and ideology.

represented the power of human knowledge in application to the service of humanity" (p.37). This essence of a vocational calling has been strongly associated with professional practice, to provide a service for the greater good with commitment to ethical and moral values. Historically this has been enacted through a social contract between a profession and society, be it implicit or explicit, by which a profession was granted the rights of autonomy and self-regulation, in return for which it was expected to be accountable to those served. Both the individual and collective aspects of autonomy were deemed to be important in terms of political, economic and technical autonomy (Elston 1991), and for their implications in power and trust relationships with both clients and other professionals. Autonomy over practice and the dominance of the professions over other occupational groups were recognised as key issues in the UK public sector in the early 1990s by Ferlie et al (1996).

This service ideal of the professional has been considered of key importance to their status (Jackson 1970). Should it then be assumed that professionals are more charitable or interested in their fellow men than anyone else, or that their services are equally valued by all sections of society? (Johnson 1972). During the last century, concerns which affected a wider population appear to have been more highly valued than short-term issues, whereas in the Western world we are now seeing a rise in a self-centred attitude, where an increasing number of individuals appear in many respects to value their own health and well-being over those of the population and global community. This may well be in response to political and media pressures placing individuals at the heart of public and commercial services, and raising the expectation that everyone can obtain such services quickly and in some cases for minimal personal cost. This has undoubtedly had an impact on the role of professionals in this country, particularly in the public sector, who have a duty to society as well as to the patient or client of immediate concern.

According to Freidson (1986), professions differ from occupations through being based on some form of higher learning which is of special interest to society, thus giving professional work a more superior status to the work of trades or commerce. Professionals are deemed to have expert knowledge that affects all, but that is restricted to an exclusive number of individuals, thus promoting their air of mystery and separating them from the mundane. This view of the professions has been reinforced by many of their activities being considered taboo to the rest of society, for example the dissection of cadavers, and intimate personal knowledge and examination of clients. Abbott (1988) believed that professional tasks had a

subjective nature and that three acts comprised the cultural logic of professional practice:

1. **Diagnosis**: the process by which information enters the professional knowledge system via colligation (forming a picture of the client using appropriate rules to determine what is relevant/irrelevant, valid/invalid and levels of ambiguity) and classification (referring to the dictionary of professional legitimate problems) to determine what the problem is and whether it falls under the field of practice of the particular profession's jurisdiction.
2. **Treatment**: where results are given to the client and a prescription offered (though the client may not be willing to accept it).
3. **Inference**: the process which takes place "when the connection between diagnosis and treatment is obscure" (p.49) in which the professional infers solutions to the problem.

It was thus thought to be the diagnostic and inferential aspects of the process that conferred special status to professional work. The construction of an air of mystery and the importance of an element of intuition and talent that could not be taught thus become boundary markers for 'the profession' (Fournier 2000).

Professionals historically became powerful by virtue of exercising the authority of the 'expert'. This term came into usage as a noun in the eighteenth century, having previously been used only as an adjective (Freidson 1986)[5]. Torstendahl (1990a) considered that 'professionalism' was bound to the English language and the society "where its social reality and conceptual subtlety were formed together" (p.59). Professionals were seen to operate in close proximity to their clients, unlike the titled gentry of unquestionable status who were just viewed from afar. This new collective of 'experts' were thus subject to public scrutiny at the closest quarters, and regarded not only with awe but also subject to suspicion and satire (Corfield 1995). The boundaries of knowledge were set by and for the profession, enabling the establishment of a monopoly of practice in their particular field, though encompassing a shifting rather than static body of knowledge. This establishment of legal monopoly was a feature strongly associated with the rising power of the traditional professions (Larson 1977). Schumpeter (1951) viewed the professions in terms of their monopoly over certain resources (including knowledge) which were appropriate to certain social needs. He also agreed that the professions had developed their niche through the process of mystification, which included the generation of further knowledge through practice and research.

[5] It is clear that there were problems of translation between European languages of associated terms such as expert, professional and intelligentsia (Freidson 1986; Beckman 1990).

Etzioni (1969) considered this generation of new knowledge (as opposed to the transmission of existing knowledge) to be of relevance to the social construct of a profession. Freidson (1986) discussed the relationship of the professions with formal knowledge and considered that knowledge must have a human agent or carrier to have any impact. Subtle differences existed between the 'intelligentsia' of Eastern Europe who were regarded as disseminators of formal knowledge, and the 'intellectuals' of Western Europe who were concerned with knowledge that transcends daily practical life in the form of ideas rather than systemic knowledge, distinguishing between the distribution of knowledge by the former and the creation of new knowledge by the latter. Freidson concluded that professionals are 'agents of formal knowledge' (p.15) in the form of practitioners, and not intellectuals *per se* (although some may fulfil both roles), and linked the concept of a profession with gaining a living though the practical application of knowledge of an intellectual and theoretical nature, rather than directly with the generation of new knowledge *per se* (Freidson 1986).

Jackson (1970) suggested that the degree of professionalism in an occupation could be judged by the extent to which sacred mysteries are part of the profession and effectively passed on through appropriate training, as in Law, Medicine and Theology. He considered that professionals were indeed the *cognoscenti* of 'sacred knowledge', which they acquired through their formal academic training, together with elements of socialisation and initiation. Experience and apprenticeship gave further specialisation and indoctrination of the professional mystique, which was associated also with the development of a set of attitudes appropriate to different audiences such as laymen, other professionals, and assistants, through which the full role-set of a professional was defined.

In addition to the acquisition of theoretical, factual, and practical knowledge and skills, extensive vocational training is thus regarded as being in the general tradition of the professions. Professions such as medicine might have originally developed outside of the universities through guild-like structures, perhaps because the practical aspects of the discipline were in conflict with a strictly rational intellectual approach. While Oxford and Cambridge universities were founded around theology, others such as Edinburgh University later developed around successful medical and law schools, as universities became able to combine the wisdom and learning aspects of the professions with the practical training. These particular disciplines then became more than merely crafts, the universities adding "lustre and supra-

authority to ideals of detachment" through a service ethic acting in the public- rather than self-interest (Jackson 1970:4). University training for professionals therefore became the norm, but Jackson highlighted the inherent tensions between the academic and practical aspects of the training process - between the pursuit of objective knowledge and the art of its effective application in practice. Others such as Etzioni (1969) were extremely proscriptive, in defining a profession as requiring five or more years of formal training.

The power balance in the professions was considered by Corfield (1995) in her historical account of 'Power and the Professions in Britain 1700-1850', and the development of the 'new professions' proved to be an area of considerable interest in this respect. As occupational groups continue to aspire to the standards and characteristics of established professions, the implication is that to be a member of a profession must still be considered a desirable status to attain (Etzioni 1969).

2.3.1 Attributes of the Professions

The sociological literature is rich with further indications of the characteristics associated with the professions, in addition to the altruism, expert knowledge and autonomy already identified. It is assumed that the acquisition, possession, and defence of these characteristics will affect and influence the behaviour and response of a profession presented with an external challenge which might compromise its role in society, especially in terms of its autonomy and status.

In a functionalist tradition, the relevance of the professions to society was considered. Barber (1963) studied professional behaviour which he defined in terms of four essential attributes:

1. a high degree of generalised and systematic knowledge
2. a primary orientation to community- rather than self-interest
3. a high degree of self-control of behaviour through an internalised code of ethics by organised voluntary associations
4. a system of rewards which primarily symbolise work achievement.

The use of knowledge which might be considered to be controlling was in this respect linked to the need to benefit the community, rather than self-interest. It is postulated that only professionals themselves know and understand the implications of their practices, hence the justification of self-regulation, and society consequently

rewards such a highly valued service with both money and honour, the latter being an end in itself and not a means to reward individual self-interest[6].

This raises the notion that reward for professionals is not linked directly to financial gain but to work achievement in a symbolic form. In reality, however, there might also be an expectation of a reasonable lifetime earnings, compensating for the long and expensive training. The work of professionals has traditionally entailed a high degree of trust, which was in turn linked to a reasonable level of income, although historically many in the church in particular worked for paltry sums. Their professional status then depended upon factors beyond financial reward, and appears to have rested mainly on their shared specialist knowledge. Johnson (1972) considered that the development of a shared set of central values was key to the rise in society of the professions, and that the relationships of professionals to their clients was of paramount importance to their continued elevated status in society.

Johnson (1972) challenged the prevailing functionalist ideas of his time in offering a very particular view of the concept of 'professionalism' which he defined in terms of the institutionalised power which a profession exerted over its members, rather than of its power over society. This highlighted the importance of power and control in relation to the professions, and the influence that the changing distribution of power in society would have on the professional/client relationship, issues which were largely ignored by the functionalists who tended not to look beyond the profession itself in their enquiries.

The professions' use of jargon, air of mystery, and success at creating a well-guarded monopoly, were perhaps resented by those who were not 'in the know', leading to an increased sense of distrust and suspicion of professionals and the way they conducted themselves (Corfield 1995). This is reflected in a modern context through the reported distrust of 'professionals' operating in a community context where education and credentials are viewed with suspicion rather than with respect (Deverell and Sharma 2000). The traditional professions have been publicly mocked and subject to satire for centuries, which originally stimulated the need to regulate those who overstretched the boundaries of public expectations of behaviour and conduct (Corfield 1995). Self-regulation became a central feature of all the established professions in order to maintain respect for their social status, which was in itself a highly valued element of their reward system. Johnson (1972) also

[6] Businessmen on the other hand are seen to be satisfied with purely financial rewards (Johnson 1972).

linked the need for regulation to the need to reduce uncertainty and increase trust and legitimacy, particularly when a professional was the most dominant partner in the professional-client relationship.

Denzin (1968) presented the idea that professions were like social movements in that:

> *"..they recruit only certain types of persons, they develop highly elaborate ideologies and supra-individual values, they have their own mechanisms of socialisation and they often attempt to proselytise and bring new persons into the fold."* *(Denzin 1968:376)*

Goldthorpe et al (1968) extended this concept of a profession as a social movement, proposing that a professional should be work-orientated to the highest degree, with a code of ethics and ideology extending beyond the workplace into their social status and lifestyle. A professional such as a doctor or clergyman was traditionally expected to be 'on duty' 24 hours a day, though more recently this has been challenged through social, legal and political pressures, and altered expectations in terms of work/life balance from both professionals, clients and regulatory bodies. The extension of behavioural codes into spheres of life outside of professional practice is a recurring theme in the literature (Johnson 1972; Corfield 1995). Conflicts between devotion to public duty, private life and political power struggles have been reflected in changes to public sector contracts for health professionals in the last decade[7]. The scandal over MPs expenses in the UK in 2009[8] has highlighted the strength of public feeling with regard to the standards of behaviour expected from those entrusted with the public good, who are still expected to behave in accordance with a certain (unwritten) code of conduct in order to command and maintain public respect and trust.

Professions have in the past developed some active degree of protection against the uninitiated learning their sacred knowledge, and in clearly defining the boundaries between those inside and outside of 'the walled garden' (Jackson 1970). This corresponds to Feld's primitive type of military organisation, where all outside of the organisation was seen as negative, dangerous and potentially corrupting to the *cognoscenti*. This opposes a competitively orientated model which accepts equally rational competitors in the same field outside of an organisation. In the last two decades this monopoly of knowledge has perhaps been threatened by global

[7] For example with GPs on-call and out-of-hours commitments initially reduced, then increased again due to political pressures and raised public expectations of 24/7 service.
[8] Over a hundred UK MPs were asked to pay back expenses totalling over £1 million which had been wrongly claimed, with 3 MPs being charged with fraud over their claims.

communication through the internet, which has opened up previously closed sources of knowledge in most professions, presenting a formidable challenge to the maintenance of their mysterious and sacred aspects. It could however be argued that it is the interpretation and application of the knowledge which sets the professionals apart from the laymen, and this distinction may now become more evident. In professions where a high degree of implicit practical skill is involved in the application of knowledge in professional practice, as in many of the healthcare professions, it seems unlikely that non-professionals or computers will make significant inroads into the delivery of the practical elements of the services in the future, though the diagnostic and decision-making elements of practice are already affected to a degree.

Fournier (2000) recognised two boundary setting practices relating to the field of knowledge for any profession; firstly, the establishment of an independent and self-contained field of knowledge for the profession; and secondly, the 'labour of division' which erected and maintained the boundaries between professional communities. This was viewed as an ongoing, reversible and constructive practice, with the field of professional jurisdiction created and maintained through constant effort of the professionals concerned. Abbott (1988) described a notion of 'cultural work' in which professions sought to employ strategies which manipulated their systems of knowledge to ensure that certain problems fell within their area of jurisdiction, thereby preserving their exclusive claim to competence over their 'chunk of the world' (p.9). Practice was thus restricted to historically and culturally defined boundaries, allowing the professions to achieve 'double closure' while retaining a considerable ability to adapt to change (Ackroyd 1996).

The attributes identified and discussed in the preceding section point towards a profession actively working to maintain its status in society, and it must be assumed that by so doing it wishes to maintain control over its practice and exercise corresponding power over at least some section of society. The issues of boundaries and monopoly status are clearly interlinked, as are those of autonomy, authority and trust. Many studies have concentrated on the collegiality, and the boundary and control issues with regard to the professions, through closure theory and the strategies adopted by professional groups to achieve control (Collins 1979; Ackroyd 1996; Fournier 2000). Turner and Hodge (1970) developed a discussion of the power implications of the control of resources by professionals. Yet others have examined the implications of the differences between the altruistic goals of professionals and those of the organisation (Harries-Jenkins 1970; Grey and

Garsten 2001). The potential conflict between commercial and professional practice has been raised more recently, especially in the light of an increasingly competitive work ethic in the public sector (Reed 1996; Ferlie et al 1996) and in healthcare delivery in particular (Welie 2004a; Dancer and Taylor 2007).

Hanlon (1997; 1998) described the internal divisions occurring within the more traditional professions which was becoming evident in the 1990s, based not only on the private-public sector divide but on the adherence of individuals to a social service ethos of professionalism, against a rising tide of 'commercialised professionalism'. The individualistic professionalism of the 19th century which serviced those who could pay, was replaced early in the 20th century by a social service ideology in which the professions willingly provided services for the whole of society based on need, but only if adequately remunerated by the state. In this relationship they enjoyed the power to control state resources and increase the legitimacy of their cultural capital and position in society. However, from the 1980s a new 'commercialised professionalism' emerged with the need for increased managerial and entrepreneurial skills, initially in areas such as accountancy and law (Hanlon 1997), but also spreading to the welfare sectors through policy to increase competition and market forces. Hanlon (1998) argued that the ability to create a profit and attract new business become paramount in professional success, giving the client a powerful voice in tailoring the service and forcing the traditional professions to become more subservient to management professionals who control their working practices through resource allocation. Hanlon (1998) strongly believed that the professionals who benefit from policy and socio-economic changes are those who subscribe to the new commercialised professionalism, who prioritise profit and are driven by a commercial rather than a technical logic.

How then is the authority of a professional recognised by society at large? Harries-Jenkins (1970) argued that their authority base did not appear to be derived from a Weberian model of bureaucratic organisations, nor from models of traditional or charismatic authority. Halsey is reported to have suggested that professional authority was enjoyed "by those who have been appointed to a 'sphere of competence' on the basis of qualifications attested by a professional group of peers, with the development of 'a kind of group charisma'" (Jackson 1970:9). This led to a situation where professionals were absolved from justifying their decisions in terms of theory, fact or value, with their expertise removing them from the control of superiors, and an external recognition conferred upon them of their sole right of competent judgement in their field (Turner and Hodge 1970). There has been a

marked change in this respect in the last two decades with increased demands for public accountability, in the light of public reports and prosecutions as a consequence of poor professional performance, especially in medicine[9].

This discussion of the attributes commonly associated with the professions reveals many issues related to their particular status and the means by which they have been able to successfully construct and maintain such a unique and relatively powerful position in society. In addition to the altruism, expertise and autonomy already identified, sociologists appear to agree on a number of further common characteristics relating to the professions, including their possession of a shared set of values and code of conduct, their setting and maintenance of professional boundaries, their social status conferring a degree of power and control, and traditional acknowledgment of their authority through a public demonstration of trust in granting self-regulatory powers. A number of potential conflicts and tensions have also become evident, such as the potential conflict between professional and business values, and the balance of interests between the professions and the society they serve.

Three main themes appear to have come to light. Firstly, the requirement for a formalised degree of learning and the acquisition of expert knowledge, enabling the practical application of theoretical knowledge. This appears to be closely linked to its arcane air of mystery, being key to the maintenance of power in professional relationships entered into, which in turn maintains the professions' unique status in society. Secondly, extending the boundaries of the professional field through the generation of new knowledge which can be guarded by the profession, which is intimately related to the sustenance of monopoly power and status in these relationships. Thirdly, the emerging conflicts of interest experienced by the professions related to the balance between self-interest and those of the society they serve, which may be made more complex still by the business and funding issues associated with the provision of professional services.

An interest in acquiring professional status apparently remains in contemporary society, despite the perception that professional status is currently being undermined in the UK. It is evident from this discussion that 'a profession' is a dynamic and complex social construct which has developed only in certain societies at a particular time, but successfully persists in our own culture. Having identified

[9] In particular, the cases of the serial murderer Dr Harold Shipman, the illegal retention of human specimens at Alder Hey Children's Hospital and high mortality rates of the Bristol Paediatric Cardiac surgeons.

the salient features of the present construct, the following section will seek to explore the process through which this construct has come into being. This detailed historical study of the development of the three traditional professions seeks to expose the circumstances and processes that enabled the social construct to become established, and to be modified and maintained throughout a number of centuries, while sustaining the altruism, expertise, autonomy and other characteristics that we might still recognise in the contemporary professions of the modern age. By this means a deeper understanding will be gained of the professions' recent and ongoing responses to change that have allowed the construct to survive.

2.4 Historiography of the professions

The literature has imparted an image of professionals who originated often from privileged backgrounds, associated with university learning and who enjoyed an elevated status in society. Accomplished learning and expertise afforded respect and trust, and the professions appeared in a position of strength and control. However, in our modern era, elements of distrust and excessive personal expectations of service have evidently altered the balance of power between professional and client, especially over the last 20 years. This change has not come about overnight, and the professions we now recognise as the modern counterparts of the traditional professions are certainly altered, but perhaps not unrecognisably.

The process by which a profession comes into being could be considered as the division of labour and consequent specialisation, leading to succession by ability (resulting in greater efficiency) rather than the traditional succession by inheritance (leading to stability) (Turner and Hodge 1970). The need for closer co-operation, control and resource management become crucial factors for effective and efficient practice in this type of system, with particular issues arising in relation to power balances and the management of expert groups (Johnson 1972). O'Day (1987) suggests that it might be beneficial to study the differences as well as the similarities between the professions, and that the social relations of a profession, including status and lifestyle, should be considered alongside the organisation and institutional aspects of its growth and development, and the functions that it performed. Torstendahl (1990a) outlined three ways in which the professions might be studied, the first of which was through an examination of their history in order to determine their place in society, the character of the professions, and of professionalism and professionalisation.

We must not be bound by our own constructionist perception of 'a profession' based only on our cultural background and experiences during our lifetime, when it is clear that these communities are dynamic and have existed in many changing forms for the past few centuries. Any response to change at the present time must be considered in the context of their previous forms and responses. By this means we might gain further insight into how the professions have responded to change, particularly with regard to their relationships with the state and their clients.

It must be acknowledged that the accounts by Corfield (1995), O'Day (1987), Prest (1987), and Carr-Saunders and Wilson (1933) proved to be particularly helpful in the preparation of these historical accounts. Space precludes the inclusion of the full narrative accounts of this study which are contained in Appendix A. A tabulated summary of the main aspects of each of the learned professions' development is given in Table 2.1. This is followed by an analysis of this historiographical material in order to contextualise the current forms of the professions and determine key aspects of their development thus far.

The Clergy in England appears to have encountered similar threats that might be perceived to challenge the professions today. Prest (1987b) argued that the clergy never regained their prestigious and privileged position after the Reformation and this might well have contributed to the longer-term demise of the clergy as one of the main professions in Britain. As the apparent origin of and template for the professions in the UK, the clergy has exhibited monopoly power, status, learning, registration, and the formation of professional groups. It has also demonstrated that a slow response to a changing social and political context, with entrenched structural and cultural elements, combined with declining demands for its services and challenge from other professional groups, has led to its loss of power and professional jurisdiction, and ultimately its demise in terms of its power and status in society.

The legal profession grew in power and wealth from the 17th century onwards and has continued to be disproportionately associated with dominance in public life (Prest 1987b). It has originated both from the university-educated aristocracy and the educated gentlemen of the middle classes, and has evolved from distinct upper and lower branches which relate in terms of mutual respect. It established a professional body which continues to perform a regulatory role, and educational

Table 2.1 Summary of the historical development of the three learned professions

The Clergy	**Origin:** Catholic church, highly structured hierarchy. From upper classes, and increasingly from well-educated lower classes. **Main features:** Altruism, ethical and exemplary behaviour, highly educated to degree level and intimately linked with universities. **Structure:** Highly hierarchically structured through the established church **Training:** closely linked to universities **Power:** Heavily controlled by the state, universities, and aristocracy, power concentrated at high levels within the profession. High levels of internal control in standards and codes of conduct. **Professional meetings:** from 17th Century **Register:** Clerical Guide to the Church of England 1817 **Symbols:** distinct dress, ceremonial role **Response to change:** Decline after the 1689 Act of Toleration allowed competition from other denominations, notably the Methodists. Pluralistic work challenged by other rising professions in 18th and 19th centuries. Lack of unification. Decline in religious beliefs during 20th century.
Law	**Origin:** the Church, then Inns of Court in London established 15th Century. Barristers from aristocracy, Attorneys from lower classes. **Structure:** divisions between upper branch of Barristers (litigation and advocacy) and lower branch of attorneys (litigation, legal documentation and advice) **Training:** apprenticeships. High levels of learning and applied study. Formal examinations and qualifications from 1729. Articled clerkship training from 1740s. In 1836 Common Law Examination Board established. **Power:** Self regulation from 1740 with those who did not meet standards excluded. **Registration:** Registration lists of practising lawyers from 1740, role taken over, together with regulation, by The Law Society from 1845. **Professional association:** 1740 The 'Society of Gentleman Practisers in the Courts of Law and Equity', by 1792 called itself 'The Law Society'. **Symbols:** Dress, conduct, language (law French and Latin), ceremony. **Response to change:** actively eliminated lay practitioners and amateurs, reacted to poor public perception of profession.
Medicine	**Origin:** The Church, then College of Physicians. **Structure:** Tripartite headed by Physicians from the gentry, Surgeons and Apothecaries (later General Practitioners) (both from the Guilds) Merged successfully with creation of GMC in 1858. Hospitals established in 1800s. **Training:** 1500s College of Physicians established training away from universities, Highly educated. University medical schools in Edinburgh and London, Formal training pathways from 19th century with new medical schools established. **Registration:** Munk's Roll of the College of Physicians in 1518, GMC formed 1858 with regulatory powers **Professional bodies:** College of Physicians 1518, Barber-Surgeons Guild 1540, Apothecaries Company 1617 Medical Journals from 1750s **Professional Association:** The Provincial Medical and Surgical Association formed 1842 became British Medical Association in 1855 **Symbols:** Title of Doctor, dress and conduct **Response to change:** Seeking respectability in face of poor public perceptions. Embracing scientific advances to advance profession. Open profession of altruism.

standards for the profession are set by this body which operates through restricted membership and with the legal authority of the state. Professional practice is self-regulating and autonomous, and the lawyers largely retain independence as self-employed practitioners, without the historical ties and structures of an overarching establishment such as 'the Church'. While they profess to be engaged in providing a

service for the good of their clients and for society as a whole, the altruistic element of the legal profession is perhaps the weakest and least evident of its characteristics.

By the end of the 18th century the medical profession had established strong professional institutions with independence from the state and university systems. By 1850 medicine was based on improved scientific understanding, a range of effective drugs, refined surgical techniques and an accepted classification of disease. Diagnosis was improving rapidly and cases were discussed between colleagues to further understanding and improve practice (Corfield 1995). In the 19th century the professional medical community grew up in strong association with the hospital structures which provided a place for professionals to meet and share their learning and experience, and hospital consultants became the medical elite[10].

The medical profession gained strength through a range of strategies and behaviours in which they successfully combined expert knowledge with a legalised monopoly of practice, elevating themselves to a status in society which commanded respect and trust. By the 20th century they had a well-established internal organisational structure with systems of registration and self-regulation through the General Medical Council (GMC), and a publicly-visible professional organisation in the British Medical Association (BMA). The success of the medical profession was closely allied to the development and acceptance of scientific thinking, and it successfully gained independence from the powers of the church and the universities at an early stage. Ultimately however it returned to a system of university learning supplemented by practical training, but with strict standards of practice determined by the profession itself, and an organisational structure in the hospital service which would later readily lend itself to state control and bureaucratisation in the public services of the 20th century.

2.5 A comparison of the early development of the learned professions

A comparison of the early developmental features of these three learned professions is presented to clarify the similarities and differences between them, in terms of a number of important issues which have emerged from analysis of the full historical accounts in Appendix A.

[10] The establishment of lunatic asylums stimulated further demand for medical services, as part of the 'medicalisation' process which pervaded society in the 19th century.

a. *Structure:* The clergy in early modern times appears to have been the only one of the three professions that already had a firm structure in place with regards to the organisational and hierarchical systems established (and subsequently re-established) at the time of the Reformation. This led to much reduced autonomy for individuals, and heavy dependence on the state in matters of decision-making and changes within the profession. While law and medicine arose from the Church and its structures, both sought to divide themselves from its power at an early stage, and subsequently secured a position of increased autonomy at both the individual and collective levels for their respective members, who in the main practiced as independent practitioners. The subsequent establishment of Royal Colleges in medicine and the Inns of Court in law were under the direct control of the professions themselves, and allowed them to assume further control over training, standards and recruitment, away from the Church-dominated university systems. Law and medicine both established for themselves a professional association, and incorporated a strong collegial element of interaction with peers, but this was not so obvious amongst the clergy who were largely already bound by historical structures within the established church, with little desire to unite or engage with associated professionals outside of this immediate sphere.
b. *Boundaries of professional knowledge and practice:* all three professions have experienced challenges to their fields of practice which stimulated action to define their boundaries and construct defensive measures to maintain them. The introduction of specific entry requirements for the clergy successfully limited access to the profession until legal changes (the 1698 Act of Toleration) allowed a much wider and less defined 'field of practice' which had no specific requirements of entrants in terms of education or gender. The lawyers made very positive efforts to eradicate the practice of 'marginals' who were not *bona fide* members of their profession, through compulsory registration and exorbitant (by the standards of the day) fees for those who wished to practise. In medicine the system of licensing under the Royal College and the effective restructuring of the tripartite profession into a united, and consequently more powerful, single professional community provided extra protection from potential interlopers. Both the law and medicine were forced to explicitly display their altruism and expert learning in order to separate themselves from tradesmen and commercial businessmen. While the clergy were already assumed to hold their practice as a vocation

by its very nature, the need and demand for its services were more questionable.

c. *Symbols:* All three of the professions have engaged in a process of developing a specific professional *persona* that the public could readily identify with them, in terms of dress, language, titles and specific ceremony which were linked to their elevated status in society and their capacity for expert learning beyond the realms of the common layman. All have also been subject to ridicule as a consequence, attracting some measure of public disdain at their behaviour and practices, bringing their motives and values into question. In medicine and law there was a reported perception of distance between the professionals and the clients that they served, which the professionals themselves appeared to have promoted and sought to maintain. The higher echelons of the clergy were almost certainly beyond the reach of the common man, although the lower clerical ranks were in daily contact with their parishioners and not in a financial position to elevate themselves. The initial use of Latin in all three professions can be attributed to their high educational standards in the classics, although they learnt to reduce their dependence on this and other forms of jargon in light of their growing unpopularity and poor public image.

d. *Relationships:* All three professions arose in close conjunction with the established church through the universities in Britain, although law and medicine extricated themselves from this arrangement as soon as they were able to negotiate and maintain a degree of freedom. It is notable that all three of these professions appear to have originally developed from both the upper and lower classes, but that all have some relation to the landed gentry in their origins. This was however far from universal for all recruits to the professions, which each appeared to have developed from an educated branch arising directly from, or by close association with, the gentry, together with a lower branch which developed in parallel from amongst the general population. Thus there are distinct similarities between the upper and lower branches of the law and the tripartite structure of early medicine, both of which were successfully merged into a united structure within the professions themselves, and backed by appropriate legislation. This without doubt aided the establishment and maintenance of a monopoly of practice in their respective fields. Their relationships with clients are not perhaps as autonomous as might be imagined, in that terms were often dictated by their patrons, in respect of the services rendered and the reward deemed appropriate. The differences between the clergy and the other professions

becomes more evident with the development of professional/client relationships in law and medicine, in which competitive bargaining became commonplace and consumers were all-powerful in dictating the reward and quality standards deemed appropriate.

e. *Science and technology:* the role of science and technology sets the medical profession apart from the clergy and law, as a specific factor contributing to its substantial growth during the 19th century, along with the subsequent increased demand for its more effective services and its ability to contribute very visibly to the common good, both directly and through public health measures.

While a number of basic similarities are seen to exist, differences between the professions become more evident as the clergy fail to develop further once effective competition enters their field of practice, apparently bound by archaic structures and systems, and unable to adequately adapt to changing social demands and pressures. The lawyers and medics share more commonalities, and appear to have been more successful in adapting to changes in social and political contexts by virtue of their relative independence. Their main differentiating factor appears to have been in the degree to which they have engaged in commercial versus altruistic practice, and whilst these are not mutually exclusive, the lawyers appear to been more successful in a commercial sense with higher financial reward, while the medics are more commonly associated with vocational aspects of practice. Both have been utilised in effectively elevating and maintaining an increased status in society, and the medics alone were further assisted by the scientific and technological advances of the 19th and 20th centuries.

2.6 Successful Growth of the professions

Continued growth of the professions assumes that their strategies to sustain and perhaps increase their status and power in society have been successful in perpetuating the social construct. The period of the industrial revolution has provided much debate regarding the rapid growth of a number of professions during this period, while others seemed less able to thrive. Larson (1977) proposed a three-stage model of professional evolution relating successive professional formations to those of the dominant mode of production at the time. Her work endorsed the premise that the professions have arisen as part of the complex modernization processes consequent upon industrialisation. Prest (1987a) pointed out that some professions were not robust enough to survive the industrial era, but those that did – including Medicine – were transformed from 'status professionalism'

into 'occupational professionalism'. Some historians regarded professionals before the nineteenth century to have been 'mere genteel parasites' dependent on the patronage of the aristocracy, and considered the existing modern-day professions to be a Victorian creation to serve the increasing needs of the urbanised industrial society, which allowed the professionals greater independence and self-respect (Prest 1987a). Jackson (1970) argued that the growth of the middle classes led to a greater demand for professional services and a wider pool for recruitment, with the increased availability of education and wealth outside of the ruling classes. This expansion of the professions was not without an element of self-interest, perhaps considered at odds with their professed altruistic 'calling'.

Ben-David (1963) suggested that professionals assumed a central place in the class system, and argued that the welfare policies which resulted in better education and health actually promoted the self-interest of professionals, who were interested in social conditions which were optimal for the performance of their activities, in the same way as businessmen and the bourgeoisie promote optimal capitalist conditions. This brought a new twist to the concept of a professional, in that they might infact be manipulating circumstances for their own benefit in financial and business terms, while being seen to be doing good for others. Freidson (1986) noted "the degree to which economic self interest rather than common good can motivate the activities of professionals and their associations", although professionals are usually regarded as "honoured servants of public need" (p.28).

An increase in the number of professions poses further challenge to the construct of 'a professional'. A dichotomy has been used to make a clear distinction between the pre-industrial or traditional professions (the Clergy, Lawyers and Doctors) and the modern professions (Teachers, Accountants, Engineers, Architects etc) that emerged from the 19th century. Social and organisational transformations during the 20th century led to further occupations taking on the characteristics of a profession, in terms of qualification, regulation and maintenance of standards, for example in nursing and computer-related fields of practice. Etzioni (1969) and others would however regard these groups as 'semi-professions' rather than as professions. Prest (1987a) questioned whether definitive stages of development could be determined in the process of professionalisation, and how broadly such a developmental framework could be applied. This issue of professionalisation will be considered in more depth in Section 3.2.1.

Carr-Saunders and Wilson (1933) and others have placed a heavy emphasis on the importance of professionals being granted membership of a qualifying association, and while this has shown to be a feature of the three learned professions described above, many sociologists have questioned the true significance of this aspect of professionalism, arguing that the existence of a professional association has been used as both a defining characteristic of, and a condition necessary for the emergence of, a profession (Johnson 1972). While professionals have often been associated with higher social status, Holmes reported on a group of Englishmen of 'the professions' who permeated all walks of life in the 18th century and were not of any particular class (Prest 1987a). There is still much debate over an adequate explanation for the rise of the professions during industrialisation, and the means by which they gained and sustained their power and status in society[11]. The importance of the rise of the middle classes (Jackson 1970) and of the division of labour as postulated by Durkheim in the 1890s cannot be overlooked, as well as issues of demand and supply.

2.6.1 Professional status in Society

The professions appear to have originated in areas of 'service', which were once thought to be common, servile and undignified. However, a distinction was developed between the higher 'liberal arts' and the more mundane 'mechanical arts' which might be practised, although difficulties still persisted in clearly defining the distinctions, such as those between surgeons and barbers, and apothecaries and doctors (Prest 1987a). The professional occupations were generally characterised by a degree of autonomy allowing a lack of close supervision on a day-to-day basis, and having no tight schedule that had to be adhered to, with most professionals historically enjoying independent self-employed status. In the 20th century this changed somewhat as more became employed in the corporate and public sectors (Ackroyd 1996). While historically there was some subservience to patrons, there was a strong sense of professional autonomy and independence from management, strengthened through contact with other professionals and through forms of double closure in the new model professions, who were largely based within established organisational structures (Ackroyd 1996). This aspect of autonomy has been particularly threatened thorough the introduction of extensive rationalised bureaucratic management in the public sector through the New Public Management (NPM) introduced since the Thatcher era of the 1980s.

[11] Prest places this debate in the arena of social history, on the premise that the professions and their clients straddled several social classes from which they could not operate in isolation (Prest 1987a).

Debate continues regarding the exact status of the professional and their potential for social ascent in the pre-industrial era, given their unique position in relation to the elite, whose class they could associate with but never join (Corfield 1995). They may have constituted a distinct genteel stratum in the 'middling sort' which at least appeared to situate them higher in the rankings than businessmen and industrialists (Prest 1987a)[12]. Increasingly from the 16th century professionals were given the courtesy title 'gentleman' which elevated their social status, despite their lack of aristocratic heritage[13]. The mental capital of expert know-how was one of the professional's most important assets, which made it difficult to classify professionals in socio-economic terms. In the theories of Adam Smith there were three social classes: those who owned land (upper class), those who owned capital (middle class) and those who owned labour (working class). Marx later recognised similar social groupings, and the difficulty in attributing a specific social status to professionals thus persisted (Corfield 1995).

Schumpeter (1951) felt that the status of professionals was determined by their newly created roles, carrying out novel and rapidly expanding social functions, and taking the place of self-made entrepreneurs and noblemen as the occupational ideal of the west. Ackroyd (1996) viewed professionals as the antithesis of entrepreneurs and stressed their defensive stance to change. Prest described the modern professions as:

> *"...middle-class or relatively high status employments which seek to monopolise the provision of certain services based on the presumed mastery of a body of esoteric knowledge."* (Prest 1987a:14)

Prest went on to propose that the only unifying factor in all professions is their ranking in a broad middle class, above the workers and proletariat but below the elite, making the boundaries of what constitutes professional status still more difficult to define. Prest claimed that the impact of the professions upon society was reflected in society's impact upon them and the social relations and roles they enacted, both with clients and with other professional groups. They might have directly contributed to the increasing class distinctions which had widened the structural divisions between the working class and those in the middle and higher echelons, while at the same time providing an opportunity of bridging this gap through social and self-betterment (Prest 1987a)[14].

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[12] Characteristically professional work did not deal in filthy lucre or dirty manual labour, though it was an active occupation.

[13] It should be remembered that titles were important in society at this time, for example with farmers being distinguished by the title of 'Yeoman' if they owned their own land.

[14] A similar argument could be made relating to the introduction of Grammar Schools into the education system in Britain in the 20th century which brought opportunity for social improvement that was previously unattainable for the working classes.

Turner and Hodge (1970) believed that the division of labour applied to all occupations and professions, and that any occupation was capable of developing those elements which we associate with professions, such as a culture, terminology, sets of rules, learning modes and disposition. This begs the question as to why some occupations have developed into a profession while others have not? Etzioni (1969) alleged (perhaps rather patronisingly) that a number of the 'semi-professions' knew that they didn't actually deserve the professional status that they outwardly aspired to. Deverell and Sharma (2000) discussed the problems of healthcare semi-professionals adopting a 'professional' stance when working in a present day community context, where this may prove to be disadvantageous in terms of the tensions and distance created in their working relationships[15]. Some of the workers in the group of HIV community workers in their study did not wish to adopt the title of 'professional', as they felt it to be counter-productive in their work.

The more traditional idea of a professional deliberately creating distance between self and client to provide impartial service and thereby command respect is thus brought into question, together with the need for formal education and knowledge as opposed to personal experience, and it could be argued that these differences might constitute some of the differentiating features between the semi-professions and true professions. The majority of professions have developed formal protective associations, guilds or trade unions to institutionalise a given position in the occupational structure, which has further defined the relationship between a profession and the wider social structure, though many occupations have also developed similar associations without being regarded as professions.

Hierarchical structures appear to have developed within professional groups, adding a further dimension to professional status. In a profession like the military, those who perform duties which only relate to the military, such as cavalry and infantry, may be viewed as having higher status than those who perform tasks also performed outside, such as medics, administrators, and so on. The same situation has existed in medicine where specialists in the hierarchical hospital structures have been ranked more highly than General Practitioners and nursing staff, who might be considered to deal with the profane and to perform functions not substantially different to other non-professional carers (Jackson 1970).

[15] They suggested that in these groups it is more important to develop a peer type of relationship with a client which is based on shared identity and experiences.

Jackson considered that teaching had been an unsuccessful profession in that it had failed to achieve and sustain its status in the monopolistic form that is associated with law and medicine.[16] Those teaching in universities have traditionally been ranked more highly in status than those teaching in schools, on the basis that they are teaching selected students in specialist subjects, and that their ultimate function is in furthering the boundaries of knowledge through carrying out research in a very specialised field. At the other end of the spectrum, it could be considered that primary school teachers teach everyone what everyone knows (Jackson 1970).

Much of the resistance to change from within the professions has been based on the maintenance of professional status and authority within society. There may be a substantial element of self-interest opposing the change, challenging the authority and privilege of those who act externally in political, managerial or administrative roles to bring about the changes affecting the professions. The question thus arises of who might be best placed to develop the professions and their practices for the future, when professionals' individual self-interest and those of the collective profession are perhaps in conflict with the needs of society?

2.7 Survival of the professions

In the previous sections the origins of the social construct of 'a profession' have been explored through the early sociological work of the trait and functionalist theorists and historical accounts of the development of the learned professions, illustrating the professions' successful responses to challenge during their historical development. While the professions originated in association with the genteel classes, it is evident from the preceding discussion that many professionals also originated from a more lowly background than the university-educated elite[17], and that the professions should thus be placed in a socio-structural context which appreciates the full importance of a range of cultural and attitudinal factors to the development of professional status. Prest (1987a) examined the differences between the professions of the 14th to 18th centuries for similarities and differences to their more modern counterparts, and observed that pre-industrial professionals were heavily dependent on their patrons and adopted their patrons' values as their own. This could be likened to the 20th century trend of increasing numbers of

[16] Derived from the church, Jackson (1970) felt that teaching had lost its mystique as the duties its members performed were within the general competence of all who had been taught themselves, and the high number of women in the profession historically was further thought to have compromised its social status.

[17] The majority of those engaged in professional practice in the 1600s were actually from the non-gentle classes, and the numbers recruited from the elite dwindled considerably over the following two centuries. Even amongst the elite barristers, only half were derived from noble blood and could truly deserve the title 'Esquire'. In other quasi-professions such as the profession of arms (the military), changes were being brought about by the release of commissions which had previously been the sole regard of the gentry, allowing 'commoners' access to officer ranks.

professionals being engaged as employees in organisations rather than as independent practitioners (Harries-Jenkins 1976; Ackroyd 1996), and the subsequent change in relations between the professions and the state in the public sector (Johnson 1972).

The assumption that a mass market for professional services only arose during the industrial era appears flawed, as there was already widespread service to the poor and lower classes by the clergy and medical professions in the early modern period. It would appear that there has always been a wide social scope for recruits into the professions and for their clientele, and that this is not a new phenomenon. Prest (1987a) argued that social and cultural factors have been more important than economic and political pressures in confirming the distinction between the learned arts and mechanical trades, and that this had been strengthened by continued, albeit dwindling, recruitment from the genteel classes.

The professions appear to have consolidated their powers through a process of 'professionalisation', which sparked suspicion and apprehension in their client groups who were somewhat in awe of their specialist powers and expertise. Closed membership has been another distinguishing feature of the professions that has elicited concern from society[18]. Why then have the professions survived while the powerful trade guilds failed to maintain their monopoly status? It is clear from the accounts given (see Appendix A) that in early modern times the majority of practising professionals lacked any formal qualifications or standardised training, and were not particularly institutionalised. The professions however successfully managed to maintain their aura of mystery in order to safeguard their position of power, and this is reflected in their continued cohesive closed membership with access restricted to those 'in the know'. This air of secrecy and mysteriousness is still to an extent endorsed by the use of arcane language and technical jargon which is not easily accessible to the lay public, and is as important as their actual knowledge and expertise in relation to the social acceptance of their claims to power (Corfield 1995). The increased perceived value of implicit expertise and the transition to a service and knowledge economy in the 20th century has also enhanced this position.

The symbols of dress and behaviour appear more latterly to have been challenged, as society's expectations of professionals have become more explicit and perhaps

[18] This was especially so in the early modern period, when craft guilds and trade companies determined very successfully who could pursue a particular living in a certain area

less respectful of inherited traditions. The use of appropriate garb is still used to match client expectations to their roles, but the more informal social standards of dress and the increasing need to favour function over professional fads has led, for example, to the recent loss of white coats for doctors in NHS hospitals[19].

The expansion and elevation of the learned professions appears then to have been dependent on a complex interplay between social and economic factors, and could not be entirely determined by the ambitions of the professions alone in terms of power, money or social status. In 18th century Britain newly emerging authority figures were recognised as such because of their professional standing rather than through their money, birth or title. This was a cultural shift of long-term importance, and Corfield argues that this was not planned or centrally directed by the state. Much of the etiquette and convention associated with the professions was established purely by custom within the professions themselves, but their status has without doubt been endorsed through timely interventions by government policy and legislation (Corfield 1995)[20]. There appears however to have been no overarching government policy directing the development and regulation of the professions, which continued virtually independent of intervention in an organic and unrestricted manner until relatively recent times in the 20th century.

Abbott (1988) indicated that great cultural changes accompanied the growth of the professions, especially with regard to growth in the volume and complexity of their professional knowledge, the emergence of new claims to the legitimacy of that knowledge, and the rise of the universities. Growth in the 'powerful trinity' of the learned professions led to a sizable expansion in the professions over time, with the lawyers multiplying most prolifically in the 17th century. In 1700 Gregory King estimated that there were 28,000 professionals in England and Wales[21].

At the beginning of the 18th century the number of professions was growing, with a multiplication of service specialisms in areas such as accountancy, science and engineering, and the recognition that mechanisms would be desirable to regulate their numbers, qualifications and performance. By the mid-18th century there had been a sizeable increase in the numbers of lawyers, and by the early 19th century

[19] Wigs and gowns provided an identifiable dress code for the legal profession that until relatively recently remained constant, reinforcing an image of respectability and trustworthiness.
[20] The government has however at certain times demonstrated its willingness to intervene in an *ad hoc* manner in order to endorse reform, as in the passing of Acts of Parliament to regulate membership and training, for example the 1729 Act for the Regulation of Attorneys and Solicitors.
[21] 10,000 'Persons of the Law', 10,000 clerics and 8,000 doctors. Teachers were struggling to attain professional status, and military and naval men were rising as a new and powerful swashbuckling group of the 'professions at arms', with their own jargon, customs and dress (Corfield 1995). However, as already noted, occupational pluralism was not uncommon with much part-time practice across professional and occupational fields of work.

substantial numbers of teachers were recorded, boosting the number of professionals overall to an estimate of 84,300 in 1803 (Corfield 1995)[22]. Thus the professions became substantially more socially visible in terms of their numerical presence in society during this period in time[23]. The diverse nature of the statistics recorded makes it difficult to gauge the growth of the professions in real terms, but there is no doubt that overall this group experienced significant growth throughout the 19th century (Corfield 1995)[24].

It would appear that each profession has enjoyed its own unique periods of strength and power in its development, and that this is dependent on the complex mix of social, economic, political and, in some cases, technological factors which have contributed to the particular context in which the profession was operating at that point in time. It could similarly be argued that perhaps the divide between the social constructs of 'an occupation' and 'a profession', or between different professions, have also shifted with time and this has contributed to the creation of new professions through legal changes, registration and the formation of new professional bodies. As the established professions continue to adapt and in many cases proactively change in response to the creation of these new professional communities, there are clear implications for the development of and changes to the relationships between the individuals and collectives concerned.

This closer consideration of the historical origins and early development of the professions up to the 20th century has brought to light a number of surprising issues that challenge our own social construct of a profession: that professionals were restricted in their practice by the wishes of their patrons and clients; that patients 'shopped around' and dictated their own treatments, withholding payment if they were not satisfactorily cured; that a wide range of practitioners provided professional services, many of them unqualified; that internal structures and hierarchies existed in the professions as they evolved; that written examinations are a relatively recent development; that much of the past training for professionals was *ad hoc* and of an

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[22] This totalled more than the number of landed gentry, and also more than the total number of shopkeepers and tradesmen in the UK at that time.

[23] In 19th century Ireland, with its own historical context based very much on land ownership and its associated power in politics, the Land Stewards and Agents became a major 'professional' force to be reckoned with. They equalled the numbers of clerics in 1851, and certainly outstripped them in terms of the power they wielded on behalf of absentee landlords. Scotland on the other hand saw a dramatic growth in the medical profession, as Edinburgh Medical School, launched in 1726, became an international institution attracting many Europeans to their studies

[24] Law, religion and medicine thrived across the UK as the senior professions, accounting for 42% of all men engaged in professional occupations in England and Wales in the census of 1851. 32% in Ireland. School teachers at that time accounted for a further 12% in England, 18% in Scotland and 22% in Ireland – where there were no accountants, but there were 2000 musicians! Despite this extensive growth, the professions only accounted for 3.9% of the males with occupations in England and Wales, and less still in Scotland and Ireland. In 1881 Perkin estimated that the ten leading professions accounted for 2.1% of all men with occupations in England and Wales, rising to 2.6% in 1911, although this did not include the accountants and engineers who would have been undergoing significant growth in numbers in the Victorian era.

apprenticeship nature; and that contracting and business practices have been essential to the dealings of the professions for centuries.

Our own reality and interpretation of the concept of a profession has been coloured by the lens of our social and cultural upbringing, which in mid to late 20th century Britain was dominated by the Second World War and the values which arose from the experiences of the population as a consequence – not least rationing, the rebuilding and restructuring of social fabric, respect for those who acted for the greater good and who put others before their own needs, and the growth of public services with the promotion of the Welfare State and particularly the inception of the NHS in 1948. Growth in the expectation that services should remain free at the point of delivery and increasingly tailored to the demands of the consumer have been encouraged by government in the last two decades, and have brought us to the present day, in which the perceived traditional values of the professions are being challenged by a consumerist society with disposable income and a rapidly changing attitude towards their rights as members of society.

2.8 Summary

The broader perspective gained through an exploration of the history associated with the traditional professions in this chapter has provided a deeper insight into the development of the social construct of 'a profession', and the historical means by which a number of the defining features of, and behaviours associated with, the professions may have originated, in order that a particular identity might be related to that social construct. At the same time it has raised a number of further issues regarding the dynamic changes experienced by professionals consequent to social change, and the process, loosely defined as 'professionalisation', by which a profession continues to develop. In the pre-industrial era, a 'profession' encapsulated an ideology which might not withstand direct comparison with contemporary definitions. The practice of applying a linear continuum to determine the development of a profession outside of the specific social and historical context of its growth did not meet with the approval of O'Day (1987), who consequently advises against the direct comparison of the development of the traditional and modern professions.

It has become evident that there is no distinct process through which a particular occupational community has become reified to the social significance of 'a profession' and that the social construct of a profession has attained many of its contemporary characteristics during the historical development of all three of the

learned professions. Clear distinctions as well as similarities have been identified between the processes through which the three learned professions became elevated in status. From a sociological viewpoint this process may be related directly to theories of the division of labour, or there might be some particular combination of characteristics, behaviours and contexts which defines this process as something over and above that which is commonly seen across the development of many other occupational communities. However, the social and economic factors affecting demand for services have been of particular importance to the establishment of the professional communities, together with the advances in science and technology, both indirectly through industrialisation and directly through their practices, affecting the medical profession in particular.

The next chapter will examine the way in which the professionalisation process continues to reflect the responses of the professions to change, and how a professional identity is established and used to strengthen the social construct. This process essentially comprises a profession's ability to accurately gauge its position in society, the challenges it faces and its potential to take effective action, both at an individual and collective level, to deal with change while maintaining its position in society. Much of the challenge inherent in this professionalisation process relates to changes in the relationships of professionals within society. These professional relationships are based on issues of trust, power and control, in turn affecting the autonomy and freedoms of the profession to determine its own regulation and strategies for continued survival. This next chapter will focus particularly on the way in which the professions deal with changes in these relationships, which constitute an apparently essential element in the maintenance of the social construct that sustains 'a profession' as a social reality in modern times.

Chapter 3: Professional Identities and Relationships

Chapter 3 Professional identities and relationships

3.1 Introduction

In the previous chapter, the historical background to the development and growth of the traditional professional groups has provided an insight into the attributes which contribute to the contemporary social construct of a profession, and how the practitioners in these established groups have come together to establish their identities in such a way that they share a range of common values, behaviours and ideologies. It has also highlighted a number of differences between the three traditional professions, including the ways in which they have reacted to challenge in order to maintain their established status in society. The continued responses of the professions to change in the 20th century will now be explored further through the literature concerning the sociology and psychology of the professions, with regard to the continuing process of professionalisation, the establishment of a strong identity for the profession and its members, and the way in which this potentially influences the professions' responses to change. This leads to a consideration of the continuing development of the professions in terms of their strategies to preserve autonomy and control, and the way in which this influences their changing professional relationships to other communities and organisations in society.

3.2 A sociological consideration of the development of the professions

A set of theoretical concepts is outlined in the literature relating to the sociological aspects of the professions, developing further the functionalist approach in looking at behaviour, roles and effects within society into the 20th century. Collins (1990a) has provided a useful summary of the development of the main theories, starting in the 1930s in the context of bureaucratic and political issues relating to the rise of Nazism. In the 1950s Parsons introduced a more altruistic element into his functionalist work on the professions, and issues relating to professionals as experts within bureaucratic organisations came to the fore, with reinforcement of the argument that professionals were driven by their altruistic motives of service and maintenance of standards (Parsons 1951). Later research began to concentrate on the relationship between professionals and organisational authority structures, and studies at this time increasingly sought to go beyond Parsonian functionalism and became concerned with the effect of professions on other social problems and interests, with specific studies relating to medicine and law in particular.

By the 1960s a number of theoretical controversies had emerged and the differences between professions and ordinary occupations became the focus of many studies,

together with 'Professionalisation', the process by which a profession comes into being. Wilensky's article "The Professionalisation of Everyone?" published in 1964 reinforced the link between the professions and power, proposing a model in which certain occupations organised themselves in such a way that they could construct an autonomous power-base. Subsequent work from this period tended to centre on the importance of autonomy and self-regulation.

In the 1960s and 1970s professions were viewed in terms of their status in society and the associated privileges they enjoyed. An interest developed in the historical context, educational attainments and skill-bases of professionals, and Larson (1977) and others proposed a conflict-orientated theory of the professions based on their monopoly status. Collins (1990a) felt that Wilensky's model "of occupational closure based upon power" (p.14) stood at the watershed between the preceding 'classic' theories which attempted to define a profession as a separate phenomenon, and the subsequent 'revisionist' theories, which concentrated on the power and control aspects of the professions (for example Jackson, 1970 and Johnson, 1972). This was developed through work in areas such as monopoly status and credentialism into theories of inequality through social closure (Murphy 1988). Since this period of politically motivated research which sought to undermine the status and power of the professions, a 'post-revisionist' theme has emerged, examining the historical variation between different professions in their developments, across various social and geographical contexts (Collins 1990a).

Figure 3.1 is an attempt to distil the broad scope of the literature on the subject of the professions, to demonstrate the complex range of characteristics and issues that concern and comprise professional communities. It would not be possible to include discussion on such a broad range of subjects in this present thesis. However, in the next section attention will be focused on the process by which new professional communities assert and maintain themselves in this domain which encompasses such a broad range of attributes, and the means by which they have been able to adapt in order to survive the challenges already encountered through their external and internal environments.

The process of professionalisation equates to the professions' responses to change in an historical context. It would be easy to adopt an underlying assumption that professionalisation - which in the present context refers to the process through which a profession comes into being and continues to develop - is a continuous process, and that once started the progress is inevitable. While there do appear to be some common

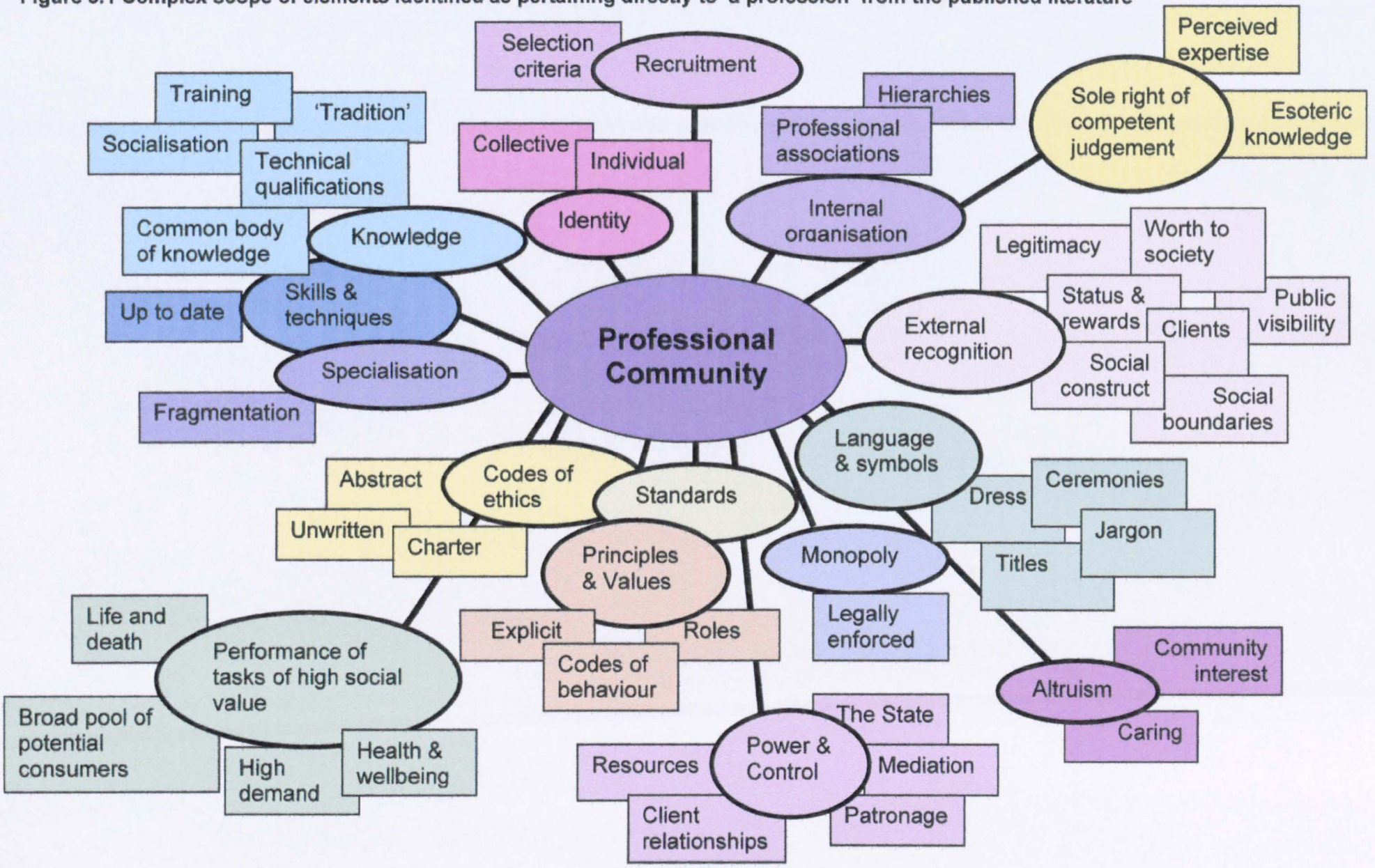
elements of development, as seen in the previous historical consideration of the three learned professions, the process does not appear to have been strictly linear, nor in many respects comparable between them. Instead they appear to have each experienced waves of periodic weakness and strength, influenced heavily by the social and political context of the time and their subsequent responses. At times these communities were sustained only by the strong internal professional institutions they had formed, which provided a tangible unified structure to the profession, or by the state support (often through legislation) which the profession enjoyed at that particular point in time[25].

Professionalisation is often understood to refer to the dynamic process by which an occupation changes certain of its critical characteristics in the direction of a profession (Vollmer and Mills 1966), implying an intentionality in the process. This also assumes that there might be an end point at which the process can be deemed to have been successful (Johnson 1972; Siegrist 1990). This begs the question 'What happens next?' While it has been suggested that the clergy and perhaps the legal profession have passed their respective professional pinnacles, has medicine in the 21st century reached – or as many would suggest, passed - the peak of its own professionalisation process? Is it now in decline, or perhaps merely experiencing a challenge to its power base and status, as it has at times in the past? We might also consider whether medicine represents a controlled unified profession in the modern age, or whether it still reflects its past diversity of roles and origins? (Pelling 1987).

It might be assumed that the professions have the same need for transformation and transition as all modern organizations, which are required to develop in order to survive the challenges presented by a rapidly changing social and economic environment. It would seem both naïve and short-sighted to view the current situation of the professions in isolation from all other organisations that we relate to in society. Professionalisation is clearly a dynamic process of continual change, highly contextually dependent and varied for differing professional communities. An over-view of the sociological perspectives of the development of the professions will provide further insight into the individual and shared aspects the professions, and their proven capacity to cope with change.

[25] Perhaps not unrelated to the fact that Parliament comprised the gentry and professionals rather than commoners at this time.

Figure 3.1 Complex scope of elements identified as pertaining directly to 'a profession' from the published literature



3.2.1 Professionalisation

Prest (1987a) suggested that further efforts should not be made to idealistically determine what a profession should be, but realistically to determine what they actually are and have been. He considered that the identification of certain traits might be helpful in describing the stages of the professionalisation process, which could then be set in the broader context of occupational differentiation and specialisation. Prest however advised that the process should not be viewed as a simple linear progression of development, but perhaps as a process of waves of growth and regression, all of which are inevitably influenced by the prevailing economic, political, cultural and social context at any given time. Even within the trinity of the clergy, law and medicine, differences are evident in the pace and direction of change each has undergone, and therefore theoretical generalisations applied across professions seem both dangerous and naïve. There is also a clear element of competition between the professions, both in terms of recruitment and the boundaries of their professional fields of practice (Prest 1987a).

Carr-Saunders and Wilson (1933) argued that the Clergy earned its place as one or the three learned professions by virtue of the fact that at one time it was the only profession, and thus the basis on which the others were built. Law was deemed to soon overtake it as the dominant profession, providing the majority of professional services before the industrial revolution. Johnson considered that the rapid growth in the professions during the period of industrialisation might prove to be a defining characteristic of industrial societies (1972). During the industrial era, inventors and entrepreneurs led the way in utilising new ideas to change the ways in which society functioned (Ackroyd 1996). Advances in science and technology allowed chemists, physicists, dentists and veterinary surgeons to apply newly researched knowledge to the improvement of their practices, in a context of rapidly changing social restructuring consequent upon urbanisation of the population and industrial organisation. In these conditions, additional service jobs were created in the new 'institutional professions' of accounting, surveying, banking, estate agency, and local government. Study of these new professions provides further insight into the professionalisation process and the changing societal construct of a profession at this time, together with strategies contributing to their successful establishment in a position of relative power in society.

Carr-Saunders and Wilson (1933) believed that a 'profession' did not come into being (in that it could not be publicly recognised) until it had formed a professional association. This implied that distributed and unconnected practitioners did not

constitute a 'profession' in the eyes of the layman, and that without a professional association a profession was not in a position of power to regulate itself internally, and define and defend its position in society. In this way they felt that a leverage point could be identified in determining the birth of a new profession, though the distinction between a professional association and an occupational association remained ill-defined. Etzioni (1969) described the aspirations of the 'semi-professions' including teachers, nurses and engineers, while Ackroyd (1996) and others have discussed the development of the 'new model professions' (see Appendix B for further notes), many of which grew in association with an established organisational structure.

Throughout the 19th century, the newly formed middle classes broadened to encompass the 'intelligentsia' of the professions. Max Weber described the liberal professions as being an acquisition class rather than a property class, with their privileged position being based upon their ability and technical training. Johnson (1972) outlined two main themes in the controversies of the early sociological studies of the professions, as outlined in Figure 3.2.

Figure 3.2 Early sociological perspectives on the professions (after Johnson, 1972).

Positive contribution to society	**Negative contribution to society**
Durkheim in 1893 Division of labour fragmentation rectified by formation of altruistic 'moral communities' with occupational membership. Stablising force on society. Collectivity-orientation. A new moral order, standing against state collectivism and laissez-faire individualism.	Adam Smith -Economic argument. Harmful monopolistic oligarchies in the form of professional associations. Marx → negative contribution of professions to surplus value Explosion of experts & technocrats → meritocracy. Lacking in human skills.

In a positive argument, altruism was viewed as the element that separated the professions from other occupations, with the development of a collectivity-orientation rather than self-orientation (Parsons 1951). Halmos (1970) believed that the service ethic which became more widespread in business in the second half of the 20th century actually originated in the professions. Carr-Saunders and Wilson (1933) viewed the professions as among the most stable elements in society in their day, though later threatened by the state interventions of the 1950s (Johnson 1972).

The 'negative' economic argument was based on Adam Smith's assertion that the professions were 'unproductive' in that they did not produce corporeal new goods, and suggested they had no tangible worth. Nevertheless, this 'unproductive' service sector was expanding and could not be ignored, and knowledge-based services appeared to be establishing a permanent base. In this more sceptical view of the professions, the economists questioned the benefits of the professions to society, in terms of their established monopolistic practices. The expansion of the professions was viewed as a threatening explosion of "men of narrow specialism and narrower vision" (Johnson 1972:16), and this new class of managers, together with the engineers and scientists, were thought to be lacking in the human skills regarded as essential in the true professions. Professional organisation and regulation increased substantially during this period, boosting collective identity and power[26].

Given that numbers in the new model professions were not yet nearly as vast as in the three learned professions, nor their services so widely required by the general population, their rise to the status of 'a profession' appears even more contextually dependent on the demand for their services, dictated by the prevailing social and economic climate of the 19th century. Larson (1977) proposed a model of change based on a long-term and powerful 'professional project' arising from the middle classes. She claimed that groups of workers were motivated to establish professionally regulated monopolies of knowledge and skill in order to control scarce resources and achieve upward social mobility[27]. It is this monopoly status that has been subject to recent specific challenge by government policy in order to undermine the established power base of the medical profession in the UK.

Despite the fact that self-regulation could confer great power, the demand for professional services still needed to be sustained or driven by increased consumer purchasing power in order to ensure a profession's future, which was thus heavily dependent on external social and economic forces. Corfield considered that Larson's model was incomplete in failing to identify the stimulus that first set the professional model into action. However, at this time when the medieval guilds were disappearing, the Trade Union movements were being formed by skilled labourers, and businessman formed unofficial 'rings'. There was also considerable competitive rivalry within the professions themselves. In this context, Corfield suggests that Larson's model was not

[26] except in the clergy where divisions remained between rival churches with no unifying professional association.
[27] Corfield (1995) suggested that in many ways this rise to power through establishing monopoly status echoed earlier satirical accounts of professionals who conspired to dupe the public for their own ends.

unique to the professions but part of a wider move to capture a position of competitive advantage, sometimes with state legislative backing (Corfield 1995).

Expansion of the service industries has been correlated with the industrial (i.e. non-agricultural) development of the towns and cities, generating effective demand from urbanised societies for specialised expertise, and adequate income for its purchase. Initially the professions were almost entirely reliant on consumers (the lay public) paying for their services, but in due course the state and civic institutions also became important purchasers and endorsers of their public roles (Corfield 1995). The trend of Professionalism continued to spread throughout the 19th century, with the State in a supporting role ready to pass appropriate legislation to endorse the movement towards qualification and regulation[28]. All professions relied upon public belief for the maintenance of their social status and professional authority, and for the continued demand for their services. Their growth was thus culturally dependent and progress was not uniform across all traditions, as is evident from the varied stages of development reported in the many case histories of professions in the UK and around the world (Corfield 1995). During the 20th century the state became more involved in control of the supply of professional services in the UK, especially in the post-war era of the Welfare State and rationalisation of the public sector through NPM from the 1980s (Ferlie et al 1996).

Wilensky (1964) attempted to define an historical sequence of events that led to the creation of a profession:

1. a full-time occupation emerges
2. the establishment of a training school
3. the founding of a professional association
4. political agitation directed towards protection of the association by law
5. the adoption of a formal code.

A uni-linear view of this development process has proved inadequate in view of the historical evidence presented in the previous chapter, and though it is acknowledged that for many professions it has been "a long drawn out process", the sequence of events is clearly not universal and is dependent on prevailing cultural and economic values with the ultimate aim of continued historical survival of the profession (Johnson 1972:28).

[28] This situation was reflected internally in Government by organisational changes within the civil service which introduced competitive entry exams in 1870, after much disquiet and resistance.

Professions have been seen to 'splinter', expand their domains and to gain new attributes through the professionalisation process. This reactive and proactive process is defined in relatively energetic terms by Olesen and Whittaker as:

> *" ..the set of thrusts, self-generated or imposed by technological advancement, shifts in cultural roles etc that propel occupations and their incumbents toward an approximation of a professional model and that enhance or deter the occupation's thrust in that direction."* *(Olesen and Whittaker 1970:184)*

This clearly articulates the notion that occupations might be swept along in this process by externally-generated forces, and are not necessarily acting to some predetermined project plan. Studies of the semi-professions introduce further doubt as to whether it is possible to determine the 'success' of the professionalisation process, when the future concept of a profession is as yet unknown, and the direction of the professionalisation process and its end point are both a matter for conjecture.

It is argued that there was a transition of type between the traditional professions and the new model professions subsequently formed, and that each profession has its own unique particular characteristics, history and shared traditions. The thread of altruism becomes less visible in many of the scientifically-based professions, perhaps interpreted more loosely in terms of the public value of their services, rather than of those rendered to individual clients. The specialist knowledge of professional communities however remains as a strength safeguarded by qualification and registration, and forms the basis of their monopolistic dominance and powerful position in society.

Before considering the influence of power on the professions and their actions, there is a further element of the professionalisation process which requires further consideration, namely the professionalisation of individual members of a profession, which in turn allows the perpetuation of a professional collective which can act both through a united community and its individual members. It will be the responses of both which alter the professional relationships and consequent status of the profession in society, and the ways in which individual and collective identities are established will have some bearing on the subsequent behaviour of the professionals and their communities. Occupational sociology is a field which includes the study of the nature of the changes that an individual undergoes in the process of socialisation, to become a member of a specific profession, for example. This involves learning and unlearning, training, the assumption of new role and status definitions, and the study of the social institutions through which the professions are organised and their means of recruitment. A dynamic exists between the process of professionalisation and the

means by which the process is achieved by individuals in particular training situations (Olesen and Whittaker 1970).

3.3 Socialisation into the professions

Beyond the arguments concerning the differences between a professional and non–professional lie a further set of issues which address the question of how an individual becomes a professional, and their experiences as such. This socialisation process has been regarded by some as a process of 'enculturation' (the experience of the individual influenced by the culture of their surrounding group). It might alternatively be viewed as 'acculturation' (the influence of one group on another), or a combination of the two. The latter might especially be the case during the course of formal study where a group of students interact with a group of professional faculty staff. The difference between professional enculturation and 'training' is a further subject for debate, as is the strong influence that sex-role enculturation has traditionally played in the development of a paternalistic autocratic professional role and associated behaviours (Olesen and Whittaker 1970).

There is a strong sense of identity associated with being a professional which can be explored further through the concepts of identity theory, originating in the work of George Herbert Mead in the 1930s and further developed extensively from the 1960s onwards by Stryker and Burke (2000). There are particular implications for professional identity and status, with the concept of identity being tied to the collective as well as to the individual. This forms the basis of the Social Identity Theory (SIT) discussed by Tajfel (1982), which relates to the situated identity perspective and multiple role perspectives. In short, an individual's identity and behaviour is shaped by the life they live in a relatively small and specialised network of social relationships, and through the roles they adopt to support their participation in the networks. This understanding of social identity formation would appear to readily apply to many aspects of a professional's world.

3.3.1 Identity

Identity is a complex concept spanning many specialist areas of knowledge. 'Identity theory' originated in the work of Mead in which he described the emergence of 'self' as an overarching conception that experiences the 'otherhood' of generalised others (Mead 1934). It subsequently combined two strands of research that were pursued through the 1960s to the present day. On the one hand Stryker and colleagues have focused on the linkages of social structures with identities (that is, the contribution of external contextual elements), while the work of Burke and colleagues has

concentrated on the internal process of self-verification (Stryker and Burke 2000). The basic goal of their research into structural symbolic interactionism has been "to understand and explain how social structure affects self and how self affects social behaviours" (p.285).

Identity in a professional context can also refer to a common identification with a collectivity or social category, as in the social identity theory discussed by Tajfel (1982). A structural symbolic interactionist approach would argue that social structures outside of the given social networks of the individual affect the probability of that person entering those networks (Stryker and Burke 2000), and in terms of professionals this would relate to the collegial networks which are limited by membership and which one has to make a particular choice to join.

William James, a late nineteenth century psychologist, postulated that individuals possess as many selves as groups of person with which they interact, and that our social roles are the expectations attached to the positions we hold in our networks. This theory asserts that role choices are a function of our conceptualised identities, and that we have an identity salience in which these are arranged hierarchically and to which we refer in our choice of role adoption in a given situation. Thus:

> *"...the higher the salience of an identity relative to other identities incorporated into the self, the greater the probability of the behavioural choices in accord with the expectations attached to the identity."* (Stryker and Burke 2000:286)

An associated concept is that of commitment, which is measurable by the costs of losing meaningful relations to others should the identity be foregone, leading to the derivation of 'Mead's formula', stating that commitment shapes salience shapes role choice behaviour (Stryker and Burke 2000). There is evidence that increasing frequency of adopting a particular role adds to the commitment to that role, endorsing stability in identity. This is shown in longitudinal studies of students who seek to establish new relationships which provide opportunities to behave in accord with the highly salient identities they had held before going away from home, stablising their self-structures (Serpe 1987). Commitment is related to the number of others that one feels connected to by possessing a particular identity (Stryker 1980), implying that being a member of a large group, such as a profession, makes an individual more committed to acting in that role, and supporting the importance of professional associations.

Burke's school of thought proposed that identity and behaviour were linked by the meanings that they shared, and measurement procedures were developed to measure

if two identities are equivalent, then this will cause stress. This might then be the case where a professional identity is in conflict with a business role in the delivery of a professional service. Membership of other social networks or groups might create identities that reinforce or impede various forms of participation. This might be applied to those who 'dabble' in practices which are seen to be beyond the acceptable boundaries of professional practice, such as cosmetic surgery and other elective enhancement procedures, who may not be accepted by the mainstream of the professional group, and so form their own new community.

The development of a professional identity assists in the reduction of uncertainty in the professional relationships which concerned Johnson (1972), enhancing both personal and organisational legitimacy (Dent and Whitehead 2002). However, as already discussed, the shifts of power and control with increasing state mediation and the changing role of clients in relation to decision-making and their choice of treatments and services, might lead to a potential loss of commitment from the individuals concerned where the traditional identities are not mutually verified, challenging the professional's identity and status within the relationship. Dent and Whitehead (2002) noted the trend of bringing into question the social and cultural assumptions associated with the term 'professional', and posit that the price paid is "a loss of faith, loss of trust and sense of order, and increased perception of risk" (p1). They talk of a search for new meanings in constructions of reality and the loss of 'anchor statuses', with a diminution of the perception of a professional as:

> *"...someone trusted and respected, an individual given class status, autonomy and social elevation, in return for safeguarding our wellbeing and applying their professional judgement on the basis of benign moral or cultural code."*
> *(Dent and Whitehead 2002:1)*

They believed however that, despite the rise of managerialism, professionals were still linked with privilege, specialism, autonomy and trust, with 'a professional' affording status beyond 'a manager'. They felt that an appropriate form of this new identity might be as:

> *"...a flexible, reflexive practitioner, the teamworker, lifelong learner, a person concerned to constantly update their knowledge and skills base, to be market orientated, managerial, if not entrepreneurial."* *(Dent and Whitehead 2002:3)*

The inclusion of commercial, managerial and entrepreneurial is notable. The drive for the adoption of this new identity comes from both internal and external pressures and desires, together with the need to conform to the profession's changing institutional norms.

self-meanings as reflexive responses to self-in-role (Burke and Tully 1977). Burke (1991) subsequently developed a model in which behaviour is organised to change the situation and bring the perceived self-relevant meanings into agreement with those in the identity standard, leading to self-verification. Behaviour is thus goal-directed, and changes the situation in order to match meanings perceived in the situation with those held in the standard. Thus a strongly held standard which might derive from the collective can potentially lead to individual behaviour aimed at changing the situation to match those in the agreed collective standard, and thus shape the situation (in society) to endorse a particular role for the profession. A mismatch between these meanings leads to negative emotion such as anger, depression and distress which can reduce commitment (Burke and Stets 1999). The inclusion of symbolic meanings such as resources in identity theory has allowed the incorporation of the individual's perceptions of occupying a role in terms of using materials, buying goods and services etc (Burke 1997).

Thus identity is linked to roles and to behaviour through meanings, and is essentially a construct derived from finding or creating situations in which an identity can be expressed, as well as being embedded in and affected by social structural contexts:

> *"The concept of identity salience implies that persons are more likely to define situations they enter, or in which they find themselves, in ways that make a highly salient identity relevant; this process enables them to enact that identity ....Situations, however, involve relations to others: the extent to which persons can verify their identities depends on the identities of those others, on how the others respond to identity claims, and on whether behaviours that could alter the situation to align perceptions with standards of self meanings in fact are viable."*
> *(Stryker and Burke 2000:289)*

Identity theory is linked to role identities, which in turn are externally linked to positions within a social structure. Individuals internalise their own meanings and expectations which they associate with a role. Social structure is made up of interconnecting positions and roles, linked through activities, resources and meanings. A role such as 'a professional' will thus be embedded in a number of groups that provide context for its associated meanings and expectations, and the structure and connectedness of these roles impacts on the identity for that particular role. A high degree of 'connectedness' increases the saliency of the identity, making it more likely that an individual will adopt that identity in a given situation, and be more strongly committed to it.

However, individuals commonly hold more than one role, in more than one group, which may reinforce each other or introduce conflict (Stryker 2000). The identity based on higher salience and greater commitment will be reflected in situations of conflict, but

Weick's (1995) work on sensemaking is of relevance to this organisational change, and is grounded in the construction of identity. Sensemaking can be triggered by failure to confirm one's self and in the effort of maintaining a self-conception, especially when negative images threaten our sense of self. In this case we may alter the sense we make of those images, even if this means redefining the organisational identity (Weick 1995). Weick also acknowledges the range of selves that we develop, and indicates that identity is partly constructed in terms of the conduct of others towards us:

> *"Identities are constituted out of the process of interaction. To shift among interactions is to shift among definitions of self."* *(Weick 1995:20)*

The conduct of others might also be influenced by us, and there is continual redefinition of self on continued presentation of self to others. However, it is not clear how much of an individual's sensemaking activity is influenced by the conduct of others, nor the process by which we select the definition of self to adopt at any given time (Helms Mills 2003). When new relationships are formed we appear to automatically default to the collective level identities we have already established, which are founded on stereotypes based on the group membership and social categories (Sluss and Ashforth 2007). This has wide ranging implications for professionals in terms of the relationships they build with both clients and other professionals, especially in terms of the systems in which they work which might encourage or prevent the establishment of professional relationships over an extended period of time.

3.3.2 Institutions and roles

Berger and Luckman (1967) in their treatise on 'The Social Construction of Reality' discussed at some length the development of 'institutions' arising from man's need to be with others in some sort of man-made social order. It is argued that the inherent instability of the human organism makes it imperative that man provides a stable environment in which to conduct himself. Thus habitualisation provides direction and specialisation of activity, and institutionalisation occurs when there is a reciprocal typification of habitualised actions by types of actors, such that the institution posits that actions of type X will be performed by actors of type X. Institutions always have a history, of which they are a product, and control human conduct by setting up predefined patterns of conduct and channelling it in a specific direction. Through successive generations institutions become objectified with a reality of their own, setting out 'this is how these things are done' (Berger and Luckman 1967:76). Transmission through generations strengthens the sense of reality and makes elements of the institution more difficult to change.

Thus an institution is a humanly produced constructed objectivity, and this reality comes to each successive generation as tradition rather than as memory. This continued consistency adds to the legitimacy of the institution, which 'hangs together' because of its common relevance to members of the collectivity. Berger and Luckman (1967) further postulate that each institution has a body of shared transmitted 'recipe' knowledge that supplies the institutionally appropriate rules of conduct and constructs the roles to be played in the institution, controlling and predicting such conduct. This knowledge is learned by the next generation as objective trust and internalised as subjective reality, reaffirmed by symbolic objects and actions, and the language in which the knowledge is conveyed.

This short theoretical description of the development of an institution is readily applied to the concept of a profession as an institution, especially in the light of the preceding historical accounts which described many of these characteristics in the early development of the learned professions. Any institution involved in transactions with the world outside itself needs to legitimise itself to that world, and these conditions of legitimacy are changing as roles within the institutions are being redefined (Harrison and McDonald 2003). The further development of roles within the institution are thus of great importance, a process described theoretically thus:

> *" There is an identification of the self with the objective sense of the action: the action that is going on determines, for the moment, the self-apprehension of the actor, and does so in the objective sense that has been socially ascribed to the action."* *(Berger and Luckman 1967:90)*

Berger and Luckman argue that the self can be only partly involved in the action as it has other roles, this one being only part of the totality of the self. There is thus scope for a 'conversation' between the different segments of self, between these interchangeable types, and the actor identifies with the socially identified typifications of conduct when 'in situ' in a particular role, but re-establishes distance from them as he reflects about them afterwards. This particular perspective denotes roles as 'types' of actors in a collectivity with an objectified stock of common knowledge, which contains standards of role performance accessible to all members of the collectivity. Most importantly, it is known that these standards are known, so that every actor of role X can be held responsible for abiding by the standards (Berger and Luckman 1967:91). Professionals thus enact their role as such, and these roles are intricately linked to standards of conduct, often acting as a representative of the wider institution in the public domain. This makes it possible for an institution to exist as a real presence in the experience of living individuals, represented through linguistic objectivations and highly

complex symbolizations of reality brought to life by human conduct (Berger and Luckman 1967:93).

It is difficult to believe that Berger and Luckman were describing an institution in society rather than specifically applying their thoughts to a profession, such are the similarities between their theoretical model and the accounts of the professional organisations already described. Perhaps we should ask if the professions are so different after all from other social institutions, and that it is perhaps merely a matter of degree that defines a professional institution as something apart, rather than of outright difference. This might lend weight to the argument that there is indeed a continuum of professionalism and that any occupation might aspire to raise its status on that scale. An issue relating to the legitimation of roles through public recognition arises from the specialisation of roles, and the need for an individual to know who to go to for the information and skills that one does not personally possess. The profession's 'typology of experts' then becomes part of the general stock of knowledge of the population, while their expert knowledge does not (Berger and Luckman 1967).

Sluss and Ashforth (2007) consider there to be a third level of identity which they call interpersonal identity, concerned with role relationships on a personal level within an organisation. This acts between the individual and collective levels of identity, and individuals gain a sense of self through a cognitive shift between all three levels. This is related to the structural functionalist concept of a role which is based on interactions, and which are "sets of behavioural expectations associated with given positions in the social structure" (p.10). Self-definition within an organisation is thus predicated by one's network of interdependent roles, which might be less well defined in a fluid team than in a more stable structure. This varies from a Situated Identity Theory perspective in that when one is a member of a group, the group's welfare becomes the main motivator and the meanings of roles are socially constructed through interaction, negotiation and other social processes. A structural functionalist approach emphasises how roles are created to fulfil institutional needs and organisational expectation, transcending the individual role occupant, rather than relying on the agency of individuals in the social construction and enactment of roles adopted in a symbolic interactionist approach (Sluss and Ashforth 2007).

Commitment is seen to increase between individuals where they mutually verify the identities held by each other in everyday interactions, as when professionals work together in their respective roles, and in traditional client/professional relationships. As

already noted, identities are multifaceted and continuously remade, and changing organisational forms, such as the more recent shifts towards flexible networked organizations, may challenge the relationships through which identities are developed and re-established (Barry et al 2003). The inherently collective nature of the traditional professions and their creation of some form of internal organisation has been postulated as the means by which the professions reinforced their status in society, shared their body of expert knowledge, and developed their rules, codes, roles and shared values. As already noted, the formation of a professional association was deemed to be an important defining characteristic of a profession (Carr-Saunders and Wilson 1933) though others considered it an important pre-condition for the initial emergence of a profession. Despite this difference of opinion, it is agreed that these professional institutions have played an important role in the professions, in terms of the development of group identity, as well as in the management of power and control balances in professional relationships.

3.4 The Professional Association

> *"A profession can only be said to exist when there are bonds between the practitioners, and these bonds can take only one shape – that of formal association."* *(Carr-Saunders and Wilson 1933:298)*

Carr-Saunders and Wilson (1933) believed that when a new profession evolved from within an existing profession, such as dentistry from medicine, it stayed for a while in its 'family home', before setting up its own association at a later date, thus delaying its formal demarcation as a new profession. They also believed that teachers and civil servants possessed no specialised technique and so lacked the incentive to associate with their own kind as the other professions did[29].

The influence of the formation and strength of trade union movements in the first half of the 20th century cannot be overlooked, and this is perhaps particularly important in those new professions which feel that strike action is appropriate in some circumstances (such as nursing and teaching) and where a professional body acts at least in part on behalf of the interests of its individual members, rather than on behalf of the collective profession[30]. The 18th century era of patronage was not conducive to individual practitioners meeting in groups with their peers, as this would undermine the

[29] Since these observations were made in the 1930s, the teachers have clearly organised themselves into a powerful professional grouping with appropriate associations for members. This perhaps bears out the argument that it hadn't reached full professional status in the 1930s, but has subsequently evolved into a recognisable profession.

[30] As the medieval guilds decayed in the 16th century, the social and economic forces of that period were not conducive to the formation of new associations, and in France after the Revolution trade associations were actually banned. At this same time in the UK, the universities, the Inns of Court and the Royal College of Physicians performed their duties purely as a means of safeguarding privileges.

relationship of subservience to their patron, asserting some form of independence which was not to be encouraged. Contracting was a major part of the professional's work at this time, and a business interest consequently dominated the professional outlook of those engaged in such work. Early associations were thus formed through a shared desire for social contact, and quickly developed into opportunities for learning, debate, discussion and study[31].

Numerous professional groups were founded in the 19th and 20th centuries, and specialist validation became an expectation of customers outside of the landed elite. Carr-Saunders and Wilson (1933) observed that virtually all professional societies had study as their primary objective, producing publications and research in their field[32]. Many of the early professional associations tended towards a flat structure with a single tier of membership, and a simple constitution[33] (Carr-Saunders and Wilson 1933).

Turner and Hodge (1970) and others were particularly interested in the importance of these professional bodies in the attainment of a profession's status, and this was linked with the monopoly status of practice, boundary-setting and the working of professionals as an allied group rather than as co-professionals (Bucher and Strauss 1961). The importance of a professional organisation as a sign of status and self-discipline became an important trend. It gave those within the profession an identity and a peer group with which to relate, and the means to set and maintain standards of practice and training. It also gave potential clients the reassurance that a professional had reached a recognised standard of proficiency, and continued to conduct themselves in an appropriate professional manner.

Johnson (1972) regarded the formation of a professional association as necessary for 'professional upgrading' and the establishment of group consciousness. Goode (1969) felt that a united group could achieve much more than individuals alone, especially in terms of transactions to improve the status of a profession. As more threats

[31] In 1793 the Society of Gentlemen Practisers in the Courts of Law and Equity (later to become the Law Society) began to meet as a dining club, combining social activities with discussion and debate of current shared issues. This heralded the start of a new era of professional associations in the UK, though they were viewed by the public with disdain and suspicion that the societies acted only in their members' own self-interest. Reformers targeted what they considered to be exclusive, selfish and slothful professional groups, characterised in the popular works of the day, such as the serialised novels of Charles Dickens.

[32] In modern times this role has diminished or been relinquished to a range of more specialist academic associations.

[33] This was in marked contrast to the guilds of previous centuries which were altogether much more complex in their hierarchies and multiple functionalities. Both the legal and medical professions appear to have experienced an episode in their development in which the prestigious specialist elite were joined with the general or lower level of practitioners who actually served the public, uniting them into a single professional body. The bridging of this segregation was a major obstacle to be overcome in the establishment of a unified profession. Carr-Saunders and Wilson (1933) considered that these same problems of unity might be encountered by some of the new professions, in terms of the need for relationships between specialists and generalists to be clearly understood.

undermined the professional establishment, the strength of the professional association was seen to counter government policy changes affecting client/professional contracts and relations, and the rise of managerialism. The relationship of registration to the professional associations has created tensions historically, in that if the professional association carried out this duty then they were regarded as an instrument of the state rather than as representative of their members. However, if the professional association was not employed in the registration process then it lost the power to decide who should be a member of the profession or who should be expelled. Carr-Saunders and Wilson (1933) felt that the professional association was in these circumstances essentially reduced in its objectives to protective functions and public activities.

The rise of localism and fragmentation in state-mediated relationships in the latter half of the 20th century may have undermined and diminished the professional associations' role in maintaining the collectivity and colleague identification, while their trade union role potentially became much more important in bargaining and dealing with conditions of work and pay (Johnson 1972). Bargaining might be regarded as in some way compromising 'professional' status, and in some professions separate bodies were established, with the state taking over the function of 'maintaining standards' and the professional association becoming more akin to an 'occupational pressure group', losing its power to prescribe the manner of practice (Johnson 1972:82). This would seem to accurately reflect the present situation in medicine and dentistry, where the GMC and GDC act as state agencies in controlling standards, while high levels of state mediation through the NHS have led to high levels of bargaining activity by the BDA and BMA. However, the continued collegial strength shared between healthcare professionals has meant that some degree of control of the ethical and community functions of the profession has still been retained by the professions themselves, despite rationalisation. While control of research and recruitment may have been at least partially ceded to the state, with government monies in many cases directed towards universities and private research establishments, practitioner involvement in the development of audit and clinical guidelines has attempted to maintain a degree of professional control in these areas.

A key element in driving the transitions in professional occupational groups appears to have been the changing balance of power between the occupational group and wider society, in terms of its relations with patrons, clients, and mediators (Johnson 1972). This leads to further debate as to the extent of independence and autonomy granted to members of a profession, and the means by which a profession might attempt to

defend their power bases in a changing society, or indeed, actively pursue a strategy of adaptive change to ensure its own survival. These issues are central to the aims of this thesis and will thus be the focus of the following discussion on the relations between professions, the state and their clients.

3.5 Power and Control

Corfield (1995) examined the relations between power and knowledge through an historical perspective, and found that well into the 1800s social power was closely tied with landownership, wealth and titles, and specialist knowledge conferred no particular advantage in this respect. These power relationships were then complicated by the rise of the gentlemanly professions who controlled key areas of specialist knowledge. Corfield considered that power in the professions was not derived from their increasing numbers, despite their growth in the 18th and 19th centuries. On the contrary, their scarcity as well as their status in society continued to endorse their powerful situation as authority figures. Their ability to 'command a corpus of knowledge' and to respond to consumer demand was thus reinforced by sufficient scarcity to safeguard exclusivity and income for individuals within the profession (Corfield 1995).

Johnson (1972) equated 'professionalism' to institutional control in the form of occupational authority. The need for this control arose from the increased uncertainty or 'indeterminacy' in relationships between consumers and the new specialist groups which had come into being through the division of labour. The power of an occupational group related directly to their level of autonomy, and was closely linked to their degree of perceived value in society, which might be enhanced by the mysticism attached to their particular practice. This in turn conferred upon them sole right of judgement in their field of practice in society. It was observed by Johnson (1972) that the greater the vulnerability of the client, the greater potential there would be for the professional to exploit the situation and thus the greater need for social control. In Johnson's terms a profession was not an occupation but a means of controlling an occupation.

Power has also been linked to the allocation of resources by professional groups (Turner and Hodge 1970), and to the monopoly of professional practice (Jackson 1970; Larson 1977). Power and control differences lead to conflict, and a number of authors allude to the tensions encountered by the professions, these being loosely defined as conflict between the authority of administrative elements and the authority of knowledge elements of the profession (Johnson 1972). This relates directly to differences between organisational and community interests (Turner and Hodge 1970),

and between the attitudinal elements of the organisation and of the professional institution (Olesen and Whittaker 1970). The rise in managerialism (Dent and Whitehead 2002) and the development of hierarchies within professions such as hospital medicine and big-firm accountancy have led to explicit conflict between the interests and practices of the managerial and professional aspects of the organisation.

Table 3.1: Characteristics of Professional Relationships based on Johnson (1972)

Relationship	Characteristics of professional relationship
Collegiate	A means of control which increased significantly in the 19th century, in which control comes from the institutional or occupational authority within the profession. This flourishes where there are large groups of consumers and a low level of specialism confers a higher group sense of identity within the profession. This shared identity is strengthened by shared experiences of training and socialisation, usually gained through an apprenticeship with close contact and peer solidarity. This is reflected in shared values, equal status, and high standards of conduct outside of the workplace. There is a highly developed system of rituals and symbols, as well as professional networks, and a distinct prestige element in the assumption of an authoritative expert role. Status is linked to length of training and reward, and great importance is placed on non-technical human skills in face-to-face encounters. While the client initiates the professional/client relationship, the professional terminates it, leading to weak levels of client power.
Patronage	A relationship in which the client defines their own needs and the manner in which those needs are met. Traditionally oligarchic patronage in 17th and 18th century England and renaissance Italy was under the control of the aristocracy, but later Corporate forms gave power to a number of large bureaucratic organisations in both private and public sectors. Recruitment was based on sponsorship and shared values with the client rather than with fellow professionals, and internal occupational hierarchies developed which fragmented the professionals further. The 'housed' practitioner, or houseman conceded autonomy and was subject to 'localism', where local knowledge and skills were developed in response to local demand, with an ethic of limited responsibility and not looking beyond the consequences of action for the patron.
Mediation	State control removes from the consumer and the producer the authority to determine the contents and subjects of practice. Citizens become guaranteed clients, with uncertainty in the professional/client relationship reduced, although the consumer/employer roles may be confused where the state is contracting for services. Recruitment is through the universities and under state control, and bureaucratisation stratifies and fragments the profession, threatening the 'complete community'. Encouragement to specialise creates further divergent interests within the professional community and localism results, often with the development of opposing interests. Efficiency becomes the yardstick of value and full-time research institutions outside of the practitioners' community become the creators of new knowledge. Professionals are asked to be involved with government decision-making in what eventually becomes a social rather than personal professional service.

Johnson (1972) usefully outlined three relationships through which control might be exercised in professional practice, summarised in Table 3.1. After the patronage arrangements of the 17th and 18th centuries, professional relationships in the 19th century lay mainly in the 'Collegiate' domain with the power resting with the professional. Increasingly through the 20th century there was a marked rise in

consumer power (a form of patronage) and state mediation in the provision of many professional services, especially in NHS healthcare and social services in the UK. More recently in healthcare, the introduction of new legislation allowing 'bodies corporate' (that is, commercial non-professional organisations) to provide healthcare services has introduced a new set of patronage relationships into the professional community. These changes in the relationships of the professions to the state, and to a lesser extent to the corporates, have led to the rise of 'the Audit Society' (Power 1994), indirectly undermining professional power and autonomy. Others, including Marquand (2004), have made explicit the neo-liberal assumption that professionals were not to be trusted to appraise themselves, acting as self-interested producer cartels and seeking monopoly rents. As a consequence of subsequent policy changes, public trust has instead been placed in the hands of 'management professionals' who are engaged in the scrutiny of other professionals.

Related to the rise of bureaucracy, Reed (1996) outlined three groups of professionals which he discussed in terms of their changing status and expert powers. He considered that the traditional independent professions were under attack both from the 'organisational' professions, including the managers and administrators, and more recently from the entrepreneurial 'knowledge professionals', in which he includes financial and IT consultants, suggesting that "the politics of expertise" remains an intensely contested field leading to further fragmentation within and between the managerial and professional classes (Reed 1996:573). Davies (2006) discusses the effect of New Labour policy on the professions in the past 10 years, and concludes, in agreement with Marquand, that a decentralised system of government requires greater authority for professionals, and not increased surveillance and co-ercion.

Two issues appear to emerge from this discussion as being closely related to the maintenance and redefinition of professional power and control. Firstly, the changing nature of autonomy in relation to professionals and their new contexts of practice; and secondly, the importance of professional relationships in the establishment, definition and maintenance of professional power. These will be explored further in the following sections with particular regard to the public sector and healthcare professions, which have been the subject of much of the existing research in this area.

3.6 Autonomy

Autonomy is understood to refer to an individual's capacity for self-determination, and has been linked particularly with issues of morality and freewill. In psychological terms

it is related to individualistic needs, including the need for achievement, and the need for freedom from the control of others:

> *" [Autonomy is] a person's investment in preserving and increasing his/her independence, mobility and personal rights."* *(Beck 1983:272)*

Kasher (2005) considered that knowing how to use reason in making decisions was of prime importance in this respect, together with the necessity of being genuinely free, neither coerced nor dependent, in forming actions, making decisions and acting. Professional autonomy can then be regarded as personal autonomy in professional practice, that is, being "genuinely free in every context of professional action" (Kasher 2005:88). Professional autonomy could be regarded in terms of three kinds of freedom, namely:

1. Framework autonomy
2. Conceptual autonomy
3. Social autonomy

Kasher argued that a profession such as engineering may have little freedom to define the concept of a profession, and is constrained by the societal envelope of its values and principles, but within these confines it has considerable freedom and independence in the way in which it imposes and applies them in professional practice. It is also independent in operating its own self-conception of its own vocation (Kasher 2005). Thus professional autonomy is not absolute, and will always operate within the constraints of dynamic societal constructs.

Professional action has become increasingly constrained, particularly in the public sector, by the move towards management through government targets, frameworks and evidence-based quality measures (Dent and Radcliffe 2003). This has especially been the case with the state control of healthcare services since 1948 with the inception of the National Health Service. The post-war configuration of welfare states came to be the taken-for-granted norm in nation states across Europe. Established "in pursuit of the national interest, for the purposes of reproducing, maintaining and developing the nation" (Clarke 2005:408), this introduced state control of the most important of public resources. The introduction of management control systems through NPM in the public sector during the last two decades of the 20th century (Ferlie et al 1996) included business process engineering in the NHS to provide a system with patients at the heart of the delivery process. This has effectively removed many professionals from their previously powerful roles in determining service delivery, and has thereby directly threatened their autonomous positions in their respective organisations.

Since the Thatcher government of the 1980s, this NPM heralded a radical break with neo-corporatist forms of management, through the widespread introduction of neo-liberal and neo-technocratic forms which were heavily biased towards measurement and targets. This led to a breakdown in 'bureaucratic trust' and the pre-existing autonomy of professionals within those services was essentially regulated by these means (Reed 1996). Professional service providers struggled with 'transparency regimes' in what Reed described as "an underlying trajectory of institutionalised distrust" (Reed 2006: personal communication), with control and power issues becoming manifest in tensions and instabilities between professional groups and managers. O'Neill (2002) expressed this thus:

> *"The new accountability is widely experienced not just as changing, but I think as distorting, the proper aims of professional practice, and indeed as damaging professional pride and integrity...[leading] to a culture of suspicion and low morale [which] may ultimately lead to professional cynicism." (O'Neill 2002:57)*

So while self-regulatory processes were historically initiated by professionals to improve their professional and social standing (Reed 1996), the external regulatory measures more recently imposed appear to have had a detrimental effect on professionals in terms of declining trust, morale and altered professional identity, especially in the public sector.

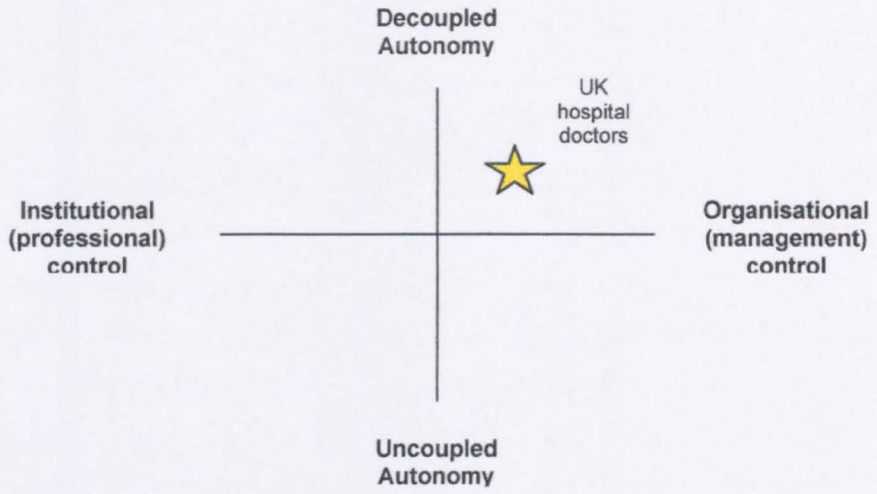
Professional autonomy originated from the need to ensure adequate self-regulation in return for the state allowing a legal monopoly of practice, and exists somewhere in the complexity and ambiguity between formal regulation and actual practice (Freidson 1986). Dent (2003) recognised that, in the health professions in particular, 'autonomy' had been redefined more in the interests of managerial controls rather than occupational autonomy. Whole rafts of managerial interventions were seen to undermine the control and power previously enjoyed by the medical profession. Accountability and quality issues were no longer in the hands of the profession, and revalidation and other tests of competence for doctors might imply that their initial training was in some way inadequate. Davies (2006) discussed the paradoxical policies of a New Labour government apparently redistributing power to local 'community' level while at the same time increasing surveillance and monitoring to unprecedented levels. He links this to the concept of 'governmentality', and suggests that professionals acting in their role of intermediary expert bodies between the state and citizens might be instrumental to the advance of policy which increases governmentality, by enabling government intrusion into the private and local lives of citizens (Davies 2006).

More recent considerations of autonomy extend the idea of 'responsible autonomy' described by Freidman (1977) as being a way in which to harness the adaptable nature of the labour force by giving workers some leeway in encouraging them to find their own ways to work independently of direct management control and to adapt to change, ultimately benefiting the organisation. This 'responsible autonomy' is viewed as being the antithesis of 'direct control' by management, and implicit in the relationship is a balance between the autonomy granted and the accountability expected of the worker in return (Fairtlough 2007). While there are some parallels between professional autonomy and responsible autonomy, responsible autonomy is clearly the outcome of management strategies, while professional autonomy arises from the actions of organised professional groups (Dent 1995). The idea of allowing workers to act entrepreneurially and to give knowledge workers enough decision-making freedom to carry out their work properly is a currently accepted management strategy to ensure an adequate balance between centralised control and the need for flexibility to adapt and find creative ways to create new processes and ways of working[34]. Fairtlough (2007) considered that responsible autonomy could lead to the development of Complex Evolving Systems (CES), that is systems that can adapt and evolve to create new order and coherence from within the internal operation of the system, rather than from any external design or control. It was acknowledged by the Economist Intelligence Unit (2009) that intelligent knowledge workers would in any case bend the rules if necessary in order to perform their jobs effectively.

A contemporary model of autonomy versus control derived from a study in European hospitals was proposed by Dent (2003), based on the shift from professional self-regulation to managerial scrutiny in relation to the quality control of healthcare. The model is based on the loose-coupling of professionalism and management control which Weick first described in 1976 in relation to educational systems in the US, where he observed that it was more difficult to systematically change loose-coupled systems, in which the coupling acts as the glue which binds together self-functioning subsystems (Weick 1976). Dent's model places a professional group in terms of their position on two scales, one of degree of control, and one of degree of autonomy (Figure 3.3).

[34] An Economist Intelligence Unit white paper at the beginning of 2009 indicated that 57% of the 227 executives surveyed were granting more decision-making authority to units outside of their central control in an effort to allow more entrepreneurial thinking to ensure their companies' survival in the economic downturn, although 42% were infact using a mixed approach of increased autonomy in some areas together with tighter central control in others.

Figure 3.3 Model of autonomy/control developed by Dent (2003)



This allows the placement of a professional group into an area of the model corresponding to the degrees of control they experience from the profession versus management, and the type of autonomy they enjoy, ranging from legitimated 'decoupled autonomy', such as autonomy in clinical judgement, to the 'uncoupled autonomy' in which collective professional autonomy is generally undermined by individual illicit behaviour, disturbing the contract between the state and the patient. It could be determined that in its early form the medical profession in the UK might have been positioned on the left side of this model, with varying degrees of autonomy based upon their independent contracting relationships. Dent placed the UK hospital doctors in the upper right quadrant in his study published in 2003. This reflected the maintenance of their degree of autonomy (albeit reduced) in clinical judgment, while being fairly heavily subjected to managerial controls and reforms as a consequence of the managed care models which have been introduced in NHS hospitals, undermining the institutional control and professional dominance previously experienced. Dent observed that the doctors found themselves in the difficult situation of having to justify their actions in a rationalised system:

> *"There is not always 'one best way' for dealing with a medical problem, nor is there always good scientific evidence, yet the medical profession has to respond to a greater or lesser extent as if there were."* *(Dent 2003:176)*

It could be argued that the model needs further development or amendment in light of further changes (especially in terms of the healthcare professions) where practitioners are increasingly subject to new forms of external regulatory control, which comes not from within the profession but from external bodies and the newly reconstituted regulatory bodies with their substantial lay-membership. This external regulatory control does not sit comfortably within the original categories of 'institutional control' or

'organisational control', and so the model does not indicate that the professionals might be subjected to increases in both organisational managerial control and external regulatory control at the same time. The regulatory controls and management controls may well be conflicting in their incentives and outcomes, in that one acts in the interests of the client group, while the other promotes the interests of the employing (or contracting/mediating) organisation.

This model does however usefully highlight both the individual and collective levels of experience, and consequently of response, to changes in levels and types of autonomy and control. The development of a shared sense of being allows the individuals within a professional community to act in some instances as a cohesive group, though it is clearly important that at other times these individuals must act independently using their own judgment.

The importance of maintaining status through strong individual and collective identity, a monopoly of practice and a high degree of autonomy and control, is evident in the bargaining and contracting elements of professional practice, which is further complicated by the large number of professionals who act as self-employed contractors rather than as employees. The nature of these contracting relationships has already been discussed in terms of the balances of power and control, and the potentially 'unfair' competition afforded by the establishment of legalised professional monopolies. This idea of 'fairness' can be extended beyond the scope of competitive tendering to the wider domain of the contracting process, in which professionals demand fairness in all their dealings with clients and the state in accordance with their strong moral and ethical professional codes. This demands some consideration of the literature pertaining to the psychological contract, which is entrenched with a fervent sense of trust and honour, undoubtedly appealing strongly to the professional ethic.

3.7 The Psychological Contract

The potential for conflict between the administrative and professional authorities in the workplace has already been identified. Since the 1960s it has been recognised that there may be tensions between organisations and professionals with respect to i. Goals, ii. Controls, iii. Incentives, and iv. Style of influence (Kornhauser 1962). Whereas organisations tended towards a predictable output achieved through hierarchical line authority using long-range rewards and with executive direction, professionals were more likely to be problem orientated and not readily programmed, valuing boundary-transcending collegial authority. They also valued the opportunity to

enhance their reputation amongst colleagues and relied on their specialised expertise to exert influence.

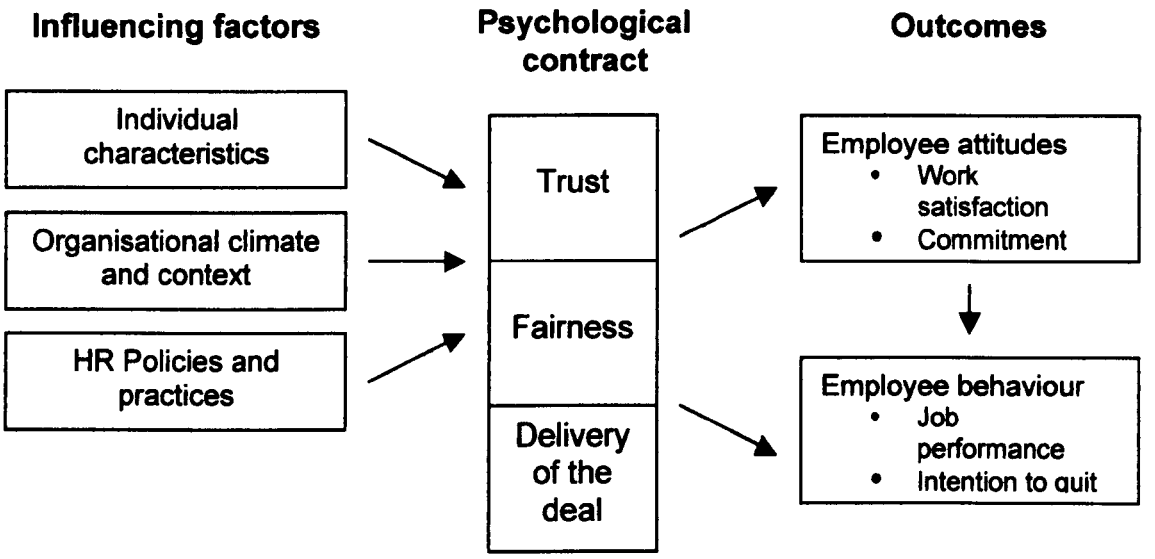
In the 1960s and 1970s, organisations are reported to have attempted to adapt to the needs of professionals by debureaucratization and increased flexibility, especially in relation to decision-making, communication and controls (Luecke 1973). In many organisations at that time, those in top-level positions were there by virtue of their professional status, such as in the Clergy and Education, with both organisational and professional contributions required. Professionals working in organisations had expressed feelings of being compromised and dissatisfied, and they were either having to adjust passively to the situation or were leaving their profession altogether (Corwin 1961). Luecke (1973) proposed a model of Organisational versus Professional Perspective, in order to analyse the functioning of organisational leaders in the Clergy, and found that those with 'organisational attitudes' were more effective leaders than those who adhered to their professional perspectives. However, a group of 'synthesisers' were identified who appeared to combine both orientations without experiencing dissatisfaction, and who were actually more effective in their leadership role in the community. Etzioni (1969) felt that some of the 'semi-professions' such as teachers and nurses might have skills and personality traits more compatible with organisational and administrative roles, as opposed to the creation and application of knowledge, and observed that many chose to take on the management roles of control, inspection and reporting.

It could be argued that professionals do not automatically lack organisational commitment, but that professionals by their nature have a high expectation of others, based on their individual and collective high standards of performance and ethical conduct (Herriot and Pemberton 1995). Although the psychological contract essentially relates to a direct employer/employee relationship, there are clearly some parallels to be drawn to the situation of professionals and their more loosely constructed but restricted contracting relationships. The psychological contract can be regarded as an employee's belief about the mutual obligations between the employee and their organisation, based on the perception that a promise has been made by the organisation and a situation of mutual obligation thus established (Kickul 2001). Difficulties arise in terms of the implicit and largely unspoken aspects of the understanding, which form the basis of trust between the two parties (Van der Heuval and Schalk 2009). The contract is viewed in terms of a set of perceptions, expectations, beliefs and schemas regarding the entitlements and obligations of the parties involved (Cortvriend 2004). It is recognised as a dynamic relationship between

an employer and employee, more latterly reframed as between an organisation and an employee, and is inherently based on an individual's perception of their own situation in relation to their organisation (Van der Heuval and Schalk 2009).

The psychological contract is constantly open to revision and is influenced by external factors such as changing social expectations and economic climate. The initial work of Rousseau from the 1990s was distilled into a model of the Psychological Contract, originally proposed by Guest and Conway (2002) and modified by the CIPD (2005) (Figure 3.4) which represents the potential links between the organisation and its employees, in terms of their experiences and responses to policy and practice. The importance of employee perceptions of fairness and trust are paramount in this relationship.

Figure 3.4 The Psychological Contract (CIPD 2005)



The importance of the psychological contract has become more widely recognised as more organisations undergo restructuring and change, with the capacity for breaches of the contract to be increased during these periods, and for the consequent responses of employees to contribute to a marked resistance to the change process. This has been noted in relation to mergers and restructuring in the NHS, where the changes can lead to increased anxiety and uncertainty leading to negative responses such as lower motivation, decreased loyalty, and increased violation responses such as exit (Cortvriend 2004). Employee responses have been studied in terms of reciprocity and equity theory, where individuals try to find an equitable balance between the social balance of what they receive and what they contribute to an organisation (Kickul and Lester 2001). Other studies have attempted to relate the employee responses to the

nature of the change and how it was managed (Cortvriend 2004; Van der Heuval and Schalk 2009). Resistance to change has been viewed by Piderit (2000) as a multidimensional attitude which comprises three components:

1. **Affective** – positive or negative feelings of the individual when confronted by change, including moods and emotions such as anger, relief and anxiety. The more negative the feelings, the more affective resistance there is to change.
2. **Behavioural** – actions or intentions to act in response to change, such as complaining and trying to persuade others that the change is not good. This leads to behavioural resistance to the change.
3. **Cognitive** – thoughts that the individual has about the change which are influenced by their positive and negative beliefs as a result of mental evaluation of the change. If these are negative then they result in cognitive resistance to the change.

Van der Heuval and Schalk (2009) found that affective resistance was particularly related to breach of the psychological contract in their study conducted in 10 Dutch companies, and stressed the importance of mutual trust in decreasing resistance to change. The negative effects of breach of the psychological contract were stronger in low trust situations, especially where change was transformational or remedial in nature, and the way in which change was managed was of paramount importance in the realisation of a successful change process (Cortvriend 2004; Van der Heuval and Schalk 2009).

While recognising that many professionals are not in a conventional organisation/employee relationship, the implications of this literature are likely to be particularly pertinent when considering the response of professionals to policy changes, especially for those who are restricted in their contracting and funding arrangements by being tied to the state and its public services. This would particularly be the case for professionals in the health sector where alternatives to NHS funding and contracting are limited. Various new forms of employment relations have recently developed between the individual and the NHS organisation, many resulting in decreased flexibility and freedom on the part of the professional concerned. The need for all managerial staff to acquire appropriate skills in this area for effective change management may have some bearing on the relationships between professionals and contracting managers in the NHS, where many managers have no prior experience of new contracting situations and have been 'thrown in at the deep end' with little support.

3.8 Summary

It becomes clear from this overview of the literature relating to the historical, sociological and psychological aspects of the development of the professions that a very broad range of issues are relevant, and thus far the following areas have been considered:

- the characteristics of a profession
- the differences between a profession and an occupation
- the socialisation process that makes an individual into a professional
- the professionalisation process that a profession goes through as it develops
- the impact of social, economic and political context on the professions
- the internal and external organisation of the professions
- the individual and collective identities established by the professions
- the relationships developed by the professions and their members
- the establishment and maintenance of professional status, power and control

There is a considerable degree of scepticism from a number of sociologists regarding the value of work in this field: Pelling (1987) expressed a view that that 'professionalism' may represent an ideal rather than a reality, in whichever social era it might be studied, and Turner and Hodge (1970) considered sociological models relating to the professions to be a poor fit with reality.

There is no clear definitive route that a profession must follow to become established and to maintain its position and status. However, while certain elements appear common across the professionalisation process of different groups, it is the social and historical context in which the profession operates which is an overwhelming factor in its conception, position in society and its further development. Influences have come from incidents of immense historical and scientific importance, and the relevance of the industrial era and its impact on the rise of the medical profession in particular has been widely acknowledged, both in terms of the rapid increase in directly relevant scientific knowledge, and the impact on society of urbanisation and its extensive social reorganisation.

A wide range of literature has been reviewed to offer a critical account and understanding of how and why the professions have developed as a viable social construct up to the present time, and particular consideration has been given to the nature of the roles and status of professionals in society. As indicated, the distinctions and similarities between the professions and occupations is closely tied to the professionalisation process through which an occupation becomes a profession and the means by which it maintains its status in society. The socially constructed and politically dependent nature of the ways by which the professions have established themselves contribute to the continuing ambiguity of what actually constitutes 'a

profession', complicated by their continually renegotiated identities and roles which dictate their present and future status and power in society. A profession then is a dynamic social construct based on an historical concept, which continues to embody the elements of trust, autonomy, power and expertise in an unstable dynamic mix which is heavily dependent on external contextual influences. Much of the existing literature is based on the professions in the healthcare sector, which are of high importance in government policy, given the close ties of the NHS to party politics and decisions on public spending.

It has become evident that each profession has developed in a unique historical, political and social context, and that these external elements have heavily influenced the characteristics, organisation and evolutionary progress of each particular profession, together with a number of internal issues which have shaped their internal structures and the relationships which have developed within and between certain professional groups. It has been established that the professionalisation process equates to the professions' previous responses to change, and the strength of a profession to resist and respond to change comes at least in part from the strength of its established identity at individual and collective levels, dependent upon the establishment of a professional association which confers increased power. Power and control aspects of the professions are intimately linked to their status in society, and they engage in a process of continually modifying their professional relationships due to challenge from contextual change, such as implementation of government policy. Threats to autonomy through increasing levels of rationalisation, especially in the public sector since the inception of the Welfare State and subsequent NPM, have been discussed and extended in terms of the implications for mutual trust in a contracting relationship. While the literature pertaining to the psychological contract relates to an employer/employee situation, many aspects of it can be directly applied to the restricted contracting relationships now established in the NHS.

Recent policy might be viewed as a direct attack on professional autonomy and power, especially through the rationalisation of public services and in the NHS in particular, where the autonomy of doctors has been directly challenged in order to undermine their power, through increased monitoring and measurement which infer distrust of their professional judgements and motives. Effective trust must be mutual and reciprocated, and a breakdown in this mutual trust may be gauged by the perceived breach in the psychological contract and consequent violation behaviours by NHS staff in the last decade.

It would be a challenging task beyond the limits of this present thesis to carry out a detailed study across the whole range of professions, and the healthcare professions themselves encompass a diverse range of varied professional groups, providing the opportunity to study both the differences between them and the relationships in which they engage. Thus the decision was made to focus this present study on the healthcare professions, while still allowing a broad range of issues to be explored. It is a set of professions which are very much in the public domain, in terms of personal and media interest, and while much research has been funded and carried out in medicine and healthcare management, other professional groups appear to have been relatively overlooked thus far. The range of challenges that these professions have faced in recent years will be examined more closely in the next chapter, particularly through the policies of the New Labour Government, together with evidence of responses thus far reported in the management literature. The findings of a preliminary study undertaken to determine perceptions of and responses to change across a range of healthcare professions are reported and discussed in light of the unique position confronting the dental profession at this time. This is anticipated to contribute to an improved understanding of the ways in which these professions have established, managed and maintained their positions of autonomy, power and status at the present time, and give an insight into how they have responded to change in order to survive and adapt in their current forms.

Chapter 4: Challenges to the Healthcare Professions

Chapter 4 Challenges to the healthcare professions

4.1 Introduction

The development of the professions has been outlined, highlighting differences and similarities between the professions and the ways in which they have reacted to external pressures, influencing their continued evolution and ultimately their survival as a social construct. The importance of a strong collective identity, enhanced by a professional association, has enabled the professions to defend their positions of power and status in society and, until recently, retain the autonomy traditionally granted by the state. The implications of the balance between autonomy and control, and its influence on professional relationships has been discussed, with an emphasis on the fairness and mutual trust demanded in the psychological contract.

The importance of the healthcare professions in the UK has been established, in terms of their relevance to all members of society and the substantial public monies spent on their services. However, government policy driven by political pressures and increased regulation in the last three decades has brought about substantial changes in the professional models of those practising in the key healthcare professions, leading to a reconfiguration of roles and changing relations internally, as well as with their respective management systems and wider social context (Dent and Radcliffe 2003).

In this chapter the issue of changing health service delivery will be considered, together with the professions' reactive and proactive behaviour stimulated by such changes. The established social construct of a professional in healthcare has been brought into question in the current context, and it could be asked whether there are elements of 'deprofessionalisation' or perhaps 'proletarianisation' in the NHS and its recent modernisation agenda (Ferlie et al 1996; Fournier 2000; Thorne 2002; Ellis 2004; Rosen and Dewar 2004; BMA 2005; RCP 2005).

The move away from the medical model of service delivery to a more holistic patient-centred approach delivered through a multi-disciplinary team of healthcare professionals commenced through 'The Patients' Charter' published in 1991[35], and continued in the New Labour policies of the 'The NHS Plan' (DH 2000), in which a framework of wider professional roles for complementary health professionals was outlined. The implications of this radical change in organisational structure and culture in the NHS, and the impact on the professionals within it, will be explored further in this

[35] During John Major's Conservative term of office

next section of the thesis. A preliminary investigation into the changes experienced within the healthcare professions will be reported upon, leading to the conclusion that the dental profession appears to be undergoing a rather different developmental change in the 21st century, setting it aside from other UK health professions at this time. The reasons for these differences will be discussed, leading to the re-statement of the research questions which form the main focus of this thesis.

4.2 The Healthcare Professions

In the context of this present discussion, healthcare professionals might be considered as belonging to three main provider groups which can be summarised as:

- **Medicine:** a traditionally male dominated profession, with well established and respected professional bodies in the GMC, BMA, Royal Colleges and specialist societies, and with professionals exercising considerable power at both individual and collective levels (Thorne 2002). It has been traditionally granted autonomous status by the state (Ellis 2004), with clear elements of professionalism incorporated into its training pathways and standards (Apker and Eggly 2004). Potentially threatened by management control and finding themselves no longer necessarily in a leadership role, the medics have had elements of their professional remit for diagnosing, prescribing and treating legally devolved to other health professionals in the last decade. They enjoy limited opportunity for practice outside of the NHS.

- **Nursing:** a female dominated, established 'subordinate' profession elevated to a higher professional status since degree courses were introduced for registered nurses in the late 1990s. The NHS Plan (DH 2000) devolved increased responsibility to nurses, with newly defined clinical roles and grades, and increased professional accountability (DH 2006). Nurses are registered and regulated, together with the midwives, by the Nursing and Midwifery Council, and the vast majority are employed by the NHS.

- **Allied Health Professionals** (AHPs): a female dominated group comprising multiple established subordinate professions including Physiotherapists, Radiographers, Occupational Therapists, Dieticians, Pharmacists, Speech Therapists and others. Since 2002 these have been elevated in their professional status collectively as AHPs, with increased clinical and managerial responsibilities, new roles and 'consultant' grades. A total of 180,000 AHPs from 14 different specialty areas are now regulated by the newly established Health Professions Council, with a range of opportunities to practice outside of the NHS.

The above three groups have been the subject of much of the published literature and previous studies (Dent and Radcliffe 2003), but in this present context the following group is added as a separate but substantial well-established profession, practising in all healthcare systems in the western world:

- **Dentistry:** a traditionally male dominated profession, historically allied with medicine through common historical links in the Royal Colleges and mirroring the regulatory mechanisms of the GMC through the GDC. As a

> profession, its membership is approximately one quarter the size of the medical profession, with approximately 32,000 dentists registered in the UK. Throughout the second half of the 20th century it has enjoyed similar degrees of autonomy, respect and social status as its medical counterpart.

In the last decade, healthcare service delivery in the NHS has moved away from the medical model towards multi-professional team delivery, not necessarily headed by a doctor, and this has led to a degree of transformation in the professional models in the first three of the above groups, altering their levels of professional and clinical autonomy, and changing inter-professional relationships. In dentistry, similar but less radical changes have been brought about through legislation which has widened the scope of practice to a newly established group of Dental Care Professionals (DCPs)[36]. However the diagnostic rights of the dentists have been legally safeguarded, ensuring their position at the head of the clinical team.

Medicine and health are strongly based on both personal and professional ethical and cognitive values. As already discussed, the medical profession may be viewed as a powerful body of practitioners whose rise was associated with industrialisation, urbanisation, and improved science and technology, being transformed from a fairly humble occupation to a valued and relatively elite profession in the 19th century (Pelling 1987).

Tighter registration from 1858 heralded the start of an era of increased external control and authority, which perhaps remains largely undiminished to the present day[37]. The medical profession was seen to differ from other professions in the peculiar requirement of their services in diagnosis, and its essential presence in virtually every individual's life[38]. As Abbott (1988) has pointed out, diagnosis is a skill that can only be acquired through prolonged and systematic training and experience, and this placed the medical profession in its own sphere of superior professional skills and practice. The medical profession has long derided the unqualified as unsuitable to carry out treatment, although a large number of essential practitioners existed in the 1930s, such as midwives, opticians and nurses, whom the doctors considered to be very inferior types. This has been interpreted as jealousy and fear of losing remuneration, and the

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[36] This group comprises the pre-existing groups of Dental Nurses, Dental Technicians, Dental Hygienists, Dental Therapists, all with newly extended roles, together with the newly created group of Orthodontic Therapists.

[37] In contrast to the assertive and proactive patients of earlier centuries (Corfield, 1995), Carr-Saunders and Wilson (1933) portrayed 19th century doctors as potentially taking advantage of patients by adopting a pompous assumption of knowledge and authority, and surrounding themselves with an atmosphere of mystery and miracle. To prevent 'quacks' imitating the doctor in these respects, it became mandatory for qualified practitioners to distinguish themselves by a public display of their qualifications, still maintained through the brass plaques outside of doctors' surgeries today, a symbol strongly associated with professional practice. The advertisement of professional services was deemed inappropriate for professionals until more recently in the 1980s.

[38] Others professions such as Law and Accountancy provided little in the way of diagnostic services, as clients presented having already decided what needed to be achieved.

medical profession at that time was reported as using its influence to restrict improvements in the training of these groups, thereby preventing their official recognition (Carr-Saunders and Wilson 1933)[39].

The intimate knowledge that a medical professional has of their client is a further feature that distinguishes them from other professional groups (Carr-Saunders and Wilson 1933). The resistance that doctors have shown historically to the expansion of the roles of other practitioners could be interpreted as their protestation that 'doctoring' is not merely about a mechanical application of cures, and that improved services require the necessary holistic overview, depth of understanding, and personal implicit knowledge which the doctors regard as their own.

Nursing is usually referred to in the literature as a 'new model profession' alongside teaching (Etzioni 1969; Ackroyd 1996). In the past women were generally restricted to these lower occupations (Corfield 1995)[40], and while nursing has risen to a more elevated status since the introduction of more rigorous academic training, many would observe that the type of recruits opting to study nursing has altered, and their commitment to practical nursing skills may have diminished as a result of the increased academic bias and reduced practical element to the training. Nursing originated as a caring profession in support of the medical input to treatment, and the professionalisation project to promote autonomy and specialisation in nursing appears to have been driven by the state and has not originated from the nurses themselves in the UK (Dent 2003). There is debate over whether the 'patient carer' and 'medical helper' roles might be separated, and The NHS Plan (DH 2000) allowed substantially increased opportunities for specialisation and promotion to independent practice for nurses, together with the opportunity to rise higher in the management structures within NHS trusts (Dent and Radcliffe 2003). This led to an increased potential for conflict with medical and allied health professionals over the ambiguity of ill-defined roles, especially where similar job titles, for example 'Consultant' and 'Practitioner', have been adopted within different professional specialisms and hierarchies[41]. The limits of clinical responsibilities have consequently become less well defined, posing a potential

[39] Carr-Saunders and Wilson (1933) acknowledged that criticism of the profession had long been widespread and stated in no uncertain terms that "the public complains that medical etiquette, at all times irritating and unnecessary, is often positively disadvantageous to the client" (p.102), although the basis for this accusation is not made evident. They also suggested that "suspicion and even hostility are almost universal among laymen who think that a privileged and sheltered profession abuses its position". These strong words were qualified by the fact that it was extremely difficult to 'get at' the doctors, who were so powerful and well organised at this time. This was felt to be partly to be due to the segregation of medical students at an early stage, in a physical rather emotional sense, and their detailed studies in anatomy and other "mysteries of our animal nature" served to distance the medical students from the society in which they would ultimately practise their skills. Thus their understanding of their human patients did not match their knowledge of the conditions they sought to cure.

[40] There are now high levels of female recruitment into most of the healthcare professions, with over 50% female recruitment in medicine and dentistry at the present time.

[41] It might be assumed that this was a deliberate move to undermine the medics who held these titles.

threat to the professional autonomy of other professional groups (Fitzgerald and Teal 2003).

Historically, healthcare professionals have arisen from diverse origins, not least when the Allied Healthcare Professions (AHPs) are added into the equation. In this group diverse 'tribes' have been brought together, again as a consequence of The NHS Plan (DH 2000), under the collective Allied Health Professions Council which provides professional accountability and regulation, with clearly defined requirements for continuing professional development and higher professional qualifications across a range of areas of professional practice, including Occupational Therapy, Physiotherapy, Radiography, Pharmacy and Speech Therapy. Their position as a newly established 'profession' in theory affords them the opportunity to create and establish for themselves particular fields for their own disciplinary jurisdiction, if Fournier's (2000) arguments regarding the formation of professional boundaries are to be accepted, though their freedom is this respect is heavily curtailed by the state. However, Dent and Radcliffe (2003) warn against the redefinition of these newer professions as being a purely skills-based commodity.

4.3 Changes in Healthcare Provision in the UK

As described in previous sections, prior to the foundation of the NHS in 1948 health services were provided primarily on a commercial basis with open competition between practitioners, and the majority of transactions were carried out on a fee-per-item basis[42]. It is often forgotten that a commercial model of healthcare delivery largely persisted until relatively recent times. When the NHS became the major service provider for state-funded healthcare in 1948, delivery of care was structured with the doctor at the centre of the delivery team, taking ultimate responsibility for organisation and decision-making in both clinical and non-clinical areas. This autocratic medical workforce had at its disposal a range of clinical support staff to effect the treatment to be carried out, as directed by the doctor. This model of care persisted until the 1980s when Margaret Thatcher's Conservative Government commissioned the Griffiths Report (DHSS 1983) through which a steady stream of monumental changes were implemented during the following decade, including the development of non-clinical managerial roles replacing the administrators who had previously been guided by the senior clinicians. The NHS and Community Care Act (1990) set up quasi-autonomous NHS Trusts and a quasi-competitive market for healthcare, with a purchaser/provider split and fund-holding primary care practitioners who acted as financial gatekeepers to

[42] Some wealthier clients would pay a retainer for an annual service.

the secondary care acute services. Also in 1990 new contracts were brought in for GPs, GDPs, and other providers, introducing substantial patient charges for NHS dentistry and optical services, and allowing limited marketing of professional healthcare services for the first time since the NHS had come into being.

The 1991 Patient's Charter (DOH 1991) resulted in a realignment of services with patient needs and a substantial increase in technocratic bureaucracy. The patient was treated as a consumer, with increased emphasis on patient access and information. The complex dynamic of the newly established manager/clinician interface became the focus of much health research in subsequent years, especially in terms of the potential conflict between increased governance and performance management, and the professional autonomous status of clinicians (Thorne 2002; Dent and Radcliffe 2003; Harrison and Lim 2003).

Between 1992 and 1997 the government's 'Health of the Nation' project identified 5 key clinical areas for improvement against clearly defined targets, producing a further external drive for extensive clinical change. Under New Labour, The NHS Plan of 2000 set out key objectives for change with major restructuring, further reinforcing the move towards multi-professional team working and potentially further reducing the powers of the medical profession. 'Agenda for Change' quickly followed in 2003, allowing NHS Trusts to determine local terms and conditions for their entire non-medical and non-dental workforce, and allowing the creation and development of new roles such as Nurse Practitioners and Consultant Physiotherapists. New contracts for medical and dental hospital staff were concurrently introduced, together with new contracts for GPs and GDPs in 2004 and 2006 respectively, amounting to a complete renegotiation of contracting arrangements with all NHS staff within a 6 year period.

Financial reform had been a key priority for the government in the light of vastly increased spending in the health sector since 2000 aimed at the delivery of targeted and prioritised improvements. Increased demands for improved governance post-Shipman, with calls for more public accountability in both spending and practice, led to demands for professional relicensing and changes to the constitutions of the professional bodies (including the GMC and GDC) in order to increase their lay-membership. These were accompanied by substantial legislative changes to the boundaries of practice. This has resulted in changed professional roles across virtually all of the pre-existing healthcare groups, who have consequently experienced changes in professional and clinical autonomy and shifting inter-professional relationships, together with the creation of a number of new professional communities.

Thus increasingly in the past two decades the medics have felt ever more restricted in their practice by the imposition of management control, governance (Harrison and Lim 2003), increased public expectations, and patient involvement in decision-making (Rosen and Dewar 2004; BMA 2005; RCP 2005). There has been much debate within the medical profession concerning the redefinition of the medical role in this updated social context, and its impact on the medical profession as it evolves in the 21st century (Rosen and Dewar 2004; RCP 2005; NHS Employers 2009). The impact of the development of managerial posts for clinicians in the form of Clinical and Medical directorships has been widely researched in terms of the dichotomy posed by working across the widely varying frameworks of values engaged by management and health professionals (Thompson 1997; Thorne 2002). The most recent European Working Time Directive (2004) regarded the medical profession as any other occupation, and its full implementation in 2009 has led to a radical alteration in work patterns, in which junior doctors work shifts which markedly reduce their training hours and clinical experience. A further government intervention in the form of the 'Modernising Medical Careers' initiative has taken yet more control from the hands of the profession, in radically restructuring professional training in medicine, bringing in assessment against performance measures in the first two years post-qualification and shortened training pathways. It has been suggested that, partly as a consequence of this reduced commitment to training and reduced work hours, the young trainee doctors might now feel less dedicated in their professional role, and view their chosen profession as a job rather than as a vocation, lacking the commitment characterised by the practitioners of previous generations.

The first decade of the 21st century has seen the increasing use of private sector resources to augment NHS services, and an increase in the perception that the NHS cannot continue to provide 'all services for all people'[43]. The government's increasing commitment to the Patient Choice Agenda has stretched resources still further, while committing PCTs to commission 'local services for local people'. In furthering the principles of free-market competition, the establishment of Foundation Trusts since 2006 has permitted these NHS trusts to enjoy their own negotiating powers, while allowing more marked differences to develop between them. The move towards tighter control and regulation has continued with a more explicit commitment to continuing professional education, and in the government white paper "Trust, Assurance and

[43] This has been especially apparent in high profile media cases relating to 'postcode lotteries' for the funding of expensive cancer treatment drugs, the inequalities in access to dental services and general debates around the decisions of NICE (the National Institute for Clinical Excellence), especially in cases where evidence-based decisions differ between England, Scotland and Wales on the services which are to be funded.

Safety - The Regulation of Health Professionals in the 21st century" (DH 2007) it set out further intentions for the regulation of healthcare professionals.

Dentistry lies a little removed from the mainstream delivery of NHS healthcare and its policies, having been almost exclusively associated with independent practitioners operating from their own premises, albeit largely contracted to the NHS since 1948. Like medicine, the dental profession has historically been male dominated, though becoming markedly more feminised in recent years, and it has been traditionally allied with medicine in sharing a common evolution and development through the Royal Colleges of Surgeons and the General Medical Council. It has been likewise well respected, with well-established professional bodies and wielding a degree of power at both the individual and collective levels, though certainly not to the same degree as the medics. It has also traditionally been granted autonomous status by the state (Ellis 2004), and Dentistry and Veterinary Science remain the only two professional practices restricted by law in the UK. However, the development of dental services has not mirrored those in medicine and healthcare generally, particularly in respect of the fact that very little dentistry is carried out in the large organisational setting of the acute hospital, and the majority of services historically have been provided by GDPs engaged in a much more independent contracting arrangement than that enjoyed by GPs.

Changes to service delivery in dentistry have also been somewhat different to those in medicine since a 'new contract' for NHS dental services was introduced in 1990, bringing in substantial patient charges for NHS treatment. Subsequent fee disputes with the Department of Health led to a shift towards more private provision of dental care (Silvester et al 2000). Dentists have since become increasingly more business-orientated in their approach to healthcare provision, especially with increased demands for non-NHS treatments by patients (Dancer and Taylor 2007). This business-mindset has increased further still since the implementation of an even more radical 'new contract' in April 2006 in England and Wales, leading to an additional 10% shift towards private practice at that time. These contractual changes have been accompanied by significant legal changes to the practice of dentistry, allowing the registration of DCPs with the GDC. Thus a number of previously restricted procedures can now be carried out by a range of suitably qualified, experienced and registered dental healthcare professionals other than dentists. There is currently a degree of uncertainty in dentistry regarding the ways in which the DCPs will fit into the overall service delivery system of the future, and the threat which they might pose in terms of reducing the work available for dentists (Cottingham and Toy 2009). However,

diagnosis and treatment planning remain exclusively in the professional domain of the dentists. Leaders in the British Dental Association (BDA) have stimulated debate around the concept of a re-defined professional model for dentistry (Ward 2007), suggesting a move towards a more commercial model of service provision, similar to that of the lawyers, to enable the profession to continue delivering a high quality professional service irrespective of its sources of funding.

The dental profession has undergone its own rather unique professionalisation process, in that it originated as part of one of the three learned professions, having originally been under the umbrella of the General Medical Council, before setting out its own stall in the early 1900s. It is thus a fairly new profession in its own right, but has undoubtedly benefited from being part of the medical profession and enjoying the status and power accorded through this association. It did not however enjoy the same degree of success as the medical profession in the 19th century and was at that time poorly developed, with its treatments restricted to the extraction of teeth and very basic fillings until relatively recent times. There have since been remarkable changes in both the practice of and the demand for dental services, especially over the past two decades, due to rapid scientific advances in the technology and materials used in dentistry, together with societal trends and pressures towards cosmetic improvements, as well as increased investment in private treatment on an individual basis and through insurance schemes.

4.4 Issues influencing the professional standing of healthcare workers

The importance of gender cannot be overlooked in the development of the healthcare professions, and continues to be an issue in terms of the status and power of these communities. Historically the 'nurturing roles' which did not require great mental intellect tended to attract women, creating roles in nursing and teaching which were regarded as only 'semi-professional', the male dominated professions continuing to wield the power[44]. Women were restricted to the lower echelons of the professions, and midwifery, nursing and teaching accounted for 94% of all 'professional' women in England and Wales in 1851[45]. Women were generally banned from practising in the elite professions in the 19th century by professional rules and regulations of the newly established professional associations which resembled gentlemen's clubs (Witz 1992;

[44] Corfield (1995) reported that in the census of 1851 there were no female lawyers, clerics, physicians or surgeons, engineers, or architects, and only one female veterinary surgeon (practising in Ireland).

[45] The women who entered the clergy were accepted as preachers only in the marginal faiths such as the Quakers and Methodists in the late 18th century, and were far from universally accepted (Corfield,1995). In England in1801 the prophetess Joanna Southcott published her spiritual communications and congregations were founded in her home Devon and in Yorkshire, for whom she officiated at some services. After a decade of success, belief in her predictions waned with the revelation in 1813 that she was pregnant with the Messiah at the age of 64 years, when she was infact bloated with a fatal illness (Corfield 1995).

Perrott 2002). Corfield (1995) would argue that the early professions were dominated by those with knowledge and skills, and not by men *per se*, and the availability of education to women has changed this situation markedly in the 20th century.

Women appealed for entry to the professions on the basis of their 'moral superiority' and their understanding of family, women and children's needs, and they have subsequently come to dominate those which most closely resemble the women's roles in the home (Perrott 2002). Medicine and other professions were seen to redefine themselves as 'scientific' rather than caring professions in order to exclude women. Although women have now gained access to the 'elite' professions, and more than half of new undergraduates are female in law and medicine, they do not appear to have had the same proportionate success in penetrating into the highest sectors of these professions. The reasons for this may lie not in the 'glass ceiling' but in the fact that women may find satisfaction in life from aspects other than achievement at work, are generally less competitive, and would prefer to have a work/life balance in which 'life' features more strongly.

It has been observed by Miller et al (2002) that the professions and individual roles that women have gained access to have been devalued, perhaps by virtue of the number of women within them. This 'genderisation' of the professions has also led to women holding more of the practising roles while men dominate the managerial roles in the same professions, presumably because of the appeal of the masculine, aggressive, depersonalised sentiments behind many management practices, in contrast to the caring ethos at the front line. Qualifications such as the MBA which have sought to 'professionalise' management have perhaps inadvertently also promoted the masculinity of senior management practices (Miller et al 2002). Thus women are seen to leave or opt out of management positions and make a positive decision to remain as a front line caring practitioner (Perrot 2002), being more motivated though relationships and relational competencies (Maier 1999).

It has also been recognised that women bring a different set of skills and perspectives to management, and may bring added value to senior positions when they do get appointed to them, being able to use both male and female frameworks of skills in a leadership position (Barry and Cook 2002). While stratification in terms of gender may have been reinforced and perhaps perpetuated though hierarchical top-down organisational structures, the move to more flexible networked organisations, especially in health and social services, where the importance of building personal relationships increases, may herald a more positive era of opportunity for women

(Miller et al 2002), especially if the flexibility is extended to working hours and other conditions of work. In other aspects of the NHS however, the workplace is becoming more competitive and perhaps more masculinised, especially where competitive practices have been introduced. This might then affect the future gender balance in those professions, particularly where competitive tendering for contracts has become the norm and business practices have become essential for survival.

There is a wide range of factors other than policy which have initiated and continued to drive change in the healthcare professions in the last two decades. Social and cultural change has been heavily influenced by the globalisation of communications and the media, leading to consumers who are more aware of standards across the western world, and with consequently increased expectations of standards and choice of treatments.

Media attention to the deviants of professional life across all professions, but most particularly in health and social care, has led to explicit demands for transparency, public accountability, freedom of information and legal redress. Increased regulatory measures have been introduced as a result of public pressure. These include bodies which have been set up to represent the public and give them a voice, such as the Community Health Councils, and public membership of NHS Foundation Trusts (Harrison and Macdonald 2003). Increased media attention to emotive health issues in the political arena, for example the rationing of resources and restricted funding of treatments, has been brought about as part of the trend for the media to become more entertainment based, and the need for 24 hour news services to attract custom in an extremely competitive and increasingly globalising market, especially in respect of the demise of the traditional newspaper and terrestrial television services with the exponential growth of online presentation of media.

Increased public awareness and access to specialist knowledge, especially via the internet, contributes to the continuing social trend of decreased respect for authority figures and professionals generally, as public expectations of personal rights and entitlements have been raised, including increased involvement in decision-making and choices relating to many areas of one's own and other's lives. These raised expectations of service provision together with diminished respect for professionals appear to be a general trend and are not peculiar to healthcare, though this may not be expressed to the same degree throughout the population, especially with regard to differences in age and social class.

The last two decades have seen the adoption of a consumerist approach in the public sector and, until the recent economic crisis, credit and borrowing were the norm, especially for younger members of the population who had grown up with readily available credit, rather than the post-war values of saving and 'making do'. Until the global economic crisis in 2008, there had been a marked increase in personal spending on non-essential and luxury goods and services, including leisure, self improvement, non-essential cosmetic surgery and other treatments. There was increased public acceptance of the need to subscribe to health insurance schemes or to pay for treatment privately, and a stronger somewhat selfish commitment to personal improvement, rather than to a consideration of measures which might contribute to the greater good. This period saw rapid economic growth in a boom period for the western economy[46]. The general feeling was that credit was limitless and anything was possible if you had the money to pay for it.

While the feminisation of some professions appears to have potentially devalued their status, the commercialisation of healthcare has in itself raised concerns in terms of the conflict between professional and business values. In addition, the existence of a 'conspiracy theory', in which the UK government is seen to be deliberately undermining the professional status of doctors and dentists in particular, is so regularly spoken of within the professions that it cannot be ignored.

4.5 Concerns regarding professionalism

> *" When a profession's performance no longer meets the values and needs of the society that suffers it, the demise of that profession is but a matter of time."*
> *(Van Maanen and Barley 1984)*

The notion that the medical profession is becoming proletarianised or deprofessionalised has been spoken of for some time (Gabe and Kelleher 1994; Potter and Morgan 1997; Fournier 2000). Abbott (1988) had talked of a process of 'degradation' during the formation of the professions, in which work became downgraded to be given to lower subordinate groups, resulting in the development of a more specialist elite group. Parallels might perhaps be drawn with the introduction of new roles for nurses and AHPs in the NHS Plan (DH 2000) arising from some medical work being 'downgraded'. Abbott (1988) also spoke of the opportunity to advance professional jurisdiction through improvements in technology and the establishment of large-scale organisations, both of which could also be seen to apply to healthcare at the current time.

[46]Wars and other detrimental incidents during this period occurred in remote locations, having little immediate impact on the domestic economy or day-to-day living, other than rising oil prices.

Harrison and McDonald (2003) discussed changes in the model of medical professionalism towards a more bureaucratised model, in terms of Weber's concept of a shift from Substantive to Formal rationality (Table 4.1)

Table 4.1 Changing models of medical professionalism from Harrison & McDonald (2003)

Dimension of model	Traditional model	Bureaucratised model
Rationality	Substantive	Formal
Knowledge	Professional empiricism against background of scientific research	Cumulative scientific evidence in foreground e.g. hierarchy of evidence, NICE
Application of knowledge	Ideal of reflective practice and open communication with peers	Increasingly bureaucratized e.g. in protocols and clinical guidelines
Patient needs	(Emergent) professional interpretation	Increasingly bureaucratized e.g. NSFs, Patient's Charter rights. But also advocacy for patients (e.g. PALS,) and public user involvement
Resource limitations	Professional pragmatism	Explicit cost-effectiveness and cost-utility analysis e.g. NICE
Regulation	Self-regulation	Increasingly external e.g. CHI
Legal basis	Empirical (Bolam test)	Possible shift to normative tests

The move from substantive to formal rationality implies a shift away from decisions which are based on values and carried out by social action, towards a rule-based model in which there is no regard for the patient. Tacit knowledge and judgment is replaced by an institutionalized hierarchy of knowledge, and reflective practice replaced by externally imposed explicit guidelines and protocols. Harrison and McDonald (2003) felt that there was a conflict of formal rationality with the western values of creativity and autonomy, and that the basis of the shift was a distrust of doctors, with the systems apparently instilling more confidence than the individual professionals, undermining the entire basis of a professional/client relationship.

Fournier (2000) also recognized the challenges that rationalization presented to the professions in that the codification of professional knowledge was eroding professional power at the same time as market forces were attacking professional monopolies. Rationalisation could potentially lead to proletarianisation or deprofessionalisation of the workforce, with a 'corruption' of professional practice towards a commercial rather than public interest, and an erosion of the professional monopoly of knowledge. The establishment, maintenance and redefinition of boundaries became all the more

important in these circumstances if a profession was to adapt and survive (Fournier 2000).

As one of the three traditional professions with a well established status and power base, the medical profession has been well aware of societal trends and government policy which has reduced the power of the profession in the past two decades. This has led to a number of publications which were commissioned to explicitly set out the basis of the profession and its principles. The Medical Professionalism Project was published in the United States in 1999 stating that medical professionalism was based on the three principles of Patient welfare, Autonomy and Social justice. In 2004 The Kings Fund published its discussion document "On being a Doctor – Redefining medical professionalism for better patient care", to act as the basis for a series of 'roadshow events' throughout the UK, in which it sought to stimulate debate regarding the medical profession, and to gauge the current range of feelings on the issue (Rosen and Dewar 2004). A Report of a Working Party at the Royal College of Physicians, entitled "Doctors in Society – Medical professionalism in a changing world", was published in December 2005, and addressed a similar range of concerns (RCP 2005). Stating that "Medical professionalism signifies a set of values, behaviours and relationships that underpins the trust the public has in doctors" (p.14), it indicated strongly that the key issue for the profession was to maintain the trust that the public had in doctors. Most recently a 'Consensus Statement on The Role of the Doctor' was published in January 2009, agreed between a wide range of associated bodies including the UK Chief Medical Officers, The Academy of Medical Royal Colleges, The BMA, The GMC and the Medical Schools Council. It opens with acknowledgment that the doctor's role is continuously evolving, and states that:

> *'Doctors alone amongst healthcare professionals must be capable of regularly taking ultimate responsibility for difficult decisions in situations of clinical complexity and uncertainty, drawing on their scientific knowledge and well developed clinical judgement. The doctor's role must be defined by what is in the best interest of patients and of the population served."*
>
> *(NHS Employers 2009)*

This appears to demonstrate a keen desire to establish the means through which the medical profession is differentiated from others in healthcare, in order to set them apart from the newly emerging range of professionals. It might be assumed that the need for so explicit a statement indicates the degree of concern within the profession at this time. There is also a sense that public trust in the profession has diminished, and that the altruistic beliefs and values of the medical profession have been brought into question. Within this same statement it is said that doctors seek to "apply their knowledge and skills to synthesise information from a variety of sources in order to

reach the best available diagnosis and understanding of the patient's problem", which not only emphasizes the altruism of a patient-centred approach, but also the emphasis on diagnosis which Abbott (1988) deemed so important in professional service.

It can therefore be argued from such publications and roadshows that the medical profession perceives itself to be under substantial threat from the organisational changes and regulation of healthcare during the last decade. It is this assumption which has led this study to focus on the internal perspective of the nature and implications of change within the healthcare professions, and how the professionals themselves have made sense of and reacted to these changes.

4.6 A preliminary investigation of perceptions of change in the healthcare professions

A picture now emerges of a range of healthcare professions, all of which have undergone recent transformation and change, largely through implementation of policy, which in many areas would be difficult to separate from concurrent social trends relating to the economy, media and world events. The literature concerning the professions and the professionalisation process is now starting to consider these 'new' healthcare professions, together with the implications of the imposition of change on them in a relatively short period of time. A unique opportunity has arisen to study the experiences of this group of professionals during this period of change, in an effort to understand the processes from their perspective, and to gauge their reactions to the externally imposed policy that will alter their professions, in terms of their future characteristics, structures, behaviours and relationships.

This study is not intended to explore the implications of policy in terms of issues such as service delivery, but is focused on identifying the current measures which are bringing about change in the healthcare professions, the perceptions of the professionals within these groups, and their responses to the changes experienced. The initial exploratory part of the study thus sought to address the following research question, within the current social and political context:

Preliminary Research Question:
R1. What has been the perceived impact of recent change on UK health professionals?

A preliminary investigative phase of fieldwork and data collection was undertaken from 2005 to 2008 in parallel with the review of the literature, as part of an iterative approach to gauge current feelings within these professions regarding changes and threats to

their professional values and institutions, in order to inform the appropriate direction and methods for the subsequent stages of the study.

4.6.1 Methods

A full discussion of the methodological aspects of this study follows in Chapter 5, and this present section will thus be limited to a description of the methods of the investigative initial stage of research, through which the basis for the main research study was established.

This initial phase of unstructured opportunistic data collection involved:

- observation (participant) – healthcare workshops, conferences, focus groups and meetings
- observation (non-participant) – healthcare workshops, conferences and meetings, conversation mapping, focus groups
- unstructured interviews
- semi-structured interviews

A semi-ethnographic approach was employed to investigate professionalism across a range of healthcare roles. Initial attendance at organised events in healthcare which were relevant to the field of study had led to the development of a specific interest in professionalism and the intention to research this area in more depth. Opportunities during the 3 year period from 2005 to 2008 arose either by invitation to existing events through academic and professional links, or via opportunities to run workshops directly related to professional development and leadership in the field. The events, all based in England, involved a broad range of healthcare professions, affording the opportunity to listen to presentations and discussions relating to professionalism in medicine, nursing, dentistry and the allied health professions. The opportunity arose to engage in direct one-to-one discussion with members of the relevant professions, either through organised round-table discussions or more informally during networking and refreshment breaks. A number of the events were in the researcher's own profession of dentistry, in which the roles of observer and participant were assumed at various times.

A number of the events were at workshops such as those hosted by the British Dental Association, the Kings Fund, the Royal College of Physicians and the General Dental Council. Others were through research opportunities in studies being undertaken for closely related research in associated areas of healthcare. At a number of events the opportunity arose to lead the discussion or learning activity, whilst in others the study was through observation, either as a participant or non-participant. A full list of the activities included in this preliminary part of the study are shown in table 4.2 below, indicating the research method employed at the event.

Table 4.2 Events included in fieldwork for the preliminary phase of the study

Event and host	Date	Method employed
Workshop of dentists who were asked to analyse their business environment and highlight main issues and concerns regarding their revised working conditions arising from changing contracts (Dancer & Taylor 2007)	June 2005	Observation – participant (workshop leader)
A conversation-mapping exercise with a group of 9 dentists in NW England to analyse their perceptions and concerns regarding major policy changes as part of a research study of incentives and governance relating to the new dental contracts to be introduced in April 2006 (Harris et al 2007)	October 2005	Observation – non-participant Notes and subsequent analysis of conversation map
Interviews with 6 GDPs in NW England as part of a research study of incentives and governance relating to the new dental contracts introduced in April 2006 (Harris et al 2007)	Nov 2005 – March 2006	Semi-structured interviews Recorded and transcribed
Interviews with 5 PCT contracting managers in NW England regarding contracting with doctors and dentists	Nov 2005 to March 2006	Semi-structured interviews Recorded and transcribed
Discussion session with a group of senior AHP therapists on a Masters level leadership module regarding issues of Tribalism and Professionalism (Dancer 2008)	June 2006	Observation – participant Recorded and transcribed
Informal conversations regarding changing professional roles with doctors and dentists on the Mentoring programmes in Mersey and Northern Deaneries	December 2006 to January 2008	Observation – participant and non-participant
Workshop of over 100 doctors and associated professionals on Medical Professionalism hosted by the Kings Fund/RCP at Liverpool Medical Institute as part of a national consultation exercise	Nov 2006	Observation – non-participant Notes taken and online survey results
Interview with the Chief Executive of the BDA	Feb 2007	Semi-structured interview Recorded and transcribed
Workshop in Lancashire with 14 GDPs hosted by the BDA on Business and Professionalism in Dentistry	Feb 2007	Observation - Participant (workshop leader) Notes taken
National workshop regarding current issues of revalidation and professionalism in Dentistry, held by General Dental Council at the British Dental Association Conference, Harrogate	May 2007	Observation – Participant Notes taken
Attendance at conference presentations in a session on 'Professionalism in Dentistry' at the British Dental Association Conference, Harrogate	May 2007	Observation – non-participant Notes taken
Meeting with 2 members of the GDC Revalidation Committee to discuss Professionalism in Dentistry and its measurement, at GDC in London	August 2007	Observation – participant Notes taken
2 focus groups relating to leadership and professionalism with groups of allied health professionals, Senior nurses and NHS managers on a Masters level leadership module, University of Liverpool	March 2008	Observation – non-participant Recorded and transcribed

A number of these opportunities arose through involvement with other research studies. A concurrent study of incentives and governance relating to the new NHS dental contracts introduced in April 2006 was undertaken with a colleague in the

Department of Dental Public Health at Liverpool University School of Dentistry[47]. The findings of this work have been subsequently published, and the current research will provide further insight into many of the issues raised in this study (Dancer and Taylor 2007; Harris et al 2007; Harris et al 2008; Harris et al 2010). The conversation mapping and semi-structured interviews included in the preliminary phase of this current study raised a number of issues, some unanticipated, with regard to the dental profession and the changes it was experiencing. The interview questions included issues relating to professionalism, professional values, and concerns regarding changes within the profession. The interview tapes were subsequently transcribed and analysed, together with notes and documents from the events.

Further concurrent research included an ongoing study of Leadership and Professional Development in Allied Health Professionals with a colleague in the School of Health Sciences at the University of Liverpool, with the award of a Northern Leadership Academy Fellowship to pursue this area study in support of the current research. This afforded the opportunity to record discussions and focus groups with senior members of the Allied Health Professions, senior nurses, and healthcare managers in both primary and secondary care settings, and to explore their perceptions of their own changing roles and the development of their newly established professions and professional councils, together with the changes they had experienced in their working lives and their perceptions of the future. These discussions were recorded, transcribed and analysed, and the preliminary findings published (Dancer 2008).

The interview with the Chief Executive of the BDA arose from a personal introduction at a regional event, and took the form of a 1 hour semi-structured interview relating to issues around the dental profession and its current context. The initial issues for discussion were identified from the publications "*On being a Doctor – Redefining medical professionalism for better patient care*" (Rosen and Dewar 2004), and "*Doctors in Society – Medical professionalism in a changing world*" (RCP 2005) both of which were distributed at the Kings Fund Workshop on Professionalism in Medicine which had been attended in Liverpool in 2006. The areas for discussion for this particular interview centred on possible differences between the medical and dental professions at that time, and whether the perceived concerns of the medical profession were also relevant in dentistry. The interview covered the following areas:

[47] This involved an initial conversation-mapping exercise with a group of 9 dentists from the North West region of England, to analyse their perceptions and concerns regarding major policy changes. The issues raised then informed the development of a questionnaire which was sent to dentists across 12 PCTs in North West England, which attracted 400+ responses, and these were followed up with a series of semi-structured interviews with a number of General Dental practitioners particularly focusing on job satisfaction and motivation. As part of this same study, further interviews were conducted with contracting managers in the same PCT areas, regarding their experiences of negotiating contracts with dentists and other health professionals.

1. **Professionals** : What would you consider to be the major changes in the concept of a 'professional' in Dentistry over the past 10 years?
2. **Trust**: What are your thoughts on the level of public trust in the dental profession at the moment and what has influenced that?
3. **Professional freedom**: What has been the impact of the new dental contract on restricting professional freedom (to define standards and organisation of care)?
4. **Development**: Are dentists sufficiently involved in the development of dental services?
5. **Leaders**: in dentistry, what would be an appropriate 'lead' organisation or person to represent the profession in a developmental role?
6. **Patient engagement**: do dentists put their own interests above those of their patients? Does the profession engage adequately with the public?
7. **Business**: do you think there is a conflict between 'business' and 'professional' interests?
8. **Expectations**: has the profession failed to respond to changes in the expectations of society? And suffered as a consequence?
9. **New ways of working**: what has been the impact of changing professional roles and the introduction of DCPs on professional identity in dentistry?
10. **The future**: does the profession need to define a new model of professionalism in Dentistry?

Further workshops and conference presentations were attended and opportunities taken to discuss relevant issues with the practitioners concerned in medicine, dentistry, nursing and the allied health professions, or to listen to discussions between the professionals attending the events, either formally or informally. Handwritten notes were made during and after each research episode, of the issues which had been discussed and of the questions raised during the proceedings. These were analysed in conjunction with any tape recordings made and the documents circulated at the events or published subsequently. The documents and notes relating to each event were revisited regularly to identify emerging themes and, most particularly, the issues which appeared to be of prime importance to the members of the professions themselves, with regard to their profession and the changes they were experiencing at the present time.

4.6.2 Main findings from the preliminary study

Through analysis of the data generated from the research episodes in this preliminary phase of work, a number of issues of importance relating to the relevant health professionals became evident:

1. All the healthcare professions felt that they enjoyed a degree of clinical autonomy, although the doctors (and to a lesser extent the dentists) felt that this was diminished by tighter state control of funding for certain treatments.

2. The AHPs were still rather uncertain of their newly developing roles and there were marked differences in what appeared to be equivalent positions across different NHS trusts.
3. Concerns were voiced by the medics regarding the future of their profession, and in particular the problems caused by an apparent lack of effective leadership and a perception of loss of public trust in the profession. This had prompted the move towards explicit redefinition of medical professionalism in the 21st century
4. AHPs reported misunderstanding of their new roles by other health professionals, and a strengthening of 'tribal' tendencies between the therapist groups, who previously would not have spoken to one another, but were now joining together in the face of what was perceived as a common threat. For example, dieticians, physiotherapists and radiographers would train separately and belong to different professional bodies but were now grouped together as 'Therapists', often with new joint working arrangements and agreements.
5. There was great uncertainty in dentistry regarding the ways in which new healthcare professionals (DCPs) would fit into the overall service delivery system, and the threat which they might pose in terms of reducing the work available for dentists in the future, especially when increased numbers of dentists began to qualify annually from 2010 as a consequence of government policy.
6. There was suspicion and mistrust by clinicians of policy changes generally in healthcare, based on poor experiences from the past and a lack of regard for those developing the policies in the Department of Health. Substantial differences in approach between clinical managers and non-clinical managers in healthcare persisted, and were becoming more pronounced in many areas of practice.
7. Both doctors and dentists shared a general dislike and low regard for 'managerial' staff (including PCT and DH staff) who they felt were driven by targets and policy, and who did not take the time to understand the clinical aspects of heath service provision, nor the implications of their policy decisions on the business aspects of the professionals' practices.
8. PCT contracting managers reported a marked difference in the way that primary care doctors and dentists related to the contracting process, with dentists being more business-like in their approach.
9. A major source of satisfaction for dentists was their ability to do a good job clinically, whether the patient realised it or not, and this professional satisfaction overrides financial reward as their main incentive to work (Harris et al 2008).

10. A major concern of primary care dentists was the potential loss of control of their own businesses and consequently of their workplace, through new NHS contracting arrangements which allowed the PCT to dictate workloads and staffing levels etc, in their practices (Dancer and Taylor 2007).
11. Uncertainty regarding the future was of universal concern across all the professions.
12. AHPs and nursing staff held in low regard the 'professionals' that they related to in social services, and were directly observed during the study event as being aggressive towards NHS managers who came from a non-clinical background.
13. There was growing debate around the conflict between healthcare delivery and the provision of commercial healthcare services. There were suggestions of a move towards a new professional attitude in dentistry which might embrace the business aspects of privately-funded practice in response to patient demand for additional (often cosmetic) services, complementing the delivery of essential healthcare services. Middle-aged and older dentists found that the business aspects of their practice conflicted with their traditional professional values, but there was a definite move towards dentists developing a more business-orientated model of professional practice which was more financially-based with a scale of professional fees.

These initial findings highlighted a number of issues: the continuing importance of autonomy and control to the majority of these professionals; the existence of ambiguous identities and problematic self-recognition of their changing professional roles; and the range of attitudes which existed within the professional groups of their relations towards other professionals, in healthcare and beyond. Other professional groups might be regarded either as a threat (as in medicine with regard to extended nursing roles), or as a group not to be trusted (as in clinicians with regard to managers and politicians). In a few cases they were regarded as new-found allies (therapists grouping together). The traditional clinical/non-clinical managerial interface remained problematic despite increased numbers of clinicians in management positions in most Trusts, and this was seen across medics, nurses and AHPs. The different ways in which the various professional groups conducted themselves became apparent, and this became more distinct between the doctors and the dentists in terms of the way they approached delivery of their professional services in a business sense, and in their reported negotiating styles during contracting.

Clear differences were evident between the attitudes of the old established traditionally male-dominated medical and dental professions, and the newer female-dominated

professions of nursing and AHPs, who were becoming more highly evolved with additional professional standing. Nurses and therapists were experiencing increased levels of responsibility and governance, with inter-professional relationships being redefined through legislation and additional requirements for professional registration and CPD, and were in some cases meeting with marked resistance from medical colleagues in their new roles. They also reported personal uncertainty over their roles and the adequacy of their training to undertake the care required. Concerns had been voiced by doctors during discussion sessions regarding the future of the medical profession and its lack of leadership as it has moved into the 21st century, and much of the discussion strongly mirrored the sentiment of the associated publications in suggesting that the medics felt under threat and were extremely concerned regarding the future of their profession. They had actively and explicitly set about redefining medical professionalism in terms of increasing engagement with patients and the trust relationship developed between practitioners and their patients (Kings Fund/ RCP workshop "Do Doctors have a future?" Liverpool, November 2006).

In addition to the changing relationships between healthcare professionals themselves, these newly evolving professional groups presented a further challenge in terms of negotiation and management of contracts, as primary care practitioners became much more closely involved with their contracting PCT, and acute trusts redefined their services in response to increased controls through financial deficits, waiting times, payment by results, and initiatives such as applications for Foundation Status, European Working time directives, Modernising Medical Careers, Agenda for Change and Revalidation. Fears were also expressed that the increased uncertainty and ambiguity over emerging clinical roles might be detrimental, both in terms of increased risk to patient care and increased inefficiencies in service delivery.

The dentists appeared more independent as practitioners and less worried over the prospect of 'deprofessionalisation' *per se*, though certainly more concerned with the practicability of continuing to run their practices in a business sense under the new NHS contracting arrangements, which had severely restricted their freedom to make business-orientated decisions independently of the PCT. They clearly resented this interference and many had adopted a fairly ruthless stance in what they perceived as their fight for survival. It became apparent that the issues faced by the dental profession had become rather distinct from those faced by other members of the healthcare professions, due mainly to their rather unique status as a freestanding profession, and also to the distinctively different ways in which their practices were established. This enhanced the relative freedom which they enjoyed to independently

engage in contracting arrangements with both the state and private sectors. The identification of this unique contextual circumstance for dentistry at this time informed the decision to pursue the dental profession as a specific case-study of a profession undergoing change for the fieldwork in the main phase of the study.

4.7 The dental profession as a focus for this study

This initial phase of fieldwork indicated that the dentists stood apart from the other groups in healthcare, not only by virtue of their unique contracting relationship with the NHS but also in their own characteristics and their attitudes towards other professional groups. A more detailed consideration of how this profession might have reached its present construct will shed light on its current form.

The dental profession, while still regarded as closely allied to medicine in terms of its status and responsibilities, has in fact developed along rather different lines from rather humble beginnings. Tooth drawing was originally rather crudely practised, but the more skilled operators became members of the Barber-Surgeons Guild[48]. In the latter half of the 18th century the likes of John Hunter made important contributions to the scientific study of teeth, and 'Operators of the teeth' became an increasingly skilled occupational group.

Thereafter a small group of educated men from the Royal College of Surgeons became 'surgeons who performed dentistry', whilst the majority of dental procedures were still carried out by uneducated and unqualified persons who attracted clients by blatant advertising (Carr-Saunders and Wilson 1933). The initial Dentists Act was passed in 1878 (modelled on the 1858 Medical Act), and the British Dental Association was founded in 1880 as an elite club for registered dental practitioners only[49]. Dental practitioners were registered with the General Medical Council, and those not on the register were forbidden to call themselves a dentist or dental practitioner[50]. However, they were not actually forbidden to practice dentistry, and so in reality the Act had little impact on preventing practice by those who were unqualified.

[48] It is a commonly held misconception that Barber-Surgeons undertook all aspects of both forms of practice, whereas infact they practiced either as a barber or as a surgeon, and the two were linked for purely administrative reasons. However, the exception was that the barbers were the tooth drawers, and this was seen to be part of their operational domain.

[49] At this point many sociologists, including Carr-Saunders and Wilson, would consider that dentistry became a profession rather than a commercial trade by virtue of the creation of its professional association.

[50] They were thus not technically allowed to recover any fee for the provision of dental operations or advice.

The Dentists Act 1921[51] did however effectively restrict the practice of dentistry to those entered on the Dentists Register[52]. Admission to the register could only be gained by holding a diploma granted by an official licensing body, but initial grandparenting clauses allowed entry to a number of those who had been practising dentistry formerly. The registration and regulation of dentists thus came much later than for their medical colleagues, and there is little to link the two professions except for the fact that the GMC was involved in both their initial registrations. There can be no doubt that the dental profession benefited greatly in status and power by its links with the medical profession in its early development. By 1933 there were 14,000 registered dentists of which half were qualified (and half grand-parented), but concerns were being expressed regarding poor practice by those not properly qualified[53]. The consequent poor reputation of the profession was blamed for inadequate recruitment levels, as well as for poor standards of practice.

At the inception of the NHS in 1948, dental care was brought under a general 'item of service' scheme for all patients regardless of their financial status, as part of the overall package of care. GDPs held independent contractor status, essentially running their own businesses. Subsequently, the concept of healthcare being delivered in a business-like manner has again become more acceptable, with the widespread adoption of private sector practices more generally within the public sector over the last two decades. Section 40 of The Dentists Act (1984) set out the scope of the 'Business of Dentistry', and subsequent amendments in regulatory changes allowed the 'marketing' of dental services in the early 1990s. The introduction of significant NHS patient charges in 1990 brought substantial cash-flow into dental practices, and the profession itself was forced to adopt more business-like practices in order to operate successfully in this new context[54].

Under this NHS fee-per-item system, dentists had the flexibility to control their income by altering their workload and influencing their revenues accordingly. They also enjoyed the power to employ dentally qualified associates and assistants who could relocate between posts with relative ease, or choose to open or purchase a practice as a principal. Newsome (2003) observed the changes in dental care over the previous three decades and made comparisons between dentistry and other fields of business. The market for cosmetic dentistry grew substantially and lifestyle media programmes

[51] Under the 1921 Act, a Dental Board of 13 members was set up, although the GMC still had the power to carry out disciplinary action.
[52] With the exception of medical practitioners, emergency extractions by chemists, and minor work carried out under the direction of a registered dentist in the publ ic dental service.
[53] Some were reportedly summoned to answer charges of "poaching for clients, of advertising, of using spot lights and illuminated signs" and needed to learn a lesson according to Carr- Saunders and Wilson (1933, p.115).
[54] This is reflected in the increasing range of business training publications and courses on offer to dental practitioners.

stimulated a greater interest in this area, with practitioners able to offer a wider range of privately-funded services to meet patient demand for lifestyle treatments[55].

At the same time, dentistry has developed an increasingly higher media profile and, while the general perception might be of a profession delivering a poor service and driven by money, individual experiences at a more personal level are more often positive. Unlike the majority of their medical colleagues, dentists do have a real choice regarding their working environment, and a viable alternative for dentists dissatisfied with the NHS has been to move partly or entirely to the private sector. The legal introduction in 2006 of DCPs (Statutory Instrument 2005) has meant that dentists may potentially find themselves in a stronger leadership role, heading an extended clinical team with more power to direct the actions of others.

It is thought that some of the differences between the medical and dental professions arise from inherent differences in the individuals who enter the professions. Crossley and Mubarik (2002) studied the motivations of medical and dental students and suggested that medical students were more motivated by altruism and intellectual challenge, while dental students were more committed to personal and financial gain. Dental students were also motivated by factors relating to status, security and the nature of their occupation such as regular hours, self employment and independence. Brand et al (1996) found that the desires to become independent, to serve others, to enjoy job satisfaction and financial security were prime motivators in Australian dental undergraduates, but were surprised to find that status and prestige were relatively unimportant. Kulich et al (1998) found that the reasons for taking up a career in dentistry included working with people, an interest in medicine, working with manual skills, being well paid, and having a high status. Hallissey et al (2000), in a survey of Irish dental students' reasons for choosing dentistry as a career, showed that the relative importance of ease of employment, being self-employed and working regular hours, followed by the opportunity of securing a good income and helping people, were their main motivators. This study also demonstrated a positive relationship between factors relating to employment conditions, indicating that dentists as a group want to have control over the running of their practices and that this is a priority for them. Thus money, status and control appear to be key motivating factors to those entering the dental profession.

[55] These would include procedures in cosmetic dentistry, tooth whitening, Botox injections, cosmetic fillers, and anti-snoring devices.

Kulich et al (1998) investigated practising dentists' descriptions of the ideal characteristics of a 'good dentist', and desirable skills included self-confidence, stress tolerance and know-how in financial management and administration. Calnan et al (2000) showed that dentists entered the profession because it was practically orientated and that they could 'help people', but few felt equipped for the business aspects of the job. Nevertheless, 88% felt that business orientation was essential to the job, and 68% felt that it was appropriate to run a dental practice in the same way as any small business. An entrepreneurial flare was demonstrated in the dentists tending towards private practice, who were more innovative and open to the adoption of new technologies, while those with more NHS patients focused on arbitrage and efficiency savings.

Chambers (2001) considered that the career satisfaction of a dentist could be partially predicted from an understanding of dentists' personalities and values. It was hypothesised that dentists seek situations where they can exercise control and establish paternalistic relationships with others. Factors such as uncooperative patients, incompetent staff and government intrusions were major 'dissatisfiers' which might threaten the dentists' core need for control. Factors such as quality of work, which were under the direct control of dentists, were identified as major 'satisfiers'

Dentists clearly value autonomy and wish to retain independent control of their own work situation. They are singular amongst healthcare professionals in their ability to mix high proportions of NHS and private work with an increasing degree of flexibility under their present contracting arrangements. From April 2006 a capped national dental budget was devolved to NHS PCTs to be distributed through local contracting agreements. From this date, the dentist as a contractor would agree to provide a target number of Units of Dental Activity (UDAs) for a negotiated monthly payment from the PCT. The impact of this 2006 contract has been studied in terms of its effect on practitioners' motivation and satisfaction (Harris et al 2007; Harris et al 2008) and has been the subject of a preliminary paper examining the practitioner's perspective in relation to the business aspects of dental practice (Dancer and Taylor 2007). This demonstrated the ability of dentists to readily adopt a business perspective in relation to their practice, and highlighted the importance of autonomy in decision-making for this particular group of practitioners. In line with expectations from studies relating to the psychological contract in other employment situations, trust and security were identified as key factors in their decision to remain working within the NHS, but concerns were specifically raised with regard to potential loss of control of their work situation.

The April 2006 contract for NHS Dentistry was heralded by the Department of Health as "the most significant reform to NHS dentistry since its inception in 1948" (BDA 2006b) and it was thus anticipated that its impact on the dental profession would figure prominently in this present study. The distinct contracting arrangements for dentistry in the NHS have led to a situation where the dental profession would appear to be at a significant juncture in its development. As a profession it does not appear to be in decline in the same way many might consider the medical profession to be, and is providing increasingly sophisticated and wide-ranging services that are in great demand. It is clearly being forced to change through specific government policy, together with wider social and economic pressures. In this respect, this particular profession provides a discrete and unique opportunity to study a profession responding to change and undergoing transformation at this present moment in time. In particular this study will seek to identify the extent to which recent government policy has affected the profession of dentistry, as perceived and expressed by its own members, and will examine particularly the issues arising for a healthcare professional delivering state-funded services in an essentially commercialised setting.

4.8 A new professional model for Dentistry?

As demonstrated in the previous section, the dental profession has evolved in its own distinct way compared to medicine and other healthcare specialities, and although in some respects it is a fairly young profession, it appears to have nurtured a strongly independent group of practitioners who value their professional autonomy and financial independence highly (Dancer and Taylor 2007). While there may currently only be 32,000 dentists registered to practice in the UK[56], this is still a substantial professional group with an annual NHS budget in the region of £1.5 billion (BDA 2008). While much funding appears to have been directed towards studies focusing on the relationship between medics and managers (see Kennerley 1993, Thorne 2002, Harrison and Lim 2003, and others), and the changing identities of and roles within the medical and nursing professions (Fitzgerald and Teal 2003; Sergeant 2003; Ellis 2004), little appears to have been undertaken in relation to changes and developments in the dental profession.

Harrison and Lim's (2003) definition of 'professional autonomy' in relation to medicine took a distinct bias towards clinical autonomy in dealing with aspects of patient care, rather than a broader 'professional' perspective. As previously discussed, it could be

[56] Compared to approximately 120,000 doctors.

argued that 'autonomy' may itself have been reduced in importance as a defining element of a healthcare profession with the advent and growth of performance measurement and clinical governance, both increasingly outside of the remit of the clinical professionals themselves (Ellis 2004). In this respect, dentists have historically been accustomed to regular external scrutiny of their clinical work and judgement through the data collection and inspections of the Dental Practice Board (DPB)[57], but dental practitioners appear less happy to relinquish further aspects of control over their businesses. While the Acting Chief Dental Officer in 2005 issued reassurances that there would be no interference in the day-to-day running of their practices through the new contracting agreements (DH 2005b), concerns over the potential for increased governance at PCT level, the reduced flexibility to control long-term developments in their practices, and uncertainty over longer-term strategy and government commitment to primary care dental services have become apparent within the profession (Dancer and Taylor 2007).

The dental profession has historically negotiated a different set of professional relationships than has medicine. It did not enjoy a period of patronage from the gentry, but it did enjoy a period of collegial professional/client private contracting relations during the first half of the 20th century, in which the professional very much controlled the proceedings and could dismiss the client at will. Once the NHS was established, dentistry did not enter into such a binding agreement as that between the doctors and the state, in which, Johnson (1972) warned, such mediated relationships might become blurred and poorly differentiated in terms of whom exactly is the client and whom the contractor. By remaining in a fee-per-item system of payment and contracting, the dentists largely retained their independence from the state, and control over their contracting relationship. While some changes were encountered with the introduction of capitation fees in the 1990s, tying the dentists more firmly to their NHS-funded commitments, their flexible commitment to the state remained virtually unchanged until the contract of April 2006[58]. The PCTs then essentially became an employing organisation for those dentists who remained in the NHS, setting targets and payment values for NHS dental work contracted to each practice or individual professional. This brought state-funded dentistry much closer to the system under which medical GPs are funded, in a strictly controlled mediated contracting arrangement.

Johnson (1972) predicted that in these circumstances of meditative control there is a sense of nationalisation, where the state defines both the needs of the clients and the

[57] Now part of the NHS Business Services Authority (BSA).
[58] This handed the purchasing power for block contracts of NHS dental work to the PCTs.

manner in which the need is catered for, removing the power from both consumer and producer in the relationship. While there is a diverse and guaranteed clientele and overall uncertainty is reduced in such circumstances, there is confusion between the consumer/employer roles. Johnson also noted that increased bureaucratisation led to stratification and fragmentation of the professions, threatening the completeness of the professional community with the development of localism, in which loyalty lies with the employer rather then the profession (Johnson 1972). There might be an increased potential for this in dentistry, where there is no dominant power group as divergent occupational interests have developed, where individual practitioners can choose to stay within the state funded system or remove themselves from it (either partially or fully), and where recent legislation has allowed a rapid expansion in the numbers of 'bodies corporate' who now directly employ dental professionals to undertake the business of dentistry. In such circumstances Johnson (1972) noted that the function of the occupational association (in this case the BDA) would assume a trade union type of role, rather than a role in maintaining 'colleagueship' and group identity.

This shift in the external contracting relationship in dentistry has been paramount in determining the power relations and autonomy retained by the profession. Most important in this respect is the dental professional's ability to retain their independence from the state and maintain a collegial type of relationship with individual clients, in which the professional retains control, although the balance of power between consumer and producer will also be subject to the prevailing economic and market forces. The increased willingness of consumers to pay for healthcare in the UK is tempered in this equation by their raised expectations of care and value, and their ability to 'shop around' as more dentists offer private care which was previously unavailable. It is of note, however, that money may not be the main driving force behind dentists' decisions to work privately. A major source of satisfaction for dentists is their ability 'to do a good job' clinically, and this professional satisfaction is reported as overriding financial reward in providing their main incentive to work (Harris et al 2007).

The closer ties between the NHS and the dentists providing its services beg further questions of how this changed relationship is viewed by those within the profession, and how they have reacted to increased organisational control through closely monitored PCT contracts. In experiencing a transformation similar to that of their GP colleagues in the 1990s, the extent to which dentists are willing to concede the shift from Professional to Responsible autonomy (Dent and Burtney 1993) is as yet unknown, and it would be difficult at this point to place the UK dental profession on

Dent's model of Autonomy and Control (2003) without further investigation (see Figure 3.2). These issues warrant further scrutiny, given this professional group's expressed desire for autonomy, together with their independence in practice and decision-making. While much of the original literature on the psychological contract of Rousseau and others pertains to the relationship between employers and employees, later work by Van der Heuval and Schalk (2009) refers to 'the organisation' rather than the employer, and many of the same principles of mutual obligations and fairness might be inherent in the largely unspoken promises and implicit understandings between the professionals currently under consideration and the NHS organisations with which they contract, based on the mutual trust established between the provider and the organisation. Again, the unique nature of the current contracting and funding systems in dentistry have allowed the professionals themselves to determine what they are prepared to accept in terms of both transactional and relational transactions (Kickul and Lester 2001), with the intention to leave, or actual exit from the NHS organisation, being a viable violation action for many.

The importance of the way in which changes are managed and introduced by the NHS, the involvement of the professionals in decision-making, and the organisation's understanding of the professionals' views of the 'psychological contract' would seem all the more important in these circumstances, if the NHS does indeed wish to retain its highly valued workforce in this area. The 'HR in the NHS' strategy has been deployed in other areas of healthcare in order to retain staff, although it has been observed that the majority of middle management in the NHS lacked the capacity and skills to mange change effectively (Cortvriend 2004). Fielden and Whiting (2007) also observed that NHS employees demonstrate higher levels of loyalty to and pride in the organisation than might be expected, especially when they had worked in it for many years, and that job satisfaction in this case might come from the variety of the work and direct patient contact, in spite of organisational shortcomings. The difficulties facing a large multifaceted organisation such as the NHS must be acknowledged. Promises are regarded as an essential building block on which the psychological contract is based, and difficulties might be anticipated where centrally-made promises arising from the Department of Health might be broken at a local level by the PCT directly involved in the contracting relationship (Fielden and Whiting 2007). The form of the relationships into which a dental professional might enter are so varied and flexible that they would appear to pose some considerable challenge in terms of the interpretation of the existing literature and findings related to the psychological contract and its management.

It would appear that the opportunity has arisen at the current time for a move towards a new professional attitude in Dentistry which might firmly embrace the business aspects of privately-funded practice, while complementing the delivery of essential healthcare services through the NHS. The move towards developing a more commercial model of professional practice (similar to their legal colleagues) which is financially-based with a scale of professional fees, indicates their freedom and desire to move away from the traditional NHS patient-centred healthcare model of service delivery into a field of practice in which they retain much-valued autonomy and control, both of their clinical work and their own individual career development, and in which they can establish and verify a new professional identity.

A series of three articles by an ethicist Welie was published in the Journal of the Canadian Dental Journal in 2004, in which he proposed two models for dentistry, one in which it is a profession and one a business, with individuals making a definite choice between the two (Welie 2004a; Welie 2004b; Welie 2004c). The dental profession in the UK however now appears to be developing a more distinct professional identity in adopting a new professional model which will combine the range of health and commercial services demanded by contemporary clients. The difficulty this engenders in terms of the public perception of dentistry as a healthcare profession is articulated by Peter Ward, Chief Executive of the BDA:

> *"When I talk on the subject of 'The Business of Dentistry' one of the first hurdles I have to overcome is people's perception that there is something wicked about money. Money is important as a vital resource for any business, and any delivery system, and you almost have to apologise for explaining the fact that the practice needs to be profitable."* *(Ward, 2007: personal communication)*

In this discussion a clear series of issues have become evident which appear to increasingly separate the medical and dental professions. The new dental contract is proving difficult to manage for a number of practitioners in terms of business continuity and service quality, and the professionals concerned are faced with a choice of how they wish to conduct their future professional practice. This appears to be the point at which the medical and dental professions are redefining themselves upon potentially divergent models, in order to continue practicing within their own spheres of healthcare in a manner which is compatible with contemporary values and demands from society. These differences between medicine and dentistry might lead us to suppose that the allegations of 'deprofessionalisation' of the medical (Fournier 2000) and other healthcare professions may not hold true for the dental profession, given its relative freedom to choose alternative forms of professional practice outside of the state funded and NHS managed services. So, too, the idea that the professions are being proletarianised (Murphy 1990; Siegrist 1990) might perhaps not be realised in this

professional group, which appears to be capable of maintaining a high degree of autonomy and control over its own practices.

There is scant literature concerning the issue of professionalism in Dentistry, and papers that have been published recently in the UK have been opinion pieces with little or no empirical backing (Ward 2007; Cottingham and Toy 2009; Trathen and Gallagher 2009). These publications have arisen in response to concerns regarding the GDC's intention to introduce revalidation for UK dentists in 2010, with 'Professionalism' being used as measure of fitness to practice and thereby retention on the dental register. These short papers highlighted the profound change that the profession has experienced in the recent past and urged debate on the issue of professionalism in dentistry. Cottingham and Toy (2009) regarded the dental profession as undergoing a process of industrialisation, and appear to assume that this will continue. It could be argued that the process is much more complex than 'industrialisation' as seen in its historical context, and that Fournier's (2000) 'labour of division' or Abott's (1988) 'degradation' would be more appropriate processes to discuss than a simplistic division of labour at the current time. There is also an assumption that dental professionals will continue to engage with this process, which would seem unlikely since they have already shown themselves to be a highly independent and entrepreneurial group who value their autonomy (Dancer and Taylor 2007).

Trathen and Gallagher (2009) attempted to establish the basis of professionalism in dentistry with reference to the RCP definition developed for medicine (RCP 2005). They compared a limited number of existing definitions of professionalism, and discussed the difficulties facing the profession in terms of balancing business and professional values. It was considered that the imminent introduction of revalidation will translate some of the present 'ought' elements of professional conduct into 'musts', reducing the discretionary element of professional ethical judgment and rationalizing dentistry further. A modified definition of professionalism for dentistry was proposed which added as a requirement that practice be conducted within "the context of a realistic economic framework" (p.252), thereby allowing the profession's services to be accessed by all who need them. While this is an admirable goal, it could be argued that professionalism *per se* is a property of those individuals who comprise the professional community, and should exist in them independently, irrespective of the economic systems in which they practice.

In this context of change, challenges, and threats which are directly affecting the healthcare professions, dentistry presents as a unique professional community at a

critical point in its professionalisation process at this specific point in time. There is ongoing debate over the conflict of operating in both a professional capacity and in a business role, in terms of the social contract inherent in the concept of professionalism which establishes priority for the needs of the people served (Welie 2004a). Dentistry may remain as an integral part of the traditional 'family' of healthcare professions with a patient-centred approach, or it may embrace a more commercial and business-like approach to professional practice; or it may manage to combine the two. The driving forces behind individual choices are likely to be many and varied, and it is likely that the perceptions of those leading the profession who are in direct contact with government and policymakers may differ from those experiencing the situation 'at the coal face'.

This qualitative study will thus set out to explore the perceptions of senior professionals and policymakers in the dental profession, and compare these to the perceptions and views held by 'frontline' dentists in clinical practice. The study will be undertaken entirely within the profession to gain direct insight into the issues concerning the dentists and the implications for their future as a profession. It is anticipated that this will shed light on the changing relationships both internally and external to the professional community, and their implications for other professional groups in healthcare, especially with the ongoing development of multi-disciplinary care in the UK and increased private funding of previously public services.

It is anticipated that a deeper understanding of the broader issues involved in the adaptive and proactive responses of this profession to ensure its survival will help members of the profession and policymakers engage in more effective and successful change management as further changes to contracting systems are brought into effect. It might also stimulate further debate regarding the establishment of criteria intended to indicate whether these professionals meet newly-set standards for 'professionalism', as part of the requirement for revalidation and continued registration being introduced across healthcare at the present time.

In a broader context, this study will aim to position the current transition in dentistry in the context of the healthcare professions, and in the wider framework of the 'professionalisation' process of the professions, in an effort to further understanding of this process and contribute to the theoretical models developed as a consequence. In particular, it will concentrate on the profession's response to change, the reasons behind its reactions, and their implications for further professionalisation and survival in the longer term.

4.9 Summary

A range of subject areas have been reviewed relating to the concepts associated with a profession and its members, and in this chapter the focus has been on healthcare and the dental profession more specifically. While undertaking the preliminary fieldwork for this study, multiple opportunities were taken to meet with a range of healthcare professionals in order to gain a deeper insight into the matters they perceived as being of importance in this respect. Analysis of the findings indicated the importance of autonomy to these groups, the ambiguity experienced in association with new professional roles, changes to interprofessional relationships, and a high degree of uncertainty across all health professions at this time. A number of issues became apparent which appeared to be specifically related to the unique position of the dental profession at the present time, leading to its selection as the casestudy for the main part of the fieldwork.

Having originally qualified as a dentist, the author has experiential knowledge of and collegial access to the dental profession, though not practicing in General Dental Practice and so not directly concerned with or affected by the issues being addressed in this context. The benefits and drawbacks arising from this personal professional status will be acknowledged and discussed in the next chapter, which will establish the methodology and theoretical perspectives which underpin the research. The main issues which have been identified in the preceding chapters have concerned the development and revision of the social construct of a profession in modern times, and the ways in which the professions have responded to change during their professionalisation processes in order to effectively defend their status and power in society These themes will thus form the basis of the main body of the study, which will seek to address the research questions outlined below, and then place the findings in the context of the literature and theories already discussed in the wider context of the professions.

4.9.1 Research Questions

The main fieldwork section will thus seek to address the following research questions in the casestudy group of the dental profession:

R2. What does it mean to members of the dental profession to be 'a professional'?

R3. How has the dental profession responded to recent change?

R4. Has the dental profession been deprofessionalised or proletarianised by these changes?

Chapter 5: Methods and Methodology

Chapter 5 Methods and Methodology

As established in the previous chapter, this study will focus on the concept of 'a profession' in a contemporary context, the responses of a profession to change and the alleged 'deprofessionalisation' or 'proletarianisation' of the professions at the present time. Having already established the basis for the choice of the dental profession as a casestudy for the main fieldwork phase, in this chapter the research issue is outlined, and the research methods employed will be discussed. This will be followed by a more detailed discussion of the epistemology and theoretical stance adopted in justification of the methodology selected for this research.

5.1 Research issues

This study set out to investigate the changing nature of the professions in the UK, taking healthcare as a particular group of professions particularly relevant in society at the present time. The current range of healthcare professions have largely arisen from the established traditional profession of medicine, together with the semi-profession of nursing and a range of allied occupations providing healthcare and diagnostic services. This has subsequently developed into a network of professional groups, especially in the last decade through the implementation of policies proposed in the NHS Plan (DH 2000).

This study thus began by taking a broad perspective in engaging with a wide spectrum of professional groups in healthcare, both traditional and newly established and, after an initial investigative stage, considered a more in-depth study of the dental profession in England as an example of a profession experiencing change at the present time.

The initial aim of this research was to explore the current changes being experienced by professionals within the healthcare professions in the UK, and their perceptions of and reactions to these changes. A number of further associated issues or problems were identified in the initial phase of the study, which directed the researcher to specific areas of enquiry in the second phase of the research.

In relation to the changes being experienced in the professions in the UK, the questions which immediately presented as being implicit in the question were:

- Should this be a concern to those within the profession?
- What is driving the change? Social changes? Policy changes?
- Is the concept of a profession still tenable? Is it useful in modern western society or are we hanging on to our established beliefs – and is this helpful?
- How are the current changes perceived by those within the profession? And how does this change their self-perception as professionals?

- How do the current changes being experienced by these professionals fit in the context of historical development, changes in society, and existing theories of the development of the professions and the professionalisation process?
- Is there any evidence of deprofessionalisation taking place?
- What can we usefully learn from this?

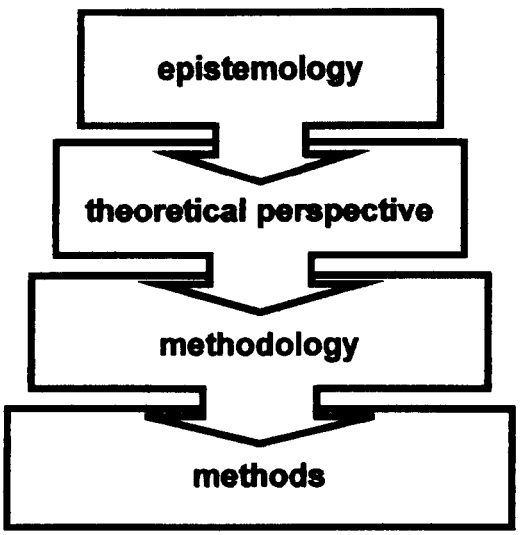
Through the initial phase of study these issues were honed to three more specific research questions to be addressed in fieldwork in the main study group:

1. What does it mean to be a professional?
2. How has the profession responded to recent change?
3. Has the profession been deprofessionalised or proletarianised by these changes?

Crotty (1998) provides a useful framework for setting out the four elements which inform one another in terms of the research approach (Fig 5.1) and in relation to these, proposes that four questions need to be answered (p.2):

- What methods do we propose to use?
- What methodology governs our choice and use of methods?
- What theoretical perspective lies behind the methodology?
- What epistemology informs this theoretical perspective?

Figure 5.1 The Four elements of the research approach (Crotty 1998)



This framework will provide the basis of the following sections of this chapter in which the methods employed will be described, followed by a justification of those methods and a discussion of the theoretical perspective and epistemology underpinning this methodology.

5.2 Overview of research methods

This study was conducted in two phases which partly overlapped in real time, with the initial unstructured investigative phase of preliminary work informing the development of the second structured data collection phase of fieldwork. The initial phase arose

from a range of opportunities which presented, mostly in the course of the researcher's work in healthcare and postgraduate education, affording both insight into the current situation as perceived by members of a number of groups of healthcare professionals, together with the further opportunity to meet with and discuss specific issues at an individual and/or group level. (These are detailed in Section 4.6 of this thesis). This allowed the researcher to gain a broad understanding of the issues which were regarded as important to the professionals concerned, together with contemporary knowledge of the wider context of NHS health provision in England during the period covered by this initial phase from 2005 to 2008. This data was analysed for emerging themes which subsequently informed the development of a more specific focus of the study, with a more clearly defined set of research questions. It also informed the choice of the profession of Dentistry as a casestudy through which to carry out more in-depth enquiry, this profession being identified as facing a set of unique challenges and decisions at this particular point in its development, the study of which might add to our understanding of the continuing development of the established professions, as well as giving insight into the ways in which professionals perceive and react to external policy and social changes affecting their profession.

Thus the second phase of the study concentrated on an in-depth investigation of the current situation as perceived by members of this specific profession, engaging directly with them in a series of semi-structured interviews, with both front-line workers and those perceived publicly and within the profession to be leaders and policymakers. The data from this second phase of the work was analysed in a thematic approach to identify the key issues as perceived by the professionals themselves, and to gain a deeper insight of their perceptions of, and reactions to, the changes they had experienced and were anticipating, as a consequence of both changing social context and external policy in their field of practice. This phase led to a deeper understanding of the issues within this particular profession, allowing ideas to emerge with regards to comparisons with existing literature and theoretical models of the process of continued development of the professions, both within healthcare and in a wider context.

5.3 Methods

The strategy for data collection was undertaken using an iterative method through two distinct phases, employing a pluralistic methodological approach. A multi-method research approach is appropriate to a broad topic area and seeks to validate data through triangulation by combining a range of data sources and methods (Tashakkori and Teddlie 1998). It also seeks to be creative in discovering new stimuli for further work, and to widen the scope of study to include contextual aspects of the situation.

The collection of different sorts of data by different means may result in a more complete understanding of the area under study (Bonoma 1985) and offer complementary insights and understandings which may not be evident from single source data (Darbyshire et al 2005). While often combining qualitative and quantitative methods, this does not have to be the case in a muti-method approach (Darbyshire et al 2005). In the present study the methods used were both qualitative (observation and interviewing) in order to combine the strengths and reduce the limitations of the individual methods selected. The initial observation stage data were collected in the natural setting and shaped and informed both the direction of the research and the content of the interview schedules for the second part of the study, comprising interviews which were conducted in a staged environment 'disturbed' by the researcher. The mixed methods approach was thus also adopted to reduce researcher bias in setting the research agenda, which arose directly from the initial stage of data collection in the natural setting.

5.3.1 Phase 1 Preliminary fieldwork: Strategy for data collection

The initial phase of unstructured opportunistic data collection already described in Section 4.6 involved a mixed set of approaches to data generation and collection:

- observation (participant) – healthcare workshops, conferences, focus groups and meetings
- observation (non-participant) – healthcare workshops, conferences and meetings, conversation mapping
- unstructured interview
- semi-structured interviews

This phase of the study employed a semi-ethnographic approach to investigating professionalism across a range of healthcare roles.

The researcher made fieldnotes during and after each event, interview or research episode, of the issues which had been discussed and raised during the proceedings. These were analysed in conjunction with the documents circulated at the events and associated publications[59]. The data relating to each event were revisited regularly to identify emerging themes and the issues which appeared to be of importance to the members of the professions themselves with regard to the current changes they were experiencing. The analysis of this data led to the identification of a further range of issues, and the development of more focused research questions, clarifying the objectives of this research:

[59] A number of specific publications were brought to the researcher's attention by virtue of attending the events, such as the Kings Fund and RCP publications on Professionalism.

a. To find out what was going on – what current changes were being experienced and how they were perceived by those within the professions,
b. To compare the perceptions of those who were policy-makers and those who were front-line workers within the profession, using the dental profession as a casestudy.
c. To analyse the findings in the context of existing theory relating to the development of the professions, the professionalisation process, and in the specific areas of autonomy and professional relationships.

The identification of a unique contextual circumstance for the dental profession (discussed in the previous chapter) then informed the decision to focus on the dental profession as a specific casestudy of a profession undergoing change for the fieldwork in the main phase of the study.

5.3.2 Phase 2 Main Fieldwork: Strategy for data collection

The second phase of structured and planned data collection involved:

- semi-structured interviews of leaders and policy-makers within the profession (Group A)
- semi-structured interviews of front-line professionals (Group B)

10 semi-structured interviews were carried out with individuals who were considered to hold key positions in the dental profession, in terms of leadership and policy-making. The interviewees comprised (in no particular order):

- Chief Dental Officer for England
- Chief Executive of the BDA
- Dean of the Faculty of Dental Surgery at the Royal College of Surgeons of England
- Dean of the Faculty of General Dental Practitioners at the Royal College of Surgeons of England
- President of the General Dental Council for the UK
- a Postgraduate Dental Dean
- Chief Dental Officer for Denplan Ltd
- Chairman of the British Dental Association
- a Dean of a newly established undergraduate Dental School
- Chair of the General Dental Services Committee of the British Dental Association.

The interviews were conducted between February 2008 and February 2009, and were digitally recorded and subsequently transcribed by the researcher. The initial interview schedule covered the following issues which had been developed during the preliminary phase of work and from relevant contemporary publications:

1. The role of a 'professional' in practice today?
2. How to build and sustain trust in the profession (rather than in individuals)?
3. How to manage raised public expectations?
4. The erosion of freedom to define acceptable standards of care, and control the content and organisation of their work - do accountability systems undermine professionals?
5. Relationships with other professionals and managers

6. New ways of working, more team and multidisciplinary work, and diversification of roles (ambiguity?)
7. Changes in working conditions and more women in the profession
8. Are professionals directly involved enough in the development of health services?
9. Is there a conflict between "business" and "professional"?
10. How has the profession responded to changes?
11. Do professionals put their own interests above those of their patients?
12. What are the differences in attitude between newly qualified and well established practitioners?
13. Where does leadership of the profession come from?
14. What role do professional bodies (GDC, BDA, Royal Colleges, etc) play in the 21st century? Do they represent the professions? Do they have a developmental role?
15. What are the relationships like between the profession and government?

The initial interview schedule was modified in response to emergent issues which arose in preceding interviews, in an ongoing iterative process which could incorporate contemporary issues arising throughout the period in which the interviews were conducted. The researcher made analytical notes after each interview so that changes could be rapidly incorporated into subsequent interviews.

30 semi-structured interviews were carried out between October 2008 and February 2009 with General Dental Practitioners (GDPs), who account for over 90% of all practising dentists in the UK, and who are anticipated to have been most affected as frontline workers by the changes in the NHS dental contract from April 2006. The study was confined to England as there were significant disparities between the NHS services and policy in the devolved UK countries[60].

The sample of dentists came from PCT areas in North-West England which had been balanced in terms of urban/rural, proximity to a dental school, and socio-economic factors for a previous study. The sample was self-selecting in that the dental practices were mailed with a letter of invitation, using publicly available listings in telephone and online directories. This allowed both private and NHS practices to be reached[61]. The letter was addressed to the principal of the practice, inviting them to extend the invitation to other practitioners within the practice, including vocational trainees. No effort was made to select on gender or age, but the sample size of 30, though large for a qualitative study, was intended to allow inclusion of a range of ages, provide a gender balanced sample, and include recent graduates and vocational trainees.

[60] Existing COREC ethical approval allowed access for the study of dentists in the NW of England in the context of a wider study relating to changes affecting the dental profession.
[61] PCT lists of dentists did not include wholly private practices.

The interviews were semi-structured and open-ended with a set of key issues to be addressed. In addition to handwritten notes, the interviews were digitally recorded and transcribed by the researcher with the aid of Dragon Naturally-Speaking voice recognition software. Denscombe (1998) reports the value of researchers transcribing materials themselves in order to assist with analysis and interpretation. Interviews were carried out at the workplace of the interviewee or at an independent location, and lasted from 20 to 70 minutes, largely dependent on the time available in the interviewee's schedule. The initial interview outline included questions arising from the key areas brought to light by the policy makers in Group A interviews, and was iterative in introducing further points for investigation in subsequent interviews as the series extended.

The following key questions explored personal perceptions of professional values and experiences of becoming a professional. They also sought to discover the impact of the new NHS contract on professional practice, and ideas regarding the perceived future of the profession. The initial semi-structured interview schedule included the following points as a basis for the interview:

1. What does it mean to you to be a professional?
2. How does someone become a professional? How did you become a professional?
3. What role do professional bodies play in the dental profession?
4. What changes have you seen in the dental profession in the past 10 years or so?
5. What do you think has caused those changes?
6. Do you see NHS policy as a threat or a challenge to dentistry?
7. What do you think the dental profession will look like in 10 or 20 years time?

As the interview schedule progressed, questions were added to include (time permitting):

8. Is there any conflict between charging for your services as a professional and the concept of being a healthcare professional?
9. Is there a leader in the dental profession? Do professions need leaders?
10. Do you think that professionals protect other professionals? Do you have any experiences of whistleblowing?
11. Are professionals good at adapting to change?
12. As a professional, do you value the right to control your working environment and standards?
13. Are there any hierarchies within the profession?
14. How do you view the move to widen the scope of practice of DCPs?
15. Is it a good profession to be in? Would you recommend it as a career?

The discrete time frame from October 2008 to February 2009 for this set of interviews was deliberately kept to a minimum, in recognition of the rapidly changing context within which the dental profession was operating. NHS Dental contracts with PCTs

were due to be renewed in April 2009, and the full impact of the global financial crisis was anticipated but unknown at this time. Both of these factors were expected to potentially influence the responses and attitudes of participants in the study, and are acknowledged as an integral part of the context in which the fieldwork was conducted. It was thus considered important to obtain a 'snapshot view' which reflected the situation in this particular professional group at a particular point in time, namely October 2008 to February 2009.

5.3.3 Data Analysis

Analysis of the data was centred on theme identification through an iterative method using an interpretative approach. All the data were collected and handled in accordance with the Data Protection Act and the terms of the COREC ethical approval which had been granted (see section 5.3.4 below).

Preliminary analysis of the observational and interview data was undertaken during the fieldwork, in conjunction with fieldnotes and other documents which arose during the data collection. This allowed the direction of subsequent interviews to be modified in line with earlier findings, and afforded the opportunity to test analysis and clarity of data on subsequent interviewees, to establish a degree of validity in the data as tested against the reality in the field (Denscombe 1998). This further informed the later stages of the study, and data collection continued until it was felt that a saturation had been achieved.

A system of open coding of the transcribed data and fieldnotes was undertaken to categorise phenomenon, in order to identify patterns and processes, themes and interconnections between the data (Miles and Huberman 1994). This process was subsequently repeated in order to refine the analysis and allow reflection on the materials. The emergent themes were fed back and discussed informally with a number of GDPs, three of whom had participated in the study. The themes and relationships identified were then compared with those already identified in the published literature, and explanations developed in line with the fieldwork to explain its agreement or conflict with existing theory.

Analysis was carried out with the help of Microsoft Word, a computer software word-processing package which enabled labelling of text, colour coding, highlighting and searching for keywords. Previous experience of computer-aided analysis using NVivo was not found to be useful in terms of its transferability and practical use for analysis, essentially acting as an organization tool for data management and in some respects

distancing the researcher from the data. Thus it was not used in this study, which employed the analysis of printed scripts, allowing a fuller contextualised appreciation of the data, aiding intuitive judgement and interpretation for the researcher concerned. Basic analysis of the sample data was carried out using Microsoft Excel and all analysis was carried out by the researcher personally.

5.3.4 Ethical approval

Formal ethical approval which covered this study was approved by COREC (now The National Research Ethics Service) which included access for interviewing and casestudy work in dental practices across 12 PCT areas in the North West of England, and access to interview PCT contracting managers[62]. This approval which had been secured by the researcher was for a wider study into the impact of the April 2006 dental contracts by a team in the Department of Dental Public Health at Liverpool Dental School.

Further university ethical approval was granted in 2008 for a study to explore professionalism and leadership in Allied Health Professionals in the University of Liverpool, which allowed focus group and interview study of AHPs and Senior Nursing staff who were enrolled on postgraduate modules in the School of Health Sciences at the University of Liverpool during the study period. This ongoing study was being carried out with the School of Health Sciences at the University of Liverpool[63].

5.4 Methodology and discussion of methods

The methods engaged in this study were intended to deepen insight of meanings and understandings of the study group participants, as well as of their behaviour, and thus a qualitative approach allowing data collection on a personal level, with the opportunity to delve deeper into the issues on an individual basis, was deemed appropriate, rather than a quantitative survey approach. It is recognised that data collection in a qualitative approach has an influence on the stimulation and production of data itself, and the interpretation of the data by the researcher is part of the process of data production (Denscombe 1998).

The pluralistic methodology embraces both an ethnographic approach, mainly in the initial phase of data collection, together with an iterative approach, though not as strictly applied as originally postulated in the grounded theory approach described by

[62] This ethical approval was gained before the university brought in its own ethical approval frameworks for research work and is necessary for all work carried out in an NHS setting.
[63] This part of the study was funded through the award of a Northern Leadership Academy Fellowship for PhD studies to the researcher in 2007.

Glaser and Strauss (1967). It attempts to generate theory through analysis, rather than be purely descriptive, and the theory which emerges and which is developed is grounded in the empirical research, arising directly from the data. It also engages in checking of the analysis and constant refinement during the research process, and has been viewed as 'a focused voyage of discovery' (Denscombe 1998). The selection and number of the participants was not predetermined, nor the direction in which the interview outlines were modified, reflecting the developing and unforeseen nature of the research project. A flexible interpretation of Grounded Theory approach was thus adopted (Layder 1993) as described by Denscombe (1998), in which:

- empirical field work was used as a starting point in the initial phase to identify the issues
- analysis was based around the fieldwork observations
- explanations were developed which were relevant and recognisable by the subjects
- the research was geared towards modest localised explanation based on immediate evidence
- an emergent design was adopted with the focus of work developed during the course of the research

The advantages of using qualitative methods rest with their grounding in the reality of the social situation being studied, and the richness and detail of the 'thick descriptions' of the complex social situations thereby obtained (Denscombe 1998). It is accepted that the explanations generated through the analysis are based on an interpretation influenced by 'self', and that more than one interpretation can be valid. The limitations of the data in terms of their representative nature and generalisability does not preclude their use for deepening understanding of the issues affecting this particular sample group, nor of generating theory through analysis of the data. The research is considered to be 'self-aware' with acknowledgement of the researcher's role in data generation, with the findings presented not as statement of fact but as a creation of the researcher.

The use of the sampling, observation and interview methods for data collection which were employed will now be discussed, together with the implications of ethnographic involvement of the researcher and the influence of 'self' on the research process.

5.4.1 Sampling for data collection

The sample of participants for this study was divided into two discrete groups. Group A was selected to represent the leaders and policy makers in the profession, who it might be assumed would present a different perspective to the front-line workers, in terms of the rhetoric in which they were engaged, their leadership roles, the influence of their respective organizations (Becker 1967), their privileged access to knowledge (Flyvberg

2001), and involvement in high-level decision-making and negotiation affecting the profession. While there is limited hierarchy in the professional community studied, Group A represented a superordinate group within the profession and afforded an opportunity for comparison with, as well as combination with, the views of the subordinate Group B, reducing one of the elements of bias described by Becker (1967). The initial selection of participants in this group was based on the visible public figures at the head of the professional bodies. Subsequent selection was based upon suggestions made by both Group A and Group B participants, with each potential subject being suggested by at least 2 different participants. A conscious decision was made to include female participants in this group although they are poorly represented at this level in the profession, to allow exploration of this issue, as well as to ensure a balanced perspective. The limit of 10 interviews for Group A was considered sufficient given the limited number of participants deemed to hold such senior positions within the profession, their availability, and the time and resource implications of travelling to their offices across the country. All the individuals who were approached in this group agreed to participate in this part of the study conducted between February 2008 and February 2009.

The sample of participants in Group B were to offer an insight into and deeper understanding of the perceptions, feelings and behaviours of members of the dental profession practising in general dental practice. Participants worked in areas of Cumbria and Lancashire which included villages, towns and cities. Arrangements were made with each participant as convenient for the interview to be conducted at their place of work or other convenient location, and they were contacted in the order in which their responses were received. It was anticipated that this group was to an extent self-selected, as only those interested in the issue and motivated to take part in the study would reply. However, by extending the schedule to include a wide range of practitioners, of varying age, experience and contracting agreements, the sampling continued until a theoretical saturation point was reached when analysis was confirmed by the new data and no further insight was gained (Strauss 1987). This sample group is not considered as representative of the entire profession, but as a suitable study sample allowing access to a deeper understanding of the issues relevant to this particular group.

5.4.2 Ethnographic approaches and the influence of 'self'

It is recognised that the researcher's self plays a significant role in the production of qualitative data and its interpretation, and the researcher's identity, values and beliefs are incorporated into this process and cannot be separated from it (Ball 1990). The

influence of self might be reduced by adopting a detached stance to the issue, suspending judgement on the social issues concerned, although it is unlikely that this will be entirely achieved (Becker 1967). Alternatively the researcher's personal agenda, background and experiences should be acknowledged together with their positive contribution to the research process (Miles and Huberman 1994). Becker (1967) discussed the implications of the distortion of findings by researcher bias and considered it unrealistic for a researcher to remain completely unsympathetic to the group studied. He recognised the potential to produce biased reporting in favour of the subordinates in a hierarchical arrangement, with implications for research which challenged the established order by exposing the subordinate perspective. In the present study both superordinate and subordinate groups were sampled to reduce this tension and to allow open analysis of their different perceptions of the issues under investigation.

The closeness of the researcher to the study group in this present study allows an appreciation of the phenomena under study from the participants' perspective, corresponding to the 'conscious partiality' (Morgan and Drury 2003) which brings the researcher closer to the reality of phenomena:

> *"The virtue of subjectivity is in how it can meaningfully shape rather than distort research accounts."* *(Smith 1998)*

Peshkin (1988) talks of the virtue of subjectivity which resides in the explicit and conscious declaration of the reasoning and evidence that has influenced the selected focus of a research account, being borne out by facts that are available to all, and not just to the researcher, producing a reasoned and evidenced account without prejudice (Smith 1998). Peshkin (1988) further argues that researchers should seek out their subjectivity while the research is actively in progress rather than retrospectively, in order to be aware of how it may be shaping their interpretation and further direction of the study.

A self-aware stance was adopted from the outset in this present study, acknowledging the contribution of 'self' which was regarded as a crucial resource and enabler to gaining a privileged insight into the issues under studied. Ethnography requires the researcher to spend time in the field and share the experiences of the subjects rather than to observe them from a detached position. This is undertaken in an effort to understand how the subject group perceive their reality in how they see their world, how they understand things, and the meanings they attach to events. It aims to determine the interlinkages between various features of the culture under study, especially in terms of interdependency and relationships, in order to produce a

construction based on self-awareness, rather then merely a description of the situation (Denscombe 1998). This allows an insight into the depth and detail of the situation, revealing the general features of human social life from the rich descriptive material generated (Hammersely 1990), while basing the study in a theoretical context relating to existing theory and generalisations about social behaviours.

Denscombe (1998) discusses the issue of reflexivity in this context and the influence of the researcher's own meanings, language, culture social background and personal experiences on the research process. Both the generation of data and its analysis and interpretation are based on what the researcher already knows and believes, resulting in a creative interpretation and reflection on the reality of the situation being studied. Hammersley (1992) accepted that "ethnographers are an integral part of the social world they seek to describe" (p. 5) and that ethnography results in the construction of a version of reality, not of reality itself. Fox (2003) considers that analysis is an ongoing process of evaluation and reflection, involving both participants and the researcher. In order to address the issue of self-awareness in the context of this study, an account will be given in the next section of the researcher's personal background, experience and interests in the area to be studied, providing insight into their possible influence on the generation and interpretation of the data.

Consideration must be given to the advantages of being able to collect and generate data in direct contact with the relevant people, the richness of the data obtained, and the opportunity to develop holistic explanations based on the relationships and processes in context (Denscombe 1998). This must be set against the reflexivity inherent in this approach, and the limited generalisability of the data. While Becker (1967) considered that:

> *"There is no position from which sociological research can be done that is not biased in one way or another....We must always look at the matter from someone's point of view." p. 245*

he also argued that by using theories and techniques we should be able to study the issues impartially, even if they run counter to our own biases, and so produce an undistorted view of the area of study, explicitly accepting its limitations in terms of generalisability.

5.4.3 Reflexive account of researcher

I was brought up by white middle class parents who derived from working class parents themselves, my mother being a teacher and my father the manager of a tyre company retail outlet. After passing the 11 Plus examination I attended a Girls' Grammar School

in Kent, and then Leeds University as an undergraduate to study dentistry, being amongst a predominately white male group of students from very varied social backgrounds. The majority were from the north of England, and in the Thatcher era of miners strikes, the north-south divide was very keenly felt by a southerner living in a northern industrial city.

After graduation I remained working entirely in the NHS hospital service for a number of years in various hospital training posts across the UK to become a consultant in Orthodontics, after an initial 3 year period of House Officer posts in Maxillo-Facial Surgery. At times I undertook sessional work in dental practices to supplement reduced earnings while studying, but only in the specialist field of orthodontics and always at evenings and weekends when no other dentists were working in the practices. My direct experience of general dental practice is thus limited to visits as a patient, and I have never worked as a GDP. I have a few friends who are GDPs, and through them and the dental press, I am aware of the political and economic influences in the profession, but in my own field of hospital work I work mainly with doctors, nurses and NHS managers.

In the past 10 years I have given up full-time employment as an NHS consultant and have experienced work in a wide variety of situations, including private specialist practice in Australia, as well as full-time and part-time work in management and business entirely unrelated to healthcare in university and private sector settings. I was a full-time MBA student at Durham University for one year with no other healthcare workers on the programme, and at present work only part-time (3 days a fortnight) as a clinician in the NHS hospital service. I have thus experienced different organisational (and international) cultures in both the private and public sectors, and have experienced life as a professional in the university academic setting, as well as in healthcare, and in management positions in the private sector. My experiences and consequent perspective are thus unlikely to be typical of a member of the dental profession, and any changes experienced by GDPs do not affect me directly. However, I do still consider myself to be a member of the dental profession, and I am a Member of the Royal College of Surgeons of England and a Specialist Fellow of the Royal College of Surgeons of Edinburgh, both by examination. In order to practice I am also required to meet the current requirements for continued registration with the General Dental Council, and so I cannot divorce myself entirely from the profession, being obliged by law to maintain current knowledge and practice to the same extent as any other member of the profession.

My interest in this field of research arises partly from my own experiences of change in healthcare in the 25 years that I have been practising in the NHS acute sector. It has also arisen from my experiences of working abroad, in university academia, and in teaching leadership and management skills to a wider range of professionals in science, engineering and healthcare. Personal observation of widely differing attitudes towards one's own 'professional' status, and the tensions which become evident between certain members of such professional groups, appeared to indicate that not all professions cope with change with the same degree of adaptability, and that this area warranted further investigation.

My objectivity in relation to the present study is demonstrated by my relative neutrality in the area of the research topic, and reasonable freedom from researcher bias (Denscombe 1998) while acknowledging that I approach the study as a white middle class southern female who has been a member of a traditionally male-dominated health profession for 25 years, but who has also experienced other fields of professional work and cultures. I feel it is important to note that I am not directly affected by the contracting changes affecting the GDPs in the dental profession that are the main issue of the study. I do however as a professional have a personal interest in the way the professions continue to develop, although I am not at the beginning of my own career and so this is unlikely to have any great degree of personal impact on me. I also, by virtue of being a member of the dental profession, enjoy the privileges accorded by that membership in terms of access to key figures within the profession, an insight into the ways in which the profession operates, and an implicit degree of trust and respect granted by other members within the profession, facilitating access to the participants and their frank and honest expression of opinions during the fieldwork phase.

5.4.4 Data collection through observation and interviews

The majority of the data collected in the initial phase of fieldwork was possible as a consequence of the researcher being able to undertake participant observation at the events by virtue of having the necessary qualifications and other attributes to act in the required role as a healthcare professional and/or lecturer. This direct observation allowed the researcher to permeate the events with her research role undisclosed, observing and participating in a natural setting undisturbed by the research work (Becker and Geer 1957). This closeness to the real life situation affords the opportunity to gain deeper insights into the culture and events of the groups concerned, without any hiding of detail from the covert researcher, thus allowing a fuller appreciation of the subtleties and complexity of the meanings and relationships constructed within the

group. This strong position in terms of contextual immersion allows for a high degree of validity to the data, but reliability is affected by the strong influence of self on the data collection, particularly in terms of the psychological factors connected to memory and perception.

Denscombe (1998) outlines the three problem areas of selective recall, selective perception, and accentuated perception, affecting both the recording of observed events and their interpretation by the individual. These are dependent on the emotional, psychological and physical state of the researcher at the time of the observation, and add to the uniqueness of the data in context. The detachment of the researcher from the direct consequences of the changes being studied in this fieldwork is anticipated to reduce the emotional involvement of the researcher. However, this dependence on self reduces the reliability of the data, and thus in the present study this stage of data collection was used only to identify key issues and problems, which were later tested in the second phase of the study. Use was also made of written published materials to substantiate the perceptions recorded as a consequence of the event, and to assist with interpretation of fieldnotes.

The advantages of having access, by virtue of the researcher's qualifications and experience, to carry out direct observation by participation in an undisturbed natural setting of organised events, resulting in data of high validity, offering rich insights into the complex realities therein, must thus be balanced with the reduced reliability of data which depends on aspects of individual perception and may have limited generalisability by virtue of its uniqueness. Denscombe (1998) suggested that it might be inappropriate to apply standard criteria of reliability and generalisability to an ethnographic method. In the present study it was felt appropriate to use this method to gain an initial insight into the issues affecting the healthcare professions, which would form the basis of further detailed study where interpretations could be explored and tested more thoroughly through the interview stage. Fox (2003) endorsed the need to remain open-minded in the initial stages of research, allowing the research question(s) to emerge once the local situation is more fully understood. The researcher was aware of the need to remain a member of the group being studied, while retaining a detachment for the purposes of the research observations. This is undoubtedly easier when working only part-time in a small specialty which lies outside the mainstream of healthcare provision, with the risk of 'going native' (Delamont 1992) much reduced. Ethical issues arising from data collection during participant observation are considered to be appropriately handled if the participants remain anonymous and unharmed by the research undertaken (Denscombe 1998).

By contrast, the data generated through an interview arise as a direct consequence of the arrangements made by the interviewer with the subject, and guided by an agenda set by the researcher. The method of semi-structured interviews was chosen as an appropriate flexible means of generating data which is based on experiences, sensitive feelings and emotions, giving the opportunity for personal exploration of this often privileged information in an open and honest manner (Denscombe 1998). The 'interviewer effect' is acknowledged in that participants react differently to different interviewers and their identities. In order to minimise this, all participants in the present study were informed that the interviewer was a member of the dental profession but not practising in general dental practice, and that the study was part of a PhD in Management Studies and was unrelated to the dental profession in its arrangements and funding. Thus all were presented with a member of their own profession who was not in a position to change or have influence over the subject's own personal or professional life. The basis of trust and rapport was thus established early on in the interview, and all participants were given a written information sheet outlining the study and written informed consent obtained to comply with the ethical approval requirements. Any further questions were answered as part of this introductory process.

The advantages of flexibility, direct face-to-face contact and the opportunity to establish the validity of data by checking accuracy and relevance during the data collection in interviewing must be weighed against the limited reliability of non-standard unique data, the extensive resources required - especially in terms of time in conducting and transcribing interviews - and the interviewer effect already discussed.

5.4.5 Reliability of data

The reliability of qualitative data cannot be assessed in terms of the same criteria as quantitative data, given that the researcher is an integral part of the data generation and collection process in a unique contextual setting, and so the same data would not be collected by repeated measurement. The reliability of factual data in the content of the transcripts, together with aspects of the analysis, was tested in subsequent interviews with further participants, to establish their consistency across the sample group. However, the reliability of the majority of the data in this qualitative study rests with the explicit statement of the aims of the research, the means by which it was conducted, and the justification of the key methodological decisions taken (Denscombe 1998), with the key stages recorded in an Audit Trail (Lincoln and Guba 1985) as outlined in Table 5.1.

Table 5.1 Audit trail of key decisions in research project based on Lincoln and Guba (1985)

Categories for reporting information
. **Raw data** - including all raw data, written field notes, unobtrusive measures (documents)
. **Data reduction and analysis products** - including summaries of notes, unitized information and quantitative summaries and theoretical notes
. **Data reconstruction and synthesis products** - including structure of categories (themes, definitions, and relationships), findings and conclusions and a final report including connections to existing literatures and an integration of concepts, relationships, and interpretations
. **Process notes** - including methodological notes (procedures, designs, strategies, rationales) and trustworthiness notes (relating to credibility, dependability and confirmability)
. **Materials relating to intentions and dispositions** - including inquiry proposal, personal notes (reflexive notes and motivations) and expectations (predictions and intentions)
. **Instrument development information** - including pilot forms, preliminary schedules, observation formats

Reliability of data in studies of social science may be related to the 'instrument' of human beings' own perceptions of a situation, and may be affected when questions are changed or the researcher exerts undue influence, as in the Hawthorne effect (Fox 2003). Acknowledgement of these influences by the researcher is balanced against the virtue of an engaged researcher who is motivated to pursue the project (Becker 1967), and the potentially positive effect of 'transgressive learning' where participants engage in reflective practice as a consequence of their research experience (Fox 2003).

5.4.6 Validity of data

The researcher's self has been acknowledged as an influence on the research data and interpretation, but not necessarily as a bias in the findings or conclusions (Becker 1967; Denscombe 1998). 'Internal validity' (the extent to which a study measures what it claims to measure) is difficult to establish for a non-scientific study, while 'external validity' (the generalisability of research findings) is also limited by the uniqueness of the research situation (Fox 2003). The area of investigation and its aims have been explicitly established as a valid field of enquiry through the preliminary phase of fieldwork, and a triangulation approach engaged at this stage to corroborate and test information and alternative explanations. Throughout the data collection phase, opportunities were taken to test the facts and themes arising from earlier interviews and to modify subsequent interviews accordingly, with opportunity for clarification at the time of the initial and subsequent face-to-face interviews. The thematic analysis was also fed back and discussed informally with a number of GDPs, three of whom had

participated in the study, to establish the validity of the analysis in accordance with their feelings and behaviours (Denscombe 1998).

The research is undertaken with the explicit aim of exploring the world and opening up new insight and meanings, rather than in seeking the truth about the world (Fox 2003). A wider perspective on the interpretation of the data will be demonstrated in the findings and discussion in Chapters 6 and 7, which will show not only how the findings fit with existing knowledge and theory, but will explore alternative explanations and potential problems with the explanations derived.

5.5 Epistemological and Philosophical approaches

As outlined in section 5.4 above, the methodology adopted for the first phase of the study engaged an iterative and ethnographic approach, with the researcher embedding themself in the research setting through attendance and participation in organised events and other opportunities relating to professionalism and associated issues in healthcare, over a two and a half year period. The second phase of the study comprised a series of semi-structured interviews informed by the initial findings, and was conducted over the subsequent 12 month period. This also incorporated some aspects of ethnographic resarch, in that the researcher is a member of the profession in which the research was conducted, and so the participants spoke openly to another of their own profession, with an implicit trust and understanding of the way in which the material would be handled and presented to those outside of the profession. Again, an iterative approach was used to continuously analyse and refine the areas and direction of enquiry. The justification for the methodology employed has been discussed and established in the previous section.

A theoretical perspective or philosophical stance describes the context of research work, and the basis for logic within it. It equates to a complex of assumptions buried within a methodology, and describes how the world is viewed. The theoretical perspective adopted in undertaking this piece of research is based on an interpretivist approach within a social constructivist epistemology. Epistemology is the theory of knowledge which has been selected to be embedded in the theoretical perspective adopted, and it essentially expresses our understanding of 'how we know what we know' (Crotty 1998).

5.5.1 Constructionism as an epistemology

This work has been approached through a constructionist view that:

> *".. all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context."* *(Crotty 1998:42)*

This rejects the objectivist positivist view that meaning resides in objects independently of their consciousness, and adopts the view that meaning is constructed not discovered. This requires consciousness on the part of the subject, who engages with the object which they interpret.

A relativist ontology is embraced in recognising that 'the way things are' equates to 'the sense we make of them' (Crotty 1998:64), and that our interpretations are historically and culturally influenced and are not eternal truths. Thus at different times and in different places we may encounter different interpretations of the same phenomenon, and different people will have different world- and life- experiences, and so construct different sets of meanings.

The realist ontological notion is also accepted, in that socially constructed reality is 'real' (Berger and Luckmann 1967), but recognises that constructions may change in their nature over time and context while still remaining 'real'. It does however reject the idealist view that what is real is confined only to ideas in the mind.

In a constructionist view, we observe objects in the world which are already there, and which on their own are meaningless. Meaning is constructed through an interaction between the subject and the world, and is not inherent in the object in isolation from consciousness. The object and subject interact (intentionality), a viewpoint popularised by Bentano, Husserl and others, and which embraces both subjectivity and objectivity into one theoretical standpoint (Crotty 1998).

Constructionism therefore argues that there is no true or valid interpretation, although some interpretations are more helpful or valid than others. Social constructionism further argues that meaning and interpretation is not just a product of the individual (as a constructivist viewpoint would maintain), but that our generation of meaning is heavily influenced by our culture and the existing social constructions of meaning at this point in time. We are heavily influenced by what we are told is there in our interpretation and understanding of it, and by the public and conventional understandings which already exist in the institutions around us. If we are told we are looking at a tree, we see it as a tree.

Crotty (1998) discusses the concept of 'bricolage' in research (p.51), extending Adorno's idea that fantasy and creativity are required in interpretation, and dismissing Denzin and Lincoln's mis-interpretation of the term in suggesting that researchers should not remain straight-jacketed by conventional meanings and should embark on a voyage of re-interpretation in a spirit of openness to potentially new and richer meaning.

5.5.2 Social Constructionism and Culture

Geertz (1973) described ' a system of significant symbols' which form our culture, and which "directs our behaviour and organises our experience" (Crotty 1998:53). It is argued that culture should be viewed as the source of our thoughts and behaviour i.e. it shapes them, and is not a product of them. The symbols referred to are generated to impose meaning upon experiences, and are largely already in existence. This means that as we, as individuals, engage with and try to make sense of the world, we are acting in a unique historical and sociological context which cannot be divorced from the process of our understanding of the world around us. Thus we don't act purely as individuals because we are heavily influenced by the world of meaning around us, and we view the world through the lenses already developed in our culture. Thus a 'social reality' is constructed using the rules already laid down for us in our particular societies. In this particular epistemology, all realities are socially constructed (Berger and Luckman1967) and although an object such as a door may exist independently as a phenomenon, it only becomes a door once we have engaged in a process of interpreting it.

Crotty (1998) argues that our culture can teach us <u>not</u> to see things, as well as how to see things, and that it does not matter if an object is physical or natural, the generation of the meaning is social (p.55). While some would distinguish between the social and natural world in the ways in which they are studied and interpreted (Flyvberg 2001), a social constructionist view is that they are not distinct and should be viewed together as one human world. The social world is studied by social scientists from within, and as such they are part of it. They must also be aware of the interpretations that already exist, which they aim to reinterpret.

This is the standpoint from which this current piece of work emanates. There is a pre-existing view in our contemporary society of what constitutes a profession, which we have experienced and been influenced by as we have developed our own social construct in our own unique culture and society. From this we have each developed our own understandings and meanings attached to that concept. We have each of us

thus modified and interpreted the social construct of 'a profession' from a starting point inherent in our own culture, and reinterpreted the concept through our own and shared experiences, our educational development, as well as changes in social and political thinking during our lifetimes. Constructivism is generally taken to relate to the meaning making activities of the individual mind in this way, whereas constructionism alludes to the generation and transmission of meaning collectively. Constructivism thereby highlights the unique experience of individuals, whereas constructionism emphasises the hold of culture on us and how we see things, adopting a more critical approach.

5.5.3 The development of Critical Thinking

It is important to recognise the barriers to effective research of this nature, in terms of the strength with which received notions can blind us to reality, and that we can become entrenched in existing theoretical interpretations. There is a danger of 'reifying' the sense we make of things into the way they are, as if they were the 'truth'. Critical thinking is suspicious of constructed meanings, with negative connotations of biased power structures, oppression, and injustice attached. It often portrays a world of battle and conflict, rather than of interaction, development and interpretation (Crotty 1998).

Social constructionism was originally derived from the work of Karl Mannheim, and from the published work of Berger and Luckmann entitled 'The Social Construction of Reality' (1967). However, the idea had existed long before in various forms. Within constructionism, various theoretical standpoints have evolved. Marx postulated that those who own the means of production have the power to effect the kind of social consciousness that dominates in that particular society, thus dictating the social structures and character of life. The strongly anti-objectivist phenomenology and the rather uncritical pragmatist school of thought had also developed at this time, and under the latter umbrella, George Herbert Mead (1934) developed the ideas of symbolic interactionism, in which every person is a social construction and that we come to be who we are as a consequence of our interactions with society (Crotty 1998:63). This recognises that human behaviour is social in origin, and that we exist in a complex social world of entangled conditions which determine the way we think, feel and behave. This latter theoretical approach to understanding society and our place in it might be considered to be an interpretative stance adopted in the current study.

5.5.4 Interpretivism as a theoretical perspective within a Constructionist Epistemology

Interpretivism is essentially contra-positivist as it "looks for the culturally derived and historically situated interpretations of the social life-world" (Crotty 1998:67). It is based

on understanding rather than explaining, and is idiographic in being concerned with human affairs and individual cases, rather than seeking universal laws. The individual actor and their actions are considered to be the basic unit of study, and it seeks to explore their unique development and their meanings and values. Traditional interpretivist approaches following Weber and Weiss attempted to make sociological studies scientific in form, but later approaches have cut free from these traditional styles, and recognise that social and human science requires different methods for its study than the natural sciences (Flyvberg 2001).

Crotty (1998) describes 3 strains of interpretivist approach:

1. Hermeneutics
2. Phenomenology
3. Symbolic interactionism

George Herbert Mead's symbolic interactionism discussed above is based on the premise that individuals owe their being to a community or society and the resultant symbolic interaction. It is argued that we act towards things on the basis of the meanings these things have for us. The meaning of such things is derived from and arises out of the social interaction we have with our fellows, and these meanings are handled in and modified through an interpretive process used by the person in dealing with the things he encounters (Crotty 1998). This process starts in childhood, when we imitate and play games in which we put ourselves in the roles of others, and we eventually take over the role of others and put ourselves in the other's place.

In methodological terms, this requires that we take the actor's role (Psathas 1973) and place ourselves so that we can view the situation as the participant sees it, and interpret it in terms of their meanings and not our own (Mitchell 1977; Denzin 1978). Thus the 'interaction' is in role-taking, and the 'symbolic' relates to the significant symbols, for example in language and behaviour. This approach supports the ethnographic methodology in the present study, using dialogue and language, and incorporating the interpretation of perceptions and feelings.

Phenomenology is a further interpretivist approach in which there is the possibility for new meaning to emerge if we lay aside existing understanding of the phenomena under study, and revisit our immediate experience of them (Crotty 1998). This assumes that there are 'things to visit', that is, objects to which our understandings relate, and this intentionality is central to the concept of phenomenology. An object is an object for someone, and cannot be described apart from the subject who relates to it. This

describes the relationship between human beings and their world, proving that we are 'beings-in-the-world' and cannot be described apart from it (Crotty 1998:79).

Constructionism assumes that each of us is born into a world of cultures and sub-cultures, which provide us with meanings. We learn these meanings in a complex process of enculturation and they heavily influence our thinking and behaviour through life. Constructivism says that we as individuals engage with the world and make meaning from it. Phenomenology urges us to adopt a more individual constructivist approach in dropping our cultural norms and meanings, and take a fresh individual look at the situation, reinterpreting it through new eyes unadulterated by preconceptions (Heron 1992). In the light of Becker's discussion of researcher bias and the impossibility of the researcher adopting a neutral position in a subject area in which they take a keen interest, the limitations of attempting to achieve a 'fresh look' in order to reinterpret the situation must be acknowledged. Thus, a constructivist approach will be adopted in this present study, while examining a potentially constructionist phenomena, in the form of the meanings and values culturally embedded in the professions.

In addition to the difficulties in a constructivist approach acknowledged above, the effect of Gidden's 'double hermeneutics' must also be recognised (Flyvberg 2001) in the interpretation of data in social science research. This considers:

1. self-interpretations amongst the subjects being studied which are subsequently explored and observed by the researcher.
2. the researcher's own self-interpretation and self-understanding which will influence data collection and analysis.

Thus the subject being studied will have formed their own perspective based on their own unique culture and experience, leading to their own interpretations of the questions asked and issues raised. The researcher will study and subsequently interpret the subject's behaviour and responses, constructing their own version of reality in terms of their own perspective of the situation based on their own unique culture and experience. This recognises that there is no one single truth, and it must be reiterated that the aim of this research is to deepen understanding rather than generate explanation.

5.6 Summary

The methods engaged in this research have been outlined and the justifications for this methodology have been discussed. Following an outline set out by Crotty (1998), an

approach has been described based on a constructionist epistemology, in which it is acknowledged that we are shaped by our cultural heritage through an enculturation process, in which we learn meanings through which we interpret the world around us. However, for the purposes of research in a phenomenological approach, we are urged to adopt a detached view of the world, dropping our cultural norms and meanings, in order to re-examine and reinterpret the findings to produce deeper understanding of the issues and behaviours in the study group. This is allied more closely to a constructivist viewpoint, and incorporates an element of criticality into the analysis and interpretation of findings. The ideas associated with Mead's symbolic interactionalism are also related to the interpretation of the findings, in terms of the role of social interaction between individuals which shapes the meanings they attach to elements in their world, This inevitably has an influence on interpretation, as does the double hermeneutics described by Giddens.

The practical application of methods arising from this epistemology and theoretical perspective have been discussed and justified in terms of adopting a qualitative approach to produce data that is contextually relevant and rich in detail, in order to deepen understanding rather than to provide explanation and fact. The influence of self on the data generation and collection has been acknowledged, as well as in its analysis and interpretation. The implications of the methods, subjectivity and reflexivity on the reliability and validity of the data have been discussed in terms of its uniqueness and close contextual qualities, potentially contributing insight into a complex human social situation. The relative advantages and disadvantages of the ethnographic observation and semi-structured interview methods chosen to effect the generation and collection of data have been discussed, together with wider implications in terms of sampling, bias and ethical issues.

It is concluded that the methods selected in order to carry out his study are justified, in acknowledging the role of self and its implications in the generation and interpretation of data, which is intended to provide deeper insight into the values and behaviours of the group which is the subject of the study. The qualitative approach has taken account of the limitations in terms of generalisability of the findings.

The findings of the initial phase of ethnographic observation have already been reported in Chapter 4, and the findings and analysis of the main phase of the fieldwork with Groups A and B are reported in the following Chapter 6.

Chapter 6: Findings

Chapter 6 Findings

6.1 Introduction

The social constructivist epistemology of the qualitative methodology employed in this study has been described and justified in the preceding chapter, outlining its critical approach to analysis. The findings of this analysis of the fieldwork data derived from the practical application of this methodology will now be presented in this chapter. The data have been interpreted and analysed in accordance with the methods already outlined, including an element of content analysis to inform the detail of the current context, together with thematic analysis to identify and deepen understanding of the main issues perceived of importance to the group concerned.

Section 6.3 will present an interpretation of the findings from the semi-structured interviews with Group A, comprising 10 'leaders and policymakers' from the profession. Five main themes are derived from this analysis: Values; Standards; Independence and Autonomy; Challenge and Attack; and the Future of the profession. These are discussed and subsequently illustrated through a more detailed report of the analysis.

The analysis of the data obtained from the semi-structured interviews with Group B, comprising 30 'frontline workers' in the dental profession will be presented in Section 6.5 following a framework derived from the four main themes identified from this data: Standards of Professionalism; Challenge to Autonomy, Independence and Freedom; Fairness; and Opportunities and the future. Again the analysis is supported through a more detailed account of the findings from data generated from this group of practitioners. A brief reflective summary brings the two areas of analysis together in conclusion.

6.2 Sample data of Group A: the leaders and policymakers

This group of 10 interviewees comprised 8 male and 2 female participants, all of whom were considered to hold positions of influence in the profession, in terms of leading certain groups within it and being responsible for devising, negotiating and implementing policy. The participants qualified at a range of UK dental schools including Liverpool, Edinburgh and Sheffield between 1962 and 1982. All had at some time in their career worked in general dental practice, although two had since given up all clinical practice to concentrate on political and administrative roles in the professional bodies, businesses, Royal Colleges, universities and government departments in which they now worked. Another two did not work in general practice,

and another had very recently retired from the profession a few months prior to the interview. In addition to dental qualifications, one participant had a law degree, one a medical degree, two had an MBA, and a number of others had Masters degrees in management or other non-clinical areas of practice.

Interpretative analysis of the data was carried out in order to deepen understanding of the situation as currently perceived by the profession, allowing a clearer insight into the issues and challenges facing the profession at this point in time. Thematic analysis using a manual coding method identified the common themes running through the data from the interview scripts and fieldwork notes, which were refined through questioning during subsequent interviews in the series, and through further analysis. These findings are reported in the following section 6.3.

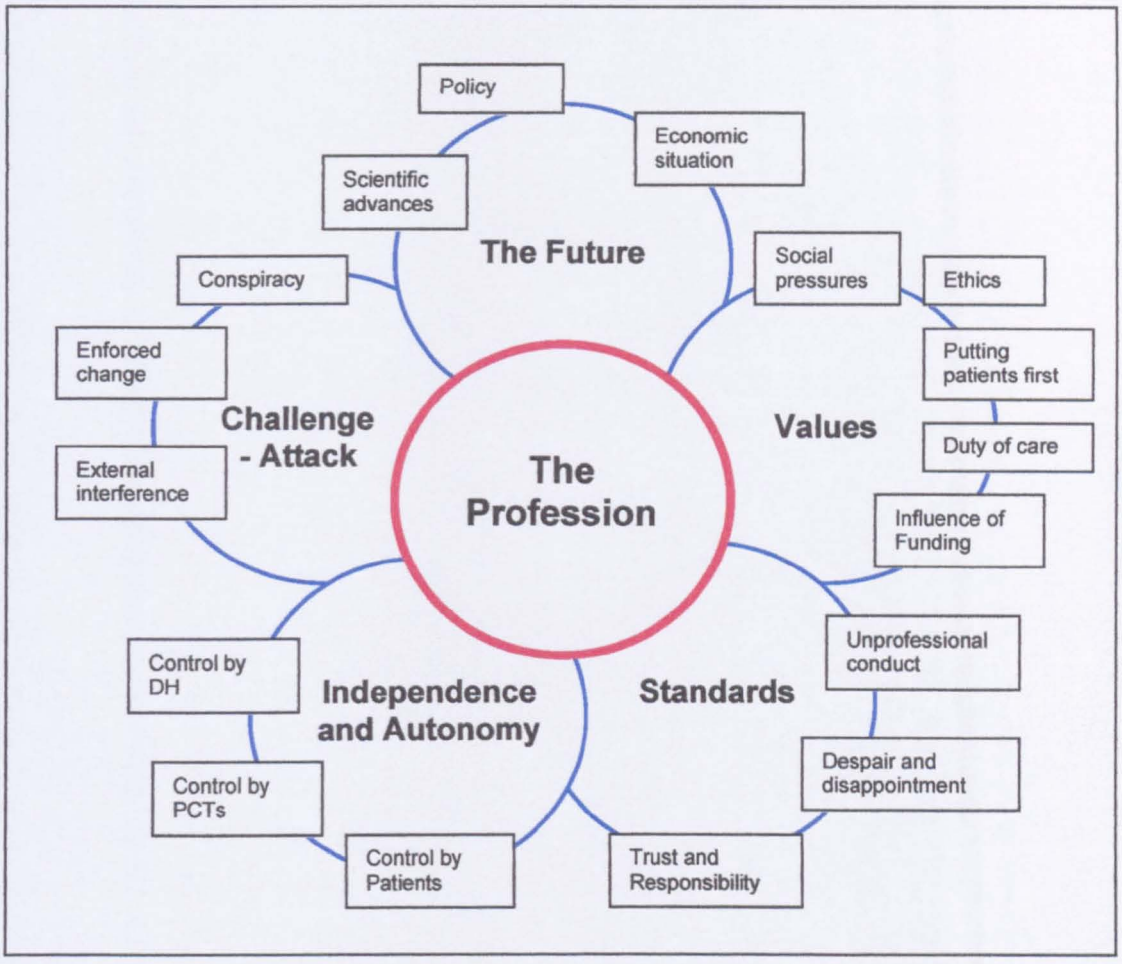
In the following sections, direct quotations have been assigned to the appropriate participant, except to ensure anonymity where they were deemed too sensitive to attribute directly to certain individuals. These quotations have been marked A*.

6.3 Thematic analysis of data from Group A: Leaders and Policymakers

Thematic analysis of the full interview scripts indicated five main themes of immediate importance to the profession, arising from the perspective of this group of leaders and policymakers, as illustrated in Figure 6.1.

Values: 'Putting others before self' was stated unanimously as the key characteristic of being a professional, and was felt to embody the altruistic values of the individual in acting in the best interest of others, including wider society. This response was offered almost as 'the correct answer' to the question, and could perhaps be the reflex response of this group of public figureheads, accustomed to acting in a 'spokesperson' role, to provide the response that would be most appropriate for public consumption. The further complexities of the implications of this element of professional practice were thoroughly considered in terms of its conflict with the commercial aspects of work, together with the implications of relating such a vocational approach to the justification of what would be deemed an adequate level of remuneration for a professional. The ability to act in the best interests of others had to be linked also with the ability to work to high standards and to maintain these standards, which would be necessary for developing the trust element of professional relationships.

Fig 6.1 Themes emerging from Group A: Leaders and Policymakers



The set of values thought to be required might in some respects appear to be inherent in an individual, and almost certainly gained from an early age through family and social contacts who acted as role models. The need for integrity is assumed rather than explicitly stated, and there is a clear statement of the need for independence, self-determination and self-governance, all of which are regarded by this group as being integral to the concept of being a professional. Although the word 'autonomy' was not used explicitly, its importance was clear in terms of the need for 'freedom' in decision-making, which appeared to be a key element of the value system of the profession.

Standards: high standards were expected in all areas of professional life, both at work and in non-working life, relating to behavioural and ethical standards, as well as directly to the quality of the care delivered. In order to practice to such high standards there was an implicit assumption that all professionals would have access to a shared body of knowledge and would wish to maintain their own personal skills and knowledge on an independent basis, this requirement being self-motivated rather than imposed by external regulation. There was also the expectation that modern professionals would

be self-motivated to pursue evidence-based practice, in addition to their commitment to lifelong learning.

Trust was implicit in all professional relationships with clients, staff, other professionals and in contracting negotiations. The impression was given that the profession worked hard to maintain public trust, but that this was against a rising tide of distrust of all professionals in society, deliberately fuelled in some cases by the government through its policies and the media. Other professions were also perceived to have 'let the side down' by engaging in what was deemed to be unprofessional behaviour, for example the nurses' conduct when bargaining for increased pay. The impression was given that it might be best for the dental profession to 'go it alone' and not suffer as a consequence of being related in the public's perception to other healthcare professions. It was appreciated that trust was a complex issue to manage, being intimately related to behaviour, responsibility and the maintenance of high standards. The act of explicitly making professional judgements clearly demonstrates all the other implicit aspects of professionalism, reflecting the trust, values, standards and altruism expected of a professional. Disappointment and despair were deeply felt by participants who dealt with poor professional conduct, with a clear sense of feeling let down, and of disbelief that members of their own profession, who apparently shared their own value system, could act in such ways.

Independence and autonomy were implicit in much of the data, though the words 'autonomy' and 'control' were rarely stated explicitly. There was a strong resistance to even the idea of control, and a deep-rooted distrust of government and authority, except from those participants directly acting on its behalf. The idea of control by inexperienced PCTs appeared to be regarded as an insult to the professionals who had invested in and built up their own businesses over many years, and it was widely held that dentistry, more perhaps than other professions, attracted individuals who valued their freedom and independence, and so were likely to react more strongly when confronted with enforced control. The element of 'control' through patients becoming more involved in their own treatments, and especially through funding of their own individual care, appeared to cause less distress, being accepted as part of the wider change in social attitudes and as a necessary part of an alternative system to state funding. It was widely held that retention of autonomy was one of the major factors influencing the decision of practitioners to leave the state funded systems, although many other factors were also involved.

These key factors reflect closely the core traits identified in the literature relating to the professions. It is possible that this range of elements arise from a combination of the community values and codes instilled into an individual member of a profession through socialisation, as well as from their own ideas and principles. The degree of consensus testifies either to the success of recruiting 'the right sort' of individuals into the profession in the 1960-1980 period, or of the success of the process through which these professionals from different background and undergraduate schools have become socialised into the profession. It could also be argued that members of the profession most strongly associated with these elements are most likely to assume leadership positions, or that by virtue of being leaders they are more likely to explicitly articulate such a viewpoint.

Challenge and Attack: The majority of this group regarded the changes in government policy affecting the profession to be in the form of a challenge, affording a range of new opportunities for the profession to develop further, removing many of the previous restrictions. However, it was conceded that many in the profession had viewed enforced policy changes as a threat or attack, and that this related both to resistance to change from a group who had worked in a highly protected environment for many years, as well as to the almost inherent distrust of government, arising primarily from previous contract negotiations in the 1990s but which now appeared to have become part of the tradition and 'recipe knowledge' of the profession to be passed on to future generations. The term 'conspiracy' was used in both the context of the government and its actions towards the professions generally, as well as alluding to society's view of the professions as 'closed shops', leading to suspicion and distrust.

Unnecessary interference in the profession and its workings from external sources was resented, although there was an understanding of the need for changes in regulation and more open transparency in order to placate public concerns arising from unacceptable practice in other associated professions. There was almost a sense of betrayal and disappointment however at the degree to which the GDC was apparently letting the profession down and had turned from being a source of great pride for the profession into a potential threat, this becoming certainly an issue for reflection, and in some respects of concern. This may have reflected a degree of anxiety over the profession's loss of control of the GDC and its deliberations, and there was clearly concern regarding future deliberations of the GDC with its increased lay membership.

The perceived importance of the professional bodies and associations to the profession varied within this group, as would be expected from their close association

with and assumed allegiance to a number of the bodies concerned. There was no doubt that a form of professional community existed by virtue of compulsory registration[64] which effectively excluded the majority of society from membership of the profession. The roles of the other professional bodies and associations were varied, and membership was not compulsory (except for membership of an indemnity body[65]). Leadership appeared to be of much less concern in the dental profession than in medicine, perhaps because of its smaller size and its lack of concern with direct influence and power in society. The role of the Chief Dental Officer (CDO) was perceived to have altered significantly over the preceding decade and this again seemed to be a cause of disappointment, with a degree of nostalgic regret that things weren't how they used to be, as with the GDC.

The Future: Technological and scientific advances were universally acclaimed to be prime stimuli for the growth of the profession, and the development of new materials and techniques had changed dentistry into a radically different service during the past 25 years. The current rate of advancement, together with the accompanying increase in public awareness and subsequent demand for its services, had brought the profession to a position which demonstrated some similarities to the medics in the 19th century, when both scientific advances and demand for services allowed its rise to become a successful profession in society. At the same time, a high level of uncertainty was expressed, in particular with regard to the distrust of future government policy, an anticipated change of government, and the potential for further legal challenges to the monopoly of the profession over diagnostic practice. The economic climate had already been observed to affect the funding of services, particularly in the private sector, and the close association of the profession with money could not be ignored as new graduates sought to repay student debt, and society increasingly encouraged indulgence in lifestyle treatments.

Each of the above themes will now be discussed in more detail in the context of the data and its analysis, in order to illustrate the points made and to substantiate the importance of these themes to this group.

6.3.1 Values

A very deep rooted set of values were thought to be of utmost importance to a dental professional, and this seemed to be one of the main justifications for setting

[64] With the GDC.
[65] The two main organizations in this field - the Medical Protection Society and the Medical Defence Union - were regarded as part of the profession, and were becoming more proactive in engaging with the profession and shaping its future.

professionals apart from other occupations and groups in society. These values were thought to be heavily influenced by childhood experiences, and perhaps accounted for some of the differences between the professions. A shared professional objective was deemed necessary for maintaining the concept of a collegial professional community, with a sense of responsibility beyond the individual patient to the benefit of wider society, expressed by one participant as a "sense of service" (A7). It was thought that members of a profession should aspire to a shared value system through a shared set of goals and objectives, in which the skills acquired in training are not merely to be utilised for self-interest, but to be dispersed into society. It is recognised that professional values are dynamic and continually change in the light of social, policy and economic pressures, while experience is still thought to be of extreme importance in proving one's worth and gaining respect:

> *" I think if you become an established dentist, it carries with it a degree of professional respect, because you are who you are, because of what you do." A6*

There was concern that perhaps this duty to serve is now diminishing in the professions, but Group A unanimously indicated the importance of the need to put others first and of acting in their best interest, although it was recognised that a balance needed to be struck, and that this altruistic approach should not be followed to the extent of potentially causing self-harm through endeavouring to uphold the highest professional standards and values:

> *" I think that's the thing that's missing, is putting others before self, but not necessarily at your own direct peril." A1*

A solid ethical base was deemed absolutely vital in promoting professionalism, with fears that this had been 'dumbed down' in more recent times with a consequent increase in dentists getting into difficulties later on in their careers due to "carelessness and not knowing how important certain things are" (A8). Some concerns were expressed at the current selection methods being employed by universities in selecting future members of the profession on academic achievement alone, not taking into account their personal values or any estimate of the students' sense of self. It was recognised that to be a successful GDP requires a very complex mix of attributes:

> *"I do think genuinely that to be a really good general dental practitioner you need an extraordinary set of skills....to be a good small businessman, practise ethically, be totally patient centred, be committed to lifelong learning, to work in a small dark cave and to do very technical things within a nanometer - nobody else does that. It's an absolutely extraordinary set of skills. I think that ought to be recognized." A10*

It was reported that a small number of dental schools are now changing their selection procedures in recognition of the flaws in the existing system, and graduate-entry

students are now selected on their successful demonstration of appropriate values and professionalism, together with their aspirations to become healthcare professionals, rather than on their academic achievement alone. However, there was acknowledgment that there is considerable variation between individuals, in that some may already have appropriate values at 18 years of age, while others may need more help in developing these during their undergraduate programme:

> *"One 18 year old is not the same as another 18 year old. So one will have absorbed those values and may actually be going into healthcare because of those values, to support people and using their skills to make things better and improve people's lives. And some 18 year olds who haven't, will I think maybe absorb that with the right role models." A9*

There was a strong sense that appropriate values had been absorbed from an early age, especially through parental influence, with many believing they had been influenced by living in a professional household with clearly defined behavioural and ethical codes of conduct:

> *" I don't get on particularly well with [my father], but I would say he is an exceptional individual. His dedication, and as a role model...I grew up in a medical family." A3*

These participants appeared to believe that their socialisation into the professional world occurred before they went to university, inferring that there may be a set of generic values applicable across a range of professions, which might then be more closely honed through training for a particular profession. Thus, upbringing and education were both thought to play a part in the development of the appropriate value system, but it was believed that having professional parents was not necessarily a pre-requisite for gaining those values:

> *" I think there are some of what used to be called working class people who have uniquely professional values. You can have professional values as a refuse collector or someone who runs a canteen or anything else, so when I say professional values, its not just about doctors and dentists." A10*

There were mixed feelings in Group A regarding the professional values of younger practitioners entering the profession, in terms of their attitude and regard for professional practice as a job rather than as a vocation. Whether they had lost their vocational commitment was questionable:

> *" One generation can't say the whole of the next generation have lost their vocation. It's vocation in a different sense, that's the only way I can put it. So it's more of a change in society and expectations in that way." A4*

The nostalgic attachment to symbols associated with the traditional profession was much in evidence, and it was observed that young dental graduates are very keen to adopt the title of 'Doctor' on graduating, with a feeling that they have 'made it'. One

participant thought that concerns over declining levels of professionalism were ill-founded:

> *"I think with this issue of dentists and their lack of professionalism - I think the vast majority of dentists, like the vast majority of people, are decent, solid, hard-working, fundamentally sound, you know. I think that's pretty much the world. There is some basic decent humanity out there." A3*

There was an optimistic feeling that the younger dentists just entering the profession have a very positive outlook, retaining the core values of providing services to people who really need it:

> *"I think there is still amongst the young a sense of vocation and a sense to want to contribute to society." A2*

Young dentists were also perceived as being more competitive and self-determined, with a broader vision of life, though perhaps more naïve regarding the business aspects of practice. They were thought to be well informed, with much better professional communications and access to publications than in the past:

> *"Having met a group of 12 young dentists this week, I think they're brilliant. I just think, 'God, if I had been like you two years post-qualification, I'd have got a lot more from life'." A7*

An increasing range of technical opportunities was seen to be making dentistry much more exciting and interesting than in the past. Those who felt younger dentists to be less dedicated saw this balanced in some respects by their despair at the attitudes of many older practitioners, who persisted in arrogant behaviour with a lack of respect for their peers and others. One participant reported that the younger dentists who were becoming engaged in dental politics were extremely professional and very mature in their approach. Their high level of debt at graduation was acknowledged to have an influence on their money-orientated approach to their careers.

A number of the participants placed their hand on their heart when they talked of values, signifying perhaps the strength of feeing within, which could not be entirely put into words. The importance of role models was thought to influence both prospective trainees and the students at Dental School:

> *"I think you have to admire the people who were professionals in your experience, and you thought there was something good about them. Which is probably why people go into these things, because they are inspired to go into dentistry by a dentist they know or who they've had experience with, a doctor or whoever it may be...they may inspire lots of people to take up the profession." A8*

The difference between being a healthcare professional and other types of professional proved a thought provoking area for some. While it was thought that all now operated

in a market context, the specific character and values associated with health made these professions somewhat different:

> *"The difficulty is that health care is not a tangible good, it's not something that you can measure as easily as tax returns or legal cases, win or lose, whatever. Health care is much less tangible and more pervasive throughout our society. It is of equal priority to everybody. Everybody's health is their own priority. You can't go out and buy some more of it, whether you go to Woollies or you go to Harrods. So, it is different. Health care is different in that respect. But we work in a market place and at the end of the day, there will always be certain marketplace laws that practices will have to conform to, or they will go out of business." A7*

Health was regarded as "a subjective thing" (A10) which was defined by the individual, as opposed to the law which was defined through legal process and government. Judgement then becomes more important and in this respect a professional would be influenced by their own competence and personal experience of the techniques and treatments in question, such that they would need to consider "What works in my hands?"(A9), accepting their own limitations. The potential to refer on to a colleague if necessary, for a further opinion or treatment, relied upon an implicit system of trust and shared professional values amongst the professionals.

Further differences between health and other professions in terms of finance were contentious, particularly in the implications for a 'value system' of providing healthcare. Many of the participants who acted in the capacity of a spokesperson were encountering difficulties in presenting the profession in a positive light to the publi by virtue of its funding systems and the problems associated with the NHS/private divide in the UK:

> *"Maybe there's an honest transaction in me providing something of value and you then paying a reasonable price for it. That, by definition, because it's not NHS, is 'private'. But by definition also it isn't glitz and gloss. It is about doing something at an honest price, and that to me isn't any different to any other service." A1*

It was thought that Dentistry might not be regarded with the same respect or cachet as medicine, and that doctors had "always been in a slightly different place" (A1) to dentists in the public perception. One participant felt that the differences between them had become more apparent in their differing attitudes towards running a business, the dentists being more successful in this respect, while doctors maintained a higher level of "professional quality" (A4) through activities such as teaching. It was perceived that dentistry and medicine were becoming more distinct from each other:

> *" I think we're becoming more separate ... not necessarily around the delivery of health care on the high street. We're becoming more separate around specialist training. We're becoming more separate in our regulation definitely. We are far more regulated than lawyers are, without a doubt. I think the medics*

would envy our regulation rather than what they have. .... I think they regard us as a profession, but not as professional as they are." A6

At the present time it was thought that some doctors envied dental colleagues for the way in which they ran their businesses with a tighter, compact lifestyle, with more independence and an income comparable to the medical profession. The ways in which other professions viewed dentistry were unclear:

" My glib answer would be that most of them haven't got a bloody clue what's going on [in dentistry], because they're too busy trying to get their own house in order." A6

6.3.2 Standards

The establishment and maintenance of a shared body of skill or knowledge was linked with the requirement to achieve the highest possible standards of professional practice. High standards were also seen as justification to set the profession apart from other occupations, and these standards were strictly applied in terms of both personal conduct and levels of clinical achievement. There was acknowledgement of "certain unspoken rules pertaining to being a professional" (A1) that one has to adopt and integrate into one's own life in order to become a member of a profession. It was perceived that a professional must behave in a particular way that meets with current professional standards, and peer and public expectations, allowing relationships built on mutual trust, honesty and integrity to be established and maintained. Codes of conduct were thus regarded as an important aspect of being a member of a profession, governing conduct beyond the workplace "in everything you do" (A2). One participant said of professionalism:

"It's a way of life. Yes, I think it actually is. It's not saying the wrong things on Facebook when you've had too much to drink. It is about conduct, and it's not creating anxieties in others that you aren't everything that you say you are; and by that I mean that you <u>are</u> somebody with integrity. Somebody that people can trust if they choose to. Or that at any point you can be relied upon to perform in every possible way; as a friend, as a colleague, as somebody doing their best for everybody really." A9

It was understood that integrity needed to be beyond question:

" I think integrity is really fundamental to professionalism, isn't it? It's a culture, it's a maturity that's a package of all sorts of things, and it does extend outside of work." A9

The link between appropriate behaviour and the trust accordingly bestowed was strongly conveyed, with the expectation that professionals maintain a standard of behaviour in putting other people's well-being above their own personal gain, acting honestly and straightforwardly with people. The issue of trust was also raised in terms of the faith that patients have to have in a dentist's ability as a professional to carry out

their work using current knowledge and techniques, and to act in their patients' best interests. As one participant put it:

> *"Something you'll never ever say to the patients is 'You will have to trust me.' You can't. Why should you do that? The onus is on me to make sure that they don't have to doubt their trust in me." A9*

Participants believed that trust and respect were interlinked, but that there had been a considerable loss of public trust in and respect for professionals during the past 10 or so years. This was firstly due perhaps to changes in wider society, and secondly because some professions such as nursing were now perceived as acting in more self-interested ways, exhibiting behaviour more befitting of a trade union in negotiations related to pay and conditions. This was thought to contribute to the public perception that the professions *en masse* were dropping their standards and consequently losing status in society.

Some professionals could recall no formal teaching in professionalism or related subjects during their training, although the majority of participants indicated that standards were engendered from the start, and constantly instilled and drummed into them during their training period. Others felt they didn't become a professional until the day they qualified, when they assumed more responsibility.

It was suggested that there might be two separate models of professionalism for which a role model might be required: firstly, academic professionalism in which the highest standards of practice are reflected; and secondly, professionalism in practice, which reflects the relationship with the patient and issues of respect in professional care. Continued training is thought to develop the professionalism of the individual through didactic teaching, apprenticeship and study, and role models continue to be "deeply important" (A10) in the form of supervisory dental staff and colleagues who are deemed to be 'expert professionals' espousing the correct values.

For the oldest participant, who qualified in the 1960s, there was no doubt that he became a professional by means of a process at dental school, beginning with learning 'the difference':

> *" I was taught 'the difference' in my first week as a student and I was told 'When you come into this hospital, you will wear a tie and you will polish your shoes, out of respect to the patients. And when you come on my clinic, you will likewise be appropriately dressed. That's number 1. Then number 2 is the patient, which is paramount, and you have to take their interests into account'.... It was there to show young men and women from totally different backgrounds that this was something different." A8*

This was echoed by a participant currently involved in the training of dental students:

> *" It's making those expectations absolutely overt, not from when you qualify, or when you get signed up by the GDC, but from the minute they walk through the door here. Absolutely there is an understanding that you've just made a life-changing decision and decided to become a healthcare professional." A10*

While agreeing that it is difficult to define the moment that you become a professional, another participant thought that professionalism could only be absorbed by example, rather than by training, through a "slow drippy sort of maturity of expectations" (A9). Some believed that professionalism could be taught, and measured against a set of published competencies, although some of those promoting this idea were directly responsible for contributing to the policy documents endorsing this approach. It was acknowledged that individual professionalisation does not have an endpoint:

> *"I don't think there's a point when you can say, yes, I have learned to be a professional. I think it's the responsibility of lifelong learning, or awareness that you have to be a professional." A6*

One participant spoke of a book he had read, 'The Reflexive Practitioner' by Donald Sharp, which related to professionals generally, and which had heavily influenced his professional development:

> *"The whole idea is that a professional worked by a process of continual self-insight through reflection in action, whatever you continually reflected on. You call that audit now, and everybody does it...we've all done it, all our lives." A7*

The very fact that it was felt necessary to teach professionalism to undergraduates was considered to be disappointing, in the same way as needing to teach citizenship in schools. The professional attitude of newly qualified practitioners was thought perhaps to be confused, in that they experienced difficulty translating the professionalism they had learned in the dental school setting into practice: "Sometimes it's difficult to know what is expected of you on day one" (A6). It was acknowledged that new graduates should essentially be regarded as 'safe beginners' in the same way as someone who has just passed their driving test, and that they weren't the equivalent of a professional with 20 years' experience.

There was a nostalgic tendency towards assuming that the old ways were better, although in the past it was admitted that professionals had learned many skills by making mistakes and covering them up. Now they were guided through a postgraduate year of Vocational Training[66], which was regarded as eminently preferable, although it was acknowledged that "these kids are assessed to death" (A6) and that the vocational training had been severely dumbed-down by changes in NHS funding: "It's all very safe and they don't do anything in the slightest bit complex" (A9). The participants offered

[66] Vocational Trainees (VTs) are now known as Vocational Dental Practitioners (VDPs), but they will be referred to as VTs throughout this thesis to avoid confusion.

constructive criticism regarding improvements to the current system, with an implicit frustration at the external interference and restrictions, which did not allow perceived optimal functioning of the training systems which they considered might be possible if the professionals themselves were allowed to organise it unhindered.

Self-regulation was regarded as having been a traditional characteristic of the professions, but participants acknowledged the need for a regulatory body governing professional conduct, to ensure that high standards were maintained, above and beyond self-regulation and self-governance, while preserving an element of individual freedom and self-determination. The exact reason for this 'need' was not made evident, other than in the need to satisfy public demands for transparency consequent to incidents occurring in other professions. It was certainly not an internally driven desire from within the profession, and appeared in the form of gracious acceptance of external pressure. The GDC was regarded as the sole regulatory body, representing the interests of patients rather than of the profession itself. It was generally thought by Group A, in a rather condescending manner, that the profession did not fully grasp the fact that the GDC did not now represent their own interests. This patronising view that fellow members of the profession were not particularly bright and needed looking after was evident through a number of similar comments, made by three of the older male participants in particular.

The need to change to a more open system of regulation was acknowledged in a very politically correct manner by Group A, perhaps not reflecting the true feelings of the participants, leading to such statements as:

> *"I think the regulation of the professions ought to be informed by the profession not led by the profession." A2*

Acceptance of the decision to include lay members on the GDC was in some cases more begrudgingly granted, with an undercurrent implying that it would have been preferable in many ways to have maintained the *status quo*, and that it has changed to something different rather than better:

> *"I think it's going to have to be a compromise situation...I don't think you can have lay regulators, nor can it be the profession. It has to be a mixture of both. And there are advantages and disadvantages to that." A4*

It was however recognised that the reputation of the profession might be enhanced with increased public confidence through the actions of the GDC, but that its fundamental role is to protect patients and "to control dentistry" (A10). Views were far from unified, and while some considered the GDC to be exemplary and very professional, there were allegations that in its present form it is incompetent, being now

so reduced in size that it cannot adequately deal with the business of dentistry[67]. One of the most senior participants showed little respect and expressed a very low opinion of the GDC, claiming that it lacked the ability to run the educational aspect of dentistry, and the 'know-how' to effectively carry out revalidation and to deal with additional qualifications and pre-registration:

> *" So you know, they are in trouble. I know they don't see that, but I think they're in trouble." A**

In Group A in particular there might well have been a feeling that the participants themselves felt that they could have done a better job if they had been part of the GDC, and there may have been some degree of insecurity on behalf of the profession, in view of the fact that it was no longer possible for the profession to engage in succession planning to effectively control membership of the GDC and thereby control many aspects of the profession. It was recognised that the GDC had been under immense pressure, especially in terms of enforced reorganisation, regulation, and confused pathways of accountability:

> *"The GDC is under pressure from all sides. It is under pressure from consumerism and consumer groups. It is under pressure from the significantly increased regulatory burden that is being thrown out by government, particularly this government over the past 10 years. ...It's been reorganised from pillar to post. ... I certainly don't envy anyone at 37 Wimpole Street[68]. It must be hell, and it always surprises me that some of the people there, like me, are very nice. I think they've got every justification for beating their heads against the wall." A7*

There was a strong feeling that not enough was being done to eliminate rogues from the dental profession. Quality standards were felt to be fundamental to professional practice, and the corporates and PCTs were seen to be acting in such a way as to undermine the profession's reputation.

6.3.3 Independence and Autonomy

A number of the participants believed that the scope to act independently and to use discretion in a decision-making role were important markers of professional autonomy, allowing one to act on one's own initiative, both in the interest of the profession as well as of one's patients and broader society. This autonomy also enabled a furthering of the profession's specialist and skills base through directing research, teaching and publication.

One participant already saw dentistry as being quite different to the other professions, particularly in terms of its relative negotiating strength and its high number of

[67] It previously had 50 members, of which 6 were lay members and 44 dentists in 2002. In 2010 it now has only 24 members, of which 8 are dentists, 4 are DCPs and 12 are lay members.
[68] The headquarters of the GDC in London.

independent practitioners. Its relatively small membership had not handicapped it to the degree one might have expected:

> *"People talk about the dental profession as though it's the same as the legal profession and the medical profession, and so on, and we're totally different. First of all, we have as many committees and as many officers as the British Medical Association, and I don't quite know the number of doctors but it's 250,000 something like that. We've got less than 50,000 dentists in the whole UK[69]. A fifth of the number of doctors. A tenth of the number of lawyers. And yet we are there with everyone. We are equal, we've got a committee set up and so on, we're at Parliament. And, everywhere, we stand our ground and make our voice heard as a profession .....The general population, they want us there because nobody knows when they're going to get a problem with their teeth... General medical practice accounts for 45% of doctors. In dentistry, 90% plus are in general practice.... It's a very different profession." A8*

It was perceived that there had been additional pressures on professionals in the requirement for them to engage with clients to achieve informed consent, which was felt to add another level of ambiguity in terms of accountability in the professional/client relationship, placing further demands on the trust elements of this relationship. The dental profession was portrayed as being under pressure from a number of such external sources, especially in terms of regulation, which it feels it has been able to overcome but would rather not have faced in the first place. It was now reported to be more difficult to enter dentistry than medicine, and dentists were generally regarded as becoming much more commercial in their practice, especially in terms of marketing, where they were adopting similar competitive strategies to the lawyers and to their US colleagues.

Underlying the professional relationships described by these professionals was a sense of distrust, apparent deception and the need for the profession to retain as much control as possible of their domain of practice by minimising the detrimental effects of the state-funded service, at both the individual and collective levels. It was implied that members of the profession have been treated unfairly in the contracting relationship with government agencies, and have consequently engaged in violation actions, including exit or expressing the intention to quit. There was a perception that government expectations of the profession were 'superhuman', pushing them beyond their limits:

> *"The 'professional' tag is being used to beat people into a situation that is hostile to their wellbeing. Professionals who try to retain that 'patient before self' attitude are running into that real dilemma that their own survival is in question. So I think the preference of most dentists I know is to retain their professional identity; but at the point where it's actually pushing them, I think its dangerous." A1*

[69] There are actually approximately 32,000 dentists registered in the UK.

*"...[the government] say 'We're going to change it, but we're not going to tell you what to'. What person will put up with that? And of course lots of people left the NHS, not because they don't care about the NHS, not because they don't care about patients, but any person put in that situation would want to regain control over their life, their future, their financial stability, I thought that was an outrageous piece of management to do that to people. It was such an insult." A**

The most successful dental professionals now appeared to be those who were successful in contracting and business skills (although this was perhaps not what they really wanted to do), allowing them to retain a higher degree of individual autonomy and professionalism.

It was perceived in Group A that the UK government in the recent past had been on the offensive and 'anti-professional' in their conduct, and that they had been attempting to undermine the roles of a number of professional groups, not only in healthcare:

*"It's the very time when all the auguries from the government and policy formers seem to be anti-professional. I talk to a range of people in a number of professions, and all of them will tell you in this country that they believe that the government is anti-professional.... there was a gathering of various professions, the barristers, lawyers, and all the rest of them, and all of them were reporting the same - there's almost a distrust of the professions in government at the moment." A**

There was an implicit expectation that a profession should be treated with honour and respect by other parties in negotiations:

" I think it's a good profession. And I think it has a right to expect not to be badly treated by the biggest purchaser of it's services, which is the government on behalf of the public ...I do believe that the changes that have been introduced have been dishonourable." A1

This was not thought to be the case abroad, where the professions were still held in high regard, for example:

" You talk to any Polish person, and ask 'Who are the professionals?' Dentists and doctors, lawyers, and that's about it, and they have far more respect for them than we do, far more - in Poland the dentist says "It is so-and-so, and it is so-and-so". And you don't disagree with what the dentist says, okay? So there are no complaints." A6

There were undercurrents of conspiracy against and distrust of the professions generally in the UK, and one participant described the 'politics of envy', where successful groups who have an advantage are targeted by those who are not part of the group, and who want to break up their advantaged situation which is perceived as a closed shop. Another felt that the professionals' own needs were being ignored:

" Until you get inside it, you don't realise why it is so important that these professionals who have a vocation need to have that bond and strength within them.... People don't seem to understand that people working in the

professions have feelings as well. And part of society wants us all to be dumbed down." A5

There was a reported difference between national media coverage and local experience of the profession, with patients apparently readily complaining about the generality of the situation despite good personal experiences. However, it was recognised that media audiences are increasingly sophisticated and well-informed, and that they do expect more control over their own circumstances. One participant felt that the internet had now replaced professionals as the gods of the modern age:

*" In ancient times, people had gods and mysterious figures they used to worship. And then people of science and medicine came into the frame, and were able to help them. And they became the newer priests. And then they were supplanted in turn by the internet, which gave them direct control of their knowledge. It's a transition away from the mystery there once was. It's now substituted by the power of knowledge. So you don't have to pray to gods. And [the public] resent the people who are the intermediaries." A**

The poor quality of information available to patients via the internet and the media raised cause for concern, in view of the fact that patients put too much trust in the information they gained from these sources:

"...because unfortunately the internet is not a five-year course in dentistry, although it does give that impression to patients." A8

Older patients in particular were seen to still seek advice and help from a professional, and want the professional to make the appropriate decisions on their behalf, rather than being left to make the choice for themselves. This reinforces the need to maintain a relationship of trust with patients, which assumes a greater importance when an individual pays for a service with their own money. Previously detached patients were now perceived to value the services provided on a personal basis, with a change in their attitude towards NHS care:

"Now patients don't trust the National Health Service and they feel that if you're doing it on the National Health Service it's got to be cheap. This is the impression they've been given and, to some extent, they're more right than they've ever been before." A8

It was thought that in a modern contracting arrangement, patients might now be regarded as partners to an agreement, with an expectation that they should 'pull their weight' and take responsibility for elements of their own care, whether state or privately funded. Now that they were directly involved with payment and subject to a 'complaining culture' in a litigation-aware society, it was reported that complaints against dentists in the UK had now recently exceeded the levels in the United States. Management of this situation demanded a "different type of professionalism...a type of dialogue" (A9) between professionals and their clients.

It was thought that the GDC essentially controlled the profession's conduct, and the 50% lay membership of the GDC had been positively welcomed by a number of participants as improving transparency and reassurance in the profession, and engaging the profession more closely with the public, enabling them to respond more quickly to public pressure. It was observed rather sceptically that the term 'lay' needed to be interpreted loosely, as many of these individuals are closely connected to other professions[70] – "its hardly the public in Tesco's, is it?" (A6). Another participant was happy to consider the lay members as representative of "the *informed* public" (A7) but there were clear displays of resentment to the way in which this change had been forced on to the profession by external pressures. The lay members are recognised as adopting a different perspective to the professional members, but it was acknowledged that the general public "probably couldn't give a stuff" that there are now 12 lay members on the GDC, and probably don't even know what the GDC is (A*)[71].

It is acknowledged that the profession is now regulated by many more organisations that just the GDC alone, in terms of meeting standards in practice demanded by the PCTs, the Healthcare Commission, the Care Quality Commission and others, and so dentists are no longer in a position to protect or shield their own or professional colleagues' poor standards as they once were. The impression was given that this change has been begrudgingly accepted, although it was also the case that some members of the profession were amazed at how long 'the old ways' were allowed to continue.

There was acknowledgment that part of the fear within the profession was founded on the belief that control in the contracting relationships had been taken away from the profession itself, and had been handed from the Department of Health directly to the PCTs. There was a fear that the PCTs are not capable of managing the new NHS dental contracts, having little experience in this newly created field. It was perceived that dentistry strongly attracted people who wanted to run their own businesses and be their own master, and many professionals had sought to reduce their dependence on the NHS due to this fear of losing control of their practice, considering alternatives such as private insurance and capitation schemes such as Denplan. This decision to change their practice to a different way of working had proved to be very difficult for many of

[70] The GDC now has 24 members, which are reported to be 12 lay and 12 professional. The current lay members include a Professor of Microbiology, three past Senior NHS executives, three lawyers, an ex-army officer, a pharmacist, an IT professional, a consultant in consumer affairs and a doctor.

[71] The introduction of lay members on other committees within the profession is also apparently being trialled, in order to introduce new perspectives into groups of individuals who may have acted together as a cohesive group within the profession for years. There is concern that the dental professionals on these committees will no longer feel that they are safe to express their true personal opinions, and so may feel ill at ease in discussing issues as openly as they would if only members of the profession were present.

the professionals concerned, and there was a view that in some respects they had been 'driven away' from the NHS by the inflexibility of its systems:

> *"They're just stuck in a rut and can't find any way to develop themselves and their practice.....they went to university for five years and they want to use their range of skills. And they want to use their range of diagnostic skills, and sometimes they don't even know that that's what they want.....And the greatest pleasure is only seen three or four years [after they have left the NHS], and they are completely different." A7*

> *" Many of the people that we've been helping have been unwilling and reluctant to part from the NHS, but what they've found is that the pressures and the tensions in the system have put them in a position where they really felt they had no choice.... So it's putting themselves in a position of survival. They've also invested huge amounts of their own money - this is what people don't seem to understand - the impact of adverse changes in the NHS for dentists is calamitous. So actually, they've had to reconsider and take stock." A1*

The benefits of escaping the state controlled systems of delivery were identified in terms of decreased bureaucracy and the improved quality of care that could be provided for patients. Group A participants perceived there to be divisions and conflicts within the dental profession between private and state-funded practitioners, which were seen to be counter-productive in maintaining the profession's reputation and its political face, but it was felt unlikely that private practitioners would ever return to the state-funded system once they had left.

Dentistry was seen by one participant to be moving towards a situation of 'relationship dentistry' versus 'episodic dentistry' based on the professional/client relationship:

> *"Interestingly, at one end of the scale, the private non-dental cosmetic Botox end of the scale is very episodic dentistry, and you see that exemplified in 'quick fix' TV programmes, which everybody likes to talk about. Oddly at the other end of the scale, NHS general practice is also moving towards episodic dentistry...in the dental access centres[72] even more so, and corporate bodies who have associates that change faster than the lightbulbs - you know, it really is very episodic." A7*

'Relationship dentistry' was clearly the preferred option in terms of building trusted professional relationships with patients over a period of time, often through multiple family generations. One participant despaired at the services provided by the new NHS Dental Access Centres who were failing to provide any degree of continuing care for patients:

> *" Thirty-seven years ago we used to call it 'The Three Ps Treatment'. When the patients came for emergency treatment: Penicillin [an antibiotic drug], Ponstan [an analgesic drug], and 'piss off'. And that's what they're getting now: emergency treatment...They don't really do the treatment that will benefit the*

[72] The NHS Dental Access Centres (DACs) have been set up as a result of government policy to provide walk-in care for anyone experiencing dental pain, and the PCTs have specific targets to meet in this respect.

*patient, they just do the minimum necessary to possibly get them out of pain." A**

The recognition that the patient played a greater part in making decisions affecting their individual treatment raised further issues for the profession, in terms of renegotiation of the boundaries of practice with respect to applying one's own professional judgement to a potentially harmful situation:

> *"I wonder about the professionalism of refusing to do something on a substituted judgement basis. That is, I say as a patient "It is my personal autonomous desire to have this thing done to me. I know you can do it. I'm fully aware of the facts and implications and I would like you to do it for me'..... When does the point arise when your judgement is better than a patient's? And particularly in this changing society, we've already said we're denying professions the right to have that paternalistic control. And we've gathered for ourselves the right of self-knowledge and self-awareness. Once you move to that path, as the enabled executor of professional services, I'm not sure where you have the right to actually put the barrier on behalf of an autonomous and knowing patient." A1*

Another participant reiterated the need to 'do the patient no harm', with the patients' interests as primary in the decision-making process, which would mean denying them treatment that they wanted but did not need:

> *"We should not be in the business of providing patients with treatment which in the long run is disadvantageous to them." A7*

In dentistry, as in other areas of healthcare, there is now acknowledgement by government and others that there are both healthcare and related procedures that can be provided, in recognition that some of the techniques are not health care *per se*, "but they look more like healthcare than anything else" (A1), and are best carried out by healthcare professionals. There were acknowledged difficulties in assessing the psychological value of many procedures, in terms of aesthetic improvements and the value that society now places upon such cosmetic enhancements, together with expectations of their availability.

The separation of a. the expertise of giving a professional opinion and of b. carrying out technical procedures to a very high standard, raised further issues. One participant with experience of working in the indemnity organisations thought that, in terms of professionalism, technical skills came secondary to the correct mindset, though the two were very much interlinked.

There was concern raised at the current lack of regulation in the private sector, especially in terms of cosmetic treatments carried out which might not be in the patient's best health interest. Two participants felt that the problem lay in clearly defining the benefits to the patient of any particular course of treatment. It was also

deemed necessary to have the 'professional strength' to say to someone that, for whatever reason, a particular treatment was not appropriate for them. Another participant suggested that patients should not always get what they wanted, and that they might refuse to carry out the treatment in certain circumstances:

> *"I don't think we're obliged to give patients what they want, but equally, we <u>are</u> able to give patients what they want, as long as we have discussed the options and alternatives to treatment...I do think it is very hard to draw the line, and you know, it's like bleaching[73]. I don't refuse to do it for patients, but I tell them I wouldn't have my teeth bleached." A3*

The challenge to the professional's traditional autonomy through the patient assuming the role of consumer is a further area in which individual professionals have had to make personal choices regarding their scope and means of practice. There appears to be a range of 'comfort zones' in which one can choose to provide professional services, and it is likely that practitioners have opted to operate within the areas in which they feel competent to make both professional and ethical judgements within their capabilities. Another participant recognised the pressure put on professionalism by private practice:

> *"If you take the massive development in cosmetic dentistry as an example, and the challenges to somebody's professionalism in saying, 'Well, do you have actually need this doing or not?' You know, I'm pandering to your aesthetic whims, but I'm going to bloody charge for it. But at the same time, your professional values say 'I will try to do it as well as I can, and I will treat the patient with respect once the deal has been made'." A6*

6.3.4 Challenge and Attack

Professional status was still considered to exist by Group A, and the 'cartel' arrangement afforded by the barriers to entry in terms of the professional registration process were deemed to be favourable to members, and the most obvious advantage afforded by payment of the annual retention fee. At least one participant felt that the professions generally had already lost their traditional status, and nostalgically described his previous experiences of the professional/client relationship in the 1970s and the respect afforded by being a dentist at that time:

> *"Patients used to call us "Mister" in Sheffield, which was the old expression for a small self-employed company worker, a Mister. ... And so people would come in and say "Good Morning Mister", and that was like you say' Doctor' now...., and that was kind of a mark of respect, if you like...I think it was easier then to slip into the groove of being considered, or considering yourself to be, a professional." A7*

Two participants alluded to the privilege that professionals have "over the generality of society" (A1 and A2), allowing them to act in certain ways in which the general population would not be allowed:

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[73] Bleaching is a controversial tooth-whitening procedure that was banned for many years in the UK due to lack of evidence as to its long-term effects.

"By virtue of your professional status, you are permitted to do things that members of the general population aren't. And with that privilege comes the responsibilities of obeying and behaving in a particular way. .....Entry to the profession is a permission to do things that only professionals can do, with a duty to abide by the rules that adhere to that." A1

The privileged aspects, of being allowed to know things that others don't and being admitted to the circle who understand the jargon and are thus cognisant of the mysteries of the profession, appear to have been stronger in the past than is currently the case, due to the widespread availability of technical information in a publicly accessible form via the internet. This decrease in the esoteric element of professional expertise however has also decreased the paternalistic elements of professionalism, while strengthening the experiential value of professional practice. Thus, demonstrable experience in the application of knowledge has become a defining mark of a successful professional:

"Putting the surgeons' results into league tables, you know, that's a very good illustration that actually people no longer will respect you for your bow tie and your half-rimmed glasses, they want to know how many you've done and how successful they were." A1

The participants in Group A appeared to consider themselves equivalent to and worthy of the status of the 'traditional learned professions', and wished to distinguish themselves from newer professions such as DCPs which might diminish their own status. At the same time, this comparison between professions potentially allowed members of the dental profession to bolster their own perceived status. The degree to which this could be achieved however was clearly tempered by the need for 'political correctness'. This might be assumed to affect all participants in Group A, as the majority of their respective organisations, such as the General Dental Council and the Post-Graduate Deaneries, have been reconstituted to embrace the whole range of 'dental professionals' including the DCPs. The role of these leaders is thus now to represent the whole range of those engaged in the dental profession, not only dentists.

The enhancement of the roles of complementary healthcare professions and the extension of their roles might be regarded as a further move in the wider political agenda to de-professionalise and remove control:

" It's all about preventing the high ground people from retaining that high ground and retaining control. So I think it's a battle to suppress and depress their importance." A1

It was felt that the profession was possibly already in a state of decline, and that it had certainly changed, having undergone a detrimental erosion of its powers and status in recent years:

" I certainly feel it's the case that it's been eroded, and corroded and corrupted...." A1

As the mystery and arcane nature of the professions appeared to have diminished, professionals were thought by some to have become more like technicians, being skills and activity based. This had introduced a commercial 'value-added' element to the dental profession, in place of the paternalistic 'overseeing and looking-after' characteristic. It was felt that this had led to confusion in society in terms of expectations:

" [Society] kind of wants to rob the profession of its mysteriousness and power, but it wants it to remain benign. But once you make something commercial and want it to stand on its own feet by way of measurement, you can't then expect the paternalistic sort of benign approach that it once had. It's one thing or the other...if you want it to be commercial and competitive and results-driven, and if you want them to remain as professionals, then don't rob them of their mystery and their special status." A1

The profession had also perhaps been demystified by the increased transparency of the regulatory systems which had been introduced in the past decade:

" To a degree, we are victims to the fact that we make it easier to make complaints and that we are more transparent." A3

A number of participants held a definite perception of the profession being under attack rather than being challenged by government, and they saw that this may have been stimulated by the actions of the profession itself, implying acceptance of the fact that some members of the profession had not acted entirely as they should have in the past. Some felt that many practitioners were effectively dealing with the attack by exit from the state-funded system, and in becoming more independent of government controls. Others felt that 'attack' was too strong a word, and that it was merely the government's response to enormous pressure to deal with previously poor delivery of NHS services. Increased transparency in systems of dealing with performance had potentially made the profession look worse in the short term, when in fact they were unchanged but being viewed with more clarity. Another in Group A felt the government had decided that dentistry was not an essential part of the health service and was moving rapidly to providing the most basic work through the state funded system, but without explicitly stating that this was the case.

Through the new contract requirements of targets, it was perceived that the government now unrealistically expected health professionals to fulfil dual roles as both 'workers' and 'professionals' simultaneously:

"You can't have both ends. You either have robotnics who produce things, or you have professionals who think and work in the best interests, and the two I think are in conflict." A1

It was perceived that there had been an unquestionable 'assault' on the professional status of the medical profession by government, and that the media had been drawn in to portray them badly in terms of their remuneration and practice. Much of this was believed in reality to be due to the poor handling of contracts and pay deals by the government, who were then attempting to claw back some of the damage in a most unprofessional manner - "an outrageous struggle and squabble...outrageously public" (A1). It was thought that the dental profession had not escaped this same manipulation of media coverage against them by government:

> *" [The Department of Health] seems to take some satisfaction in the fact that the media coverage of the dental profession is against the dental profession, rather than against the Department of Health. I actually don't think this perception is right, but the very fact that it was articulated in that way suggests to me that there is a desire to take it down that road." A**

It was acknowledged that the professional associations now have no choice but to engage in media relations in order to promote dentists in the best possible light, and that this was in many respects "a bit of a game" (A9) which nonetheless required integrity and personal respect on the part of all those engaged in its pursuit. A set of unwritten rules of engagement was acknowledged within the profession in terms of personal issues being out of bounds:

> *"That is part of a professional grown-up game, but there are steps over which you don't tread....you have an understanding. People within the profession have an understanding of where the limits lie." A9*

It was generally understood that the media set out to portray dentists, along with other health professionals, in a negative light, and that positive stories were very difficult to convey in the media:

> *"The BDA years ago stopped trying to get a good storyline in 'Eastenders[74]'; it's just not going to work. The storyline in 'Eastenders' goes 'Dentist has attractive patient in the chair, and drives off in his Porsche with her credit card'. It's very hard to sell a <u>good</u> story." A3*

Other examples were given of the press failing to report 'good news' and a sense of shared despondency was evident regarding further apparently futile battles that the professionals couldn't win in terms of conflicting expectations of costs and quality standards:

> *"If you look at the media coverage, dentists will be damned for being expensive, while another dentist will be damned for not applying modern methods and modern cleanliness standards.... if you are expecting that level of professional service and provision, then its got to be reflected in the charges and costs. You can't have a cheap and cheerful thing, and have it at the high level of quality you expect." A1*

[74] 'Eastenders' is a very successful soap opera which is televised 4 times a week in the UK and has run for over 25 years.

The high impact of media coverage on the public perception of the dental profession was acknowledged. The UK has the lowest rate of dental decay in the world according to WHO statistics, and yet the public perception is that dental health in the UK is terrible:

> *"There was a blog in the Guardian - there was an American guy coming in saying 'Why don't you have a system like we have in America? We don't have people pulling their teeth out with pliers in America.' Well, quite frankly, we don't in England. .. I think the media are hugely influential and I think they can do immense damage sometimes." A2*

The unacceptable power and conduct of the media was again conveyed through a further personal expression of helplessness and the futility of argument:

> *"I think the media has no conscience, and it is not interested in truth... the Daily Mail isn't a newspaper, it's a political organisation, and so is the Sunday Telegraph. I have to live with that, and I cope with that, but it doesn't make me feel any better about it." A**

The previous role of the Royal Colleges in defining the boundaries in the health professions was recognised as now defunct and it was thought appropriate that the GDC in protecting patients should be responsible for setting the boundaries of the profession, with the profession informing "the art of the possible" (A1) and society then demarcating the rules of "the acceptable". There was an obvious area of ambiguity at the margin of the profession's boundaries of practice at the present time, with limits of what was deemed to be professional and non-professional in relation to purely cosmetic treatments such as Botox injections. The GDC's failure to make key decisions and poor handling of issues arising from such marginal practices was considered to be a problem area:

> *"What is dentistry? And where does dentistry start and where does it finish? It would have to be the GDC who says 'This is not dentistry'.... they would have to change the Dentists Act, and it's not in the Dentists Act as such. So I'm not sure where that would leave everybody ....it's probably in the 'Too Difficult' box"....." A6*

Changes in the demand and supply of professional services were felt to have altered the profession, in that a shortage of dentists had led to unbalanced market conditions, at present favourable to the profession, although this was anticipated to change in the next 5 years due to external policy measures to increase the number of graduates and trainees. The NHS contract changes in 2006 were also recognised as hugely challenging for the profession, with the degree of change being vast:

> *" Usually if you've got a load of pillars infront of you and a couple of those pillars are feeling a bit unsteady, you can just grab the next couple of pillars. But the problem at the moment is that all of those pillars are shaking. You know, there's going to be greater skill mix, the regulation is changing, the private sector is going to be regulated, the contractual arrangements have been*

changed, the workforce situation has changed, you know, everything is changing at the moment. And change is very upsetting, very de-stabilising. And we need to come out at the end of that as quickly as we possibly can". A2

The increasing number of women in the profession was deemed positive in countering the macho attitude that had sometimes been associated with entrepreneurial and commercially-minded dentists, bringing a change in approach to professional practice. Recruitment at undergraduate level had recently moved from 50:50 to 60:40 female to male. However, the higher echelons of the profession were still seen to be a 'boys club' and so women might actively choose not to join their ranks. It was thought by those in such positions that women needed extra confidence and stronger 'male traits' in order to succeed in these roles. The profession itself was recommended to women because it isn't a 'textbook profession' and is "very, very diverse"(A10). There was recognition that feminisation of the profession could be detrimental in lowering of salaries, and the flooding of the market with extra graduates in the next two years would also bring down the cost of dentistry, potentially lowering incomes for the professionals concerned.

The profession was seen by Group A to be in a more significant period of transition than at any time in living memory, and it was stressed that this would take some time to settle into a form of normality. It was anticipated that issues over the funding and further development of state-funded services would continue indefinitely, continuing to evolve through forthcoming governments, and affecting the way in which the profession conducts itself and in how it is perceived by the public. There was a long-held perception within the profession that the government was privatising dentistry 'by stealth' and that the latest contracting changes were deliberating forcing dentists out of the NHS.

A conflict between the commercial aspects of practice and being a healthcare professional was not thought necessarily to exist, in that individual patients are seen to have the right to choose what they would like to pay for in health care as in other aspects of life, and professionals who provide a privately-funded service are essentially expanding the choice for this group of individuals. It was postulated that the new contracting arrangements could potentially encourage dentists to act less professionally in their duty of care towards patients. It was however maintained that it was still possible to provide an ethical service through the NHS contracts, but that the financial constraints meant this was at the cost of the dentist's personal lifestyle. In some cases this had forced the professionals to change their practice to the detriment of the patient:

"So what the new contract has done is create an unacceptable tension between the professional ethic and the expected personal lifestyle of the provider... I think a lot of the dentists have been standing by their professional ethics, and wanting to do the right thing and wanting to avoid a change in their behaviour. At the point where the pressure of that becomes so extreme as to drive them into a position that they can't sustain it, that's when that [tension] happens." A1

It appears that the final decision as to what is deemed acceptable conduct to a professional lies with the individual, and will consequently be heavily dependent on their own personal values. The increased financial risk associated with the business aspects of practice was also seen to influence professional behaviour. While many of those who were not prepared to risk financial collapse, lower their standards, or relinquish control of their practice had decided to leave the state-funded system, some professionals were seen to be abandoning their professional values, at least in part:

"There is a limit of how they will do that. Some of them go as far as to break the law. Some, well, just shun the system and others won't. Others will just stick religiously to what they're supposed to do and do it - but probably moan like hell about it or leave the system." A6

"Xxx once said to me in a meeting 'Look at my hands. They're much better today than they were yesterday, because I joined Denplan[75] last night.'" A3

The introduction of corporates into the market place raised concerns that this had introduced a profit- and target-driven mentality which lacked a professional work ethic, and made it harder for dentists to be totally professional. There was an overt distrust and dislike of business practices which had been applied to the profession by external agencies, failing to take into account the professional ethics of the practitioners they employed.

A potentially detrimental effect of privately-funded practice on professionalism and ethics was observed:

"I think the profession is losing some of its values around professionalism in search of the nirvana of private practice..... the whole gambit of private practice means you've either got to sell it and do it better than other people, or at least to convince the public that are paying that you do it better than any body else. And of course, what I'm saying is, that you are sacrificing professional values. At all times in dentistry, money has perhaps driven treatments that may or may not be healthy or positive." A6

It was considered that the new NHS contract had changed the way that the profession conducts itself, and that this was one of its objectives: " It was designed to make [the profession] think" (A3). It was also perceived that an externally imposed culture of targets and of insufficient funding had gradually over a period of time undermined the profession and its values. The profession was regarded as having proven ability in

[75] Denplan is a privately funded capitation scheme, providing a popular means by which dentists can leave the NHS system.

taking the opportunities presented to it and acting, often entrepreneurially, to develop an improved practice, in both the clinical and business senses:

> *"I think [the profession] has proved itself on numerous occasions, that whatever it is expected to do, it will do it. Sometimes begrudgingly, but it will do it. ... Dentists have had it forced upon them, but they still manage to go with it. Some have kicked, some haven't, but I think, as a profession, they are notorious for being flexible, for the good and bad of themselves. You cannot beat the entrepreneurship or the skills of the average GDP in making the system work for themselves." A6*

This entrepreneurial flare was perhaps linked to their independence as practitioners, and possibly to the increasing numbers of ethnic practitioners who are known to demonstrate more entrepreneurial behaviours. The younger members were thought to be very good at adapting, though older practitioners were more likely to have become set in their ways and reluctant to change.

It was felt that the remuneration system should not influence professional practice, with the vast majority of dentists making the right decisions for their patients, regardless of the payment system. It was universally refuted that private healthcare professionals might be deemed less professional than their state-funded colleagues:

> *" To prefer utilitarianism over a bespoke individual product and then to define that as greater professionalism, I don't think that's true." A1*

One participant saw that private funding might help accelerate advances which would be fuelled by market demand, and the continued development of professional skills was thought to be higher by professionals in the private sector. Decisions as to appropriate limits to practice again appeared to be based almost exclusively on the values and beliefs of the individual professional concerned. There was a general feeling that as long as the practices were properly regulated then they were acceptable to the profession, but more than one of the participants expressed extreme personal discomfort about what he referred to as "the non-dental stuff'(A3) that was not clearly included in the current legal remit of professional dentistry:

> *"If dentists do it, then we have to regulate it, and I think dentists are wrong to start doing sweaty feet and armpits and injecting collagen[76] into other parts of the body which people might ask. I really don't think it's particularly smart, and I don't think it does anything for professionalism." A3*

Another two participants in Group A felt that the judgement of the clinician was paramount in determining the ethical position in such borderline cases of practice. It was seen to be of extreme importance that every case was judged on its merits, with every option explored and informed consent obtained, and the practitioner had a professional obligation to act upon available evidence:

[76] Collagen injections provide cosmetic enhancement to remove wrinkles and make skin firmer.

"A professional person would consider the evidence and a non-professional person would do anything and take the money.... I think people that don't care about the evidence are unprofessional." A10

The boundaries of practice are still considered to be shifting in terms of the health/lifestyle nature of the treatments provided, and demand for cosmetic work is seen to be related more to the changes in the society we live in, rather than the professions providing them:

" I wouldn't say I haven't got a problem with it, but I think my problem is not with the dental professional doing the work, but with the state of our society which encourages this quite frankly." A2

The public's perception of dentists over the past 50 years has strongly associated them only with the provision of NHS funded healthcare treatments with mainly positive connotations for the profession, while the broader range of privately funded treatments now offered are perhaps perceived to downgrade the profession to the status of a business rather than a profession in the public view. There has in reality been an almost continuous association between the dental profession and money in the UK, though some would like to believe that this financial aspect is limited in its impact on the profession:

" I think dentistry is a healthcare profession with a business element. What it isn't is a business with a healthcare element." A2

There was a unanimously positive response to the expanding roles of DCPs, taking into consideration the positive effects in delivering more cost-effective services. None of the participants admitted to seeing this as a threat to the profession, though again there was almost certainly a degree of political correctness attached to these comments. The boring nature of carrying out routine dental treatment was recognised and the introduction of DCPs was seen to be a welcome solution to this problem:

*"I think it's a positive development... by its nature, dentistry is a repetitive mechanical task, its something that should be eminently devolvable.....it's part of the university system, but we've progressively enhanced the intellectual base to train people to do it. So inherently you've built a cadre of people who are infinitely more intelligent than they need to be to do a repetitive mechanical task. So to be able to have it broken down into constituent parts that can be done by technicians, if you like, I think is not a bad thing." A**

One participant felt that the introduction of registered DCPs would wake up some professionals who had existed in a detached work environment perhaps for too long. Most particularly the recognition that dental nurses and other registered practice staff will now be required to report substandard work might prompt a change in professional behaviour and attitudes, adding another level of challenge and governance into clinical practice:

"One of the problems is that dentists work in their own little world, with their nurses who say 'yes sir, no sir' and that doesn't help. But I think the registration of DCPs is actually very positive because I think the professionalism in DCPs will reinforce it in the dentists.....or at least it will stop the rot." A3

The concept of team-working was not new to dentistry, and nurses, technicians and hygienists had played key hands-on roles in successful practice in the past. Dentists were encouraged to seize the opportunity to potentially elevate their professional status, by adopting the leadership role of "diagnoser" and "gatekeeper to strategic treatment planning" (A7) in developing a close-knit team with shared ethical obligations and responsibilities, to enhance service delivery and delegate more of their responsibilities. Professional authority was not deemed to be immediately threatened, especially in light of the dentist's financial control of the practice.

Another participant saw the dentist's role developing more in the form of a co-ordinator:

"I think the intellectual part of the exercise should be as the conductor of an orchestra, somebody being able to see the big picture and to oversee it and make sure it's delivered properly. So that role as a dentist, as the planner and co-ordinator, seems to be a relevant and appropriate one, and working with multidisciplinary teams seems to be very sensible." A1

In general surgery it had been observed that once nursing staff were trained to carry out routine procedures, then surgeons themselves became more specialised, narrowing down their field of work, and this might happen in dentistry. It was felt important to clearly distinguish the dentist from the other professionals within the team, and to emphasise that the only person within the team with the training and breadth of knowledge to lead and take responsibility for diagnosis and treatment planning would remain the dentist:

" It's the old, old thing, If all you've got is a hammer, everything looks like a nail – it's about exercising your judgement. Given a choice between seeing a trained DCP who's done 2000 cases and a highly trained dentist who's done 2000 cases, I think I'd rather see the dentist. He or she would have better judgment probably." A4

6.3.5 The Future

The correct application of relevant knowledge is deemed essential in professional practice and cannot be taken over by a computer or untrained individual:

" You know, I can read or do a computer programme about landing planes, but you wouldn't let me near a plane to try to fly it - it's all about the practical application of your skills and knowledge, and that's something patients will never have....the judgement, skill and experience." A4

The future of the profession was thus thought by Group A to be secure, believing it would not be possible to deliver its practical skills and expertise other than by human hands:

"Dentistry is still a pretty safe bet. They are never going to turn it into a .com. You will never get your tooth filled using a keyboard and mouse. You are always going to actually have to go along to get it done." A7

However, there were rumours of dental unemployment by 2010, and the following advice was offered to help newly qualified professionals adopt the necessary mindset to cope:

"What's happened is you've just missed a 58 year period of protected expectation in business. It is a business. If you go out into the wide world and sell furniture or flowers or fish, then you wouldn't expect to have a pre-ordained expected level of return, you'd have to work at it. You'd have to set your stall out; you'd have to build your business up. If you choose to be unemployed because there isn't an NHS job for you, you can be. But, there are people that want what you have got, and you've got the ability to give it - then you can succeed. But it will take effort." A1

Research and training was seen to be important in ensuring that you did not maintain a second-rate out of date system but money was acknowledged as a major influence on the future of the profession, especially in a new business culture of contracting deals for dental services, and the interest of global investment companies in the financing of dental corporates in the UK[77].

It was thought that the profession in the UK might divide into two distinct groups in the future. There was potentially the need for a group of practitioners providing basic preventative care at one end of the scale for the younger generation, and another group of professionals providing advanced skills to treat complex conditions in the ageing population at the other end of the scale. It was thought that the profession might thus become more diverse and richer (but not in a financial sense), due to opportunities for increasing diversification and specialisation, with a very definite continuing commitment to the care of society.

The demand for cosmetic work was predicted to level off after reaching a peak, and the workforce projections for dentists beyond 2035 indicated that the need for dentists would reduce rather than grow, with a potential surplus in the near future. However, it was perceived that many new graduates don't see themselves as spending the rest of their lives in dentistry, viewing it merely as a means to generate income:

"Yes, they see it as a means to an end, a lot of them: 'Yes, I want to be a member of a profession. I want to have some degree of autonomy over what I do. I like contributing and I like working with children, and I will use it as a means to an end. And I will have money'." A6

[77] For example, private equity firm Duke Street Capital bought the dental corporate 'Oasis' for £76.9m in January 2007.

There were thoughts that a slightly different split in the profession in the UK might provide different services for different consumer groups:

> *"There may well be a split where there are those plying their trade independently. For them to survive, they have to differentiate on personal quality value-added. There will also be those who choose to be salaried robotnics, the automatons, the actors who work just to do the job. And that will also be OK. But they will be a different crew to the people who are doing it on an individual level. So maybe where the profession goes is in two directions, one utility level, one value-added level. And I think people are going to decide where they want to be and then equip themselves accordingly." A1*

There might thus be dentists who will provide care for consumers who want the no-frills, no extras "EasyDen" type of health care (A9), although this professional group might in reality be deskilled and no more than "glorified therapists" (A9). The other group might work on relationship dentistry, to build a rapport, confidence and a perception of worth with patients, requiring a higher level of personal input and investment into their professional relationships over the longer term.

There was a perception that the NHS had in some way restricted the profession's development, based on the public's assumption that 'commercial' was contra to 'professional', and that commercial was something new to dentistry, neither of which was the case:

> *" I think there's been a hiatus and an illusion that's lasted 58 years. I actually don't think my generation of dentists are necessarily typical or right, I think they've lived in a particular bubble... I think the cradle to grave, the welfare state part of it, is perfectly legitimate. I think what it does to your providers of care is that it creates an illusion of what professionalism is." A1*

Concerns were voiced over the fact that graduates are now entering the profession with an average of £40,000 debt which is predicted to have an impact on their attitude towards a more commercial type of practice in enabling them to recover that cost, perhaps focusing more towards their income than the professional aspects of their practice. Commercial awareness was thought to be an essential professional duty in order to safeguard continued running of a practice without the fear of bankruptcy, thus allowing the professionals to continue providing their professional services to their patients and maintain staff in employment:

> *" However society chooses to define professionalism, it has to be viable, it has to be financially sustainable." A1*

While the split between NHS and private earnings in the dental profession was reported as balanced at 50% in 2008, 75-80% of the care was still being provided in the state-funded system. There was a degree of annoyance at the government spin leading patients to believe that there are enough funds to deliver a full range of services for everyone, and their tendency to blame the profession for shortfalls:

"What you are doing is outsourcing the blame. Whenever there is a shortage, its not the fact that the funds aren't there to properly fund it, it's about the professionals becoming the scapegoats." A1

It was thought that continuation of the existing NHS contracts would in time lead to a narrowing down of the state-funded treatments to a 'core service', with a restricted of scope of practice for NHS dentists which might impact upon the range of experience gained by new graduates. There are difficulties in defining what exactly might constitute this 'core service' for the future state-funded system, and a definitive list of services could potentially undermine the clinical and ethical judgement of the professionals who will be delivering the service to the individual patients. This potential de-skilling was not viewed as equating to de-professionalisation *per se*, as the core services would still be delivered in a professional patient-centred manner. It does though appear to relate to a degree of proletarianisation of the work of the profession, or at least of this section of the professional community.

Technology and advances in the biological sciences are seen to be driving dentistry forwards:

"Technology will drive it ever further and that will drive up the risks as well ... but potentially there are greater rewards. Biological sciences hold huge, huge potential for dentistry, whether we will be growing teeth in test tubes, the way they can grow babies - growing a tooth must be easy, mustn't it? It is only a few structures, enamel, cement, dentine, pulp, so it will be easy." A7

The rapid technical advances in materials and techniques were likely to play a very significant part in the services provided by the profession in the future, though it was acknowledged that a major change in economic circumstances might rapidly alter this situation:

" The attitude of the patients, the vast majority of the population, may change depending on their economic circumstances. It may be something like this crisis that has been happening to us over the past week or so, when the global financial circumstances have been put under threat. If that had been allowed to carry its natural course, and everybody had lost everything, we could be back to very basic dentistry. But I think that, allowing for the fact that that's not going to happen, and will definitely not happen, I suspect that dentistry will continue to be a significant part of the healthcare professions." A8

It was perceived by one participant nearing the end of his practising career that that there would always be a need for two elements of professional services: the basic health aspect of dentistry, and the technical aspect, which was the element that was changing so rapidly. There was an anticipated need for a wider variety of different treatments, and specialist services would still be required, although the boundaries of a number of the existing specialist areas of practice were likely to change. Generally perceptions of the future were very positive:

"The future of dentistry? Orange really, pretty orange. I do, I see it being very good actually. I see it will continue to be a valued profession. It will. It will always have a place, whatever that is." A6

"I think it's got a bright future, I think it's much more appreciated by the public. I think it's got to accept that change isn't optional – I don't mean just now, I mean forever.... for me its been one of the most interesting times the dental profession's ever been through, at the moment, and it's also one of the most trying times I think the profession's been through, for almost exactly the same reasons." A2

Overall dentistry was still regarded as a very popular undergraduate course, because it was seen to be challenging academically, while offering an altruistic element of care and being very practically orientated. However there were perhaps far less challenging and more rewarding career options available in other fields in healthcare. It was thought that there might be one serious omission in the profession:

"If there's anything I think we're missing as a profession, in terms of professional values, it is that we don't say nearly often enough how much we actually do care about our patients, and how much we actually do care about doing it well. The pride that we take in our work, the pride we take in a job well done - I don't think we do that enough. If you talk to dentists, these are the things that matter to them." A10

6.3.6 Summary of Group A findings

Although the participants knew the interviewer to be a member of the profession, they had no personal knowledge of the individual nor of the study being undertaken other than the immediate information given, and were therefore responding in the manner they would normally adopt in a press interview or when asked for public comment. It is most likely that the initial sections of the interviews attracted more stock responses, and the impression is that the interviewees became more relaxed and assured as the interview progressed, revealing more personal insight and comment later on. This occurred especially after the tape had been switched off, indicating this group's awareness of the importance of 'saying the right thing' in public.

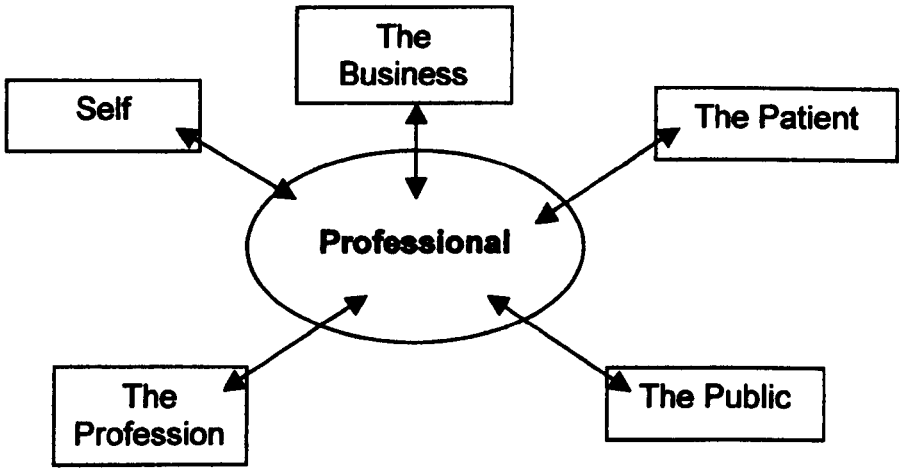
The elements expressed might be considered to be the positive aspects of professionalism, and autonomy and control were conspicuous by their relative absence in terms of explicit statement, although many aspects of the data revealed an underlying tendency to engage in behaviour which promoted self-control on behalf of the profession. This may have been due to reluctance on the part of these leaders to use explicit language that might be considered detrimental to the public face of the profession. Power does not seem to be an important issue for the dental profession, in that it does not appear to seek to control any element of society other than in its own specific field. It appears to accept that its influence in society is small compared to

medicine, as this brings other advantages in being allowed to act more independently and to be less subject to scrutiny in many respects.

The overwhelming sentiment was that a professional needed to have a set of values which extended to their life and not just in the workplace, and that this in some way, perhaps rather patronisingly, set them apart from the lay public and made them in some respect 'special' and different. It was thought that as a consequence of having this set of personal values, these individuals were initially attracted to entering a profession in which they would be 'buying into' or subscribing to an agreed communal set of standards and personal integrity, extending beyond the workplace. There was an element conveyed from these leaders, of professionals being in some respects different from other occupations in their approach to work matters, especially in terms of the ways in which they use their judgement for the good of others, and this clearly in their minds sets a profession apart from a trade or other business, where the driver is ultimately financial rather than ethical considerations.

There appeared to be the requirement of a balance to be achieved between the professional aspects of healthcare and the business aspects of being able to keep a practice solvent. Thus, in addition to maintaining and living out the collective values of the professional community, individuals would also be required to make their own judgements on their own standards of practice. The five aspects of this balance are illustrated in Figure 6.2.

Figure 6.2 The balance of interests required of a dental professional



This difficult balance of interests would lead them to personal judgements in terms of clinical and quality issues, and also in terms of their personal financial security and the sustainability of their business. There is therefore a perceived balance to be struck

between their individual values and those of the collective, as well as between their professional and business values. The discrepancies across this multi-dimensional model would then account for the wide range of individual standards associated with the conduct of professional practice, and of the cases of breach of professional standards reported both publicly and within the profession.

The overall sentiment behind the findings was that the profession is strong, although this may have been the habitual rhetoric of those placed to publicly promote the profession and who were directly involved and responsible for the future development of the profession. The portrayal of a community of individuals who value the opportunity to work independently and without tight controls may again reflect the wishes of this particular group, and the image they wish to convey to government in terms of future negotiations on policy, indicating the way in which they expect the profession to be perceived and managed. There is acknowledgement of the diversity within the profession, which is viewed as a strength rather than a weakness, and of the opportunities afforded by the profession's ready acceptance of new technology and scientific improvements over the past 20 years.

The profession is thus presented as being adaptable and in a strong position to continue in its development in the face of rapid social and technological change. External 'threats' and 'attacks' on the profession are regarded as a 'challenge' by the majority, who, it was believed, had proved their entrepreneurial adaptability in the past, and would continue to exhibit this trait. This may again have been part of the rhetoric expected from the leadership of the group who are used to acting in a defensive position in the face of government, public and media scrutiny. Some of the participants did appear to be rather more engaged with the political interface and detached from the reality of the main body of the profession, especially those who no longer practised and thus had no intimate engagement with patients or other clinical professionals in the workplace, having adopted a more idealistic and institutionalized approach to the profession and its future development.

The profession is currently regarded as being in an exciting stage of its development, having shown that it could adapt and react to challenges which it had encountered in terms of government policy and social pressures. It is certainly not perceived to have been 'de-professionalised' by the changes it has already experienced, in that professionalism is not deemed to be about power and control but about the values, standards and judgments that are applied in a patient-centred approach. These elements of the profession are thought to remain undiminished but in need of

safeguarding. A degree of proletarianisation in relation to some aspects of professional practice is conceded as a consequence of policy changes in roles and funding, and the continued expansion of the corporates into the profession is anticipated to contribute detrimentally to this trend.

The introduction of new 'professional' roles into the dental team is perceived as an opportunity for the profession to adopt a clear leadership role in directing a team approach to care delivery. There is an implicit underlying assumption that these roles are not truly 'professional' in the same sense as the dental profession itself, as the new 'professionals' were not graduates and certainly would not share the status or responsibilities of members of the dental profession. As such they are not perceived as a threat in themselves, as it seemed unlikely their professional bodies could ever challenge the existing powerbase within the profession. This in turn assumes that dentists themselves will retain their monopoly over diagnostic and treatment planning services, maintained by legal restrictions which offer a degree of comfort that, at least in the immediate future, the existing dental profession will not lose its power and status. The threat would then only arise if government chose at some future juncture to remove this legal protection of their diagnostic role. In so doing it would severely undermine the legitimation of the profession and its established training pathways.

The uncertainty still facing the profession is regarded as an opportunity in terms of its potential to increase the range of future roles within the dental profession itself, including salaried career options to cater to an increasingly diverse range of professional needs and expectations. This might prove increasingly important to a workforce with increasing numbers of females and their consequent demands for a change in work/life balance. The means of funding future services is acknowledged as a factor in dentistry's further development as a profession, in that it might restrict its growth in some areas, and might also affect the choices of future recruits and young professionals to practice in one particular area of the profession over another.

As would be anticipated in a group of leaders with the responsibility of promoting the profession's interests, there appears to be little if no doubt in any of the participants' minds that the profession is strongly positive, and will continue as a very valued contributor to society in the UK, despite challenges from the media, government and other external parties. The participants appeared to offer very genuine and honest views throughout the interviews, and it was apparent at the conclusion that they would not have been so open or trusting with an interviewer from outside the profession. In this respect, the degree of implicit trust afforded the interviewer was at times surprising,

especially with regard to the use of recorded materials and notes, testifying to the unwritten code of ethics to which all members of the profession are expected to subscribe. Although only one of the participants was known personally to the interviewer prior to this study, and the list of participants was not made known to the participants directly, it might be assumed that they may have discussed their involvement with others in the study before or after their participation, and that this might have influenced responses gained in subsequent interviews, although no-one indicated that this was the case and each was keen to present their own views and perspective. However, it was clear that many of those in this group had considered the issues before in other circumstances and were readily able to articulate their views in the interview setting.

6.4 Sample data from Group B: the frontline workers

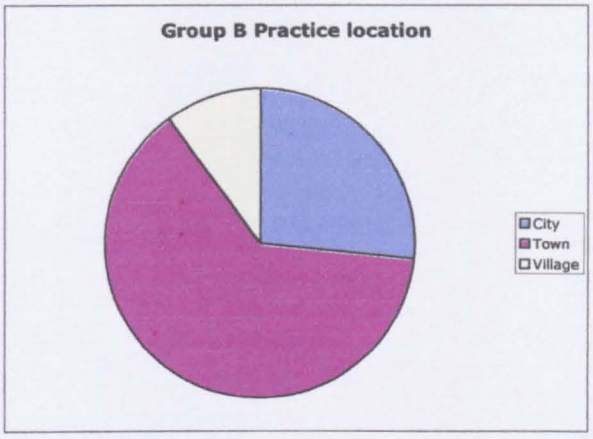
This group comprised 30 'frontline workers' in the form of General Dental Practitioners (GDPs) who were providing dental services to the public as part of the primary care services. The sample was partly self-selected, having responded to a letter sent to practices in two areas of Cumbria and Lancashire. The practices were spread across urban and rural locations, with the majority being situated in towns (Fig 6.3a).

The sample was made up of 16 males and 14 females, who had qualified at 11 UK dental schools between 1969 and 2008. There was a higher proportion from Liverpool (8) and Newcastle (9) as these were the local dental schools in the areas sampled, but there were Liverpool graduates in Cumbria and Newcastle graduates in Lancashire. The graduation years of the participants was spread between 1969 and 2008, indicating an age range of approximately 23 to 60 years. However there were no participants recruited who had qualified between 1997 and 2006 in the 24 to 34 year age range. This might be due to the difficulty in reaching this group who were not yet principals or partners, and so not yet named on the public materials through which the contact names were derived, although other associates were reached and included in the study. It might also indicate their lack of interest in this issue or in being part of such a study, with other life issues taking priority at this stage in their career.

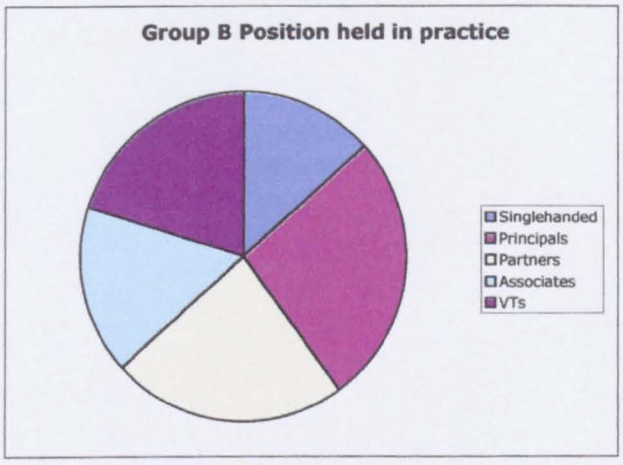
6 Vocational Trainees (VTs) were included in the study, and these had by definition qualified in the preceding year (2008). They were recruited either through their vocational training scheme (in Cumbria) or volunteered through their trainers (in Lancashire). They had graduated from 4 UK dental schools, and were currently being trained through 3 different VT schemes in the North West. The participants otherwise held a range of positions within their practice (Fig 6.3b) and provided treatments across

a range of funding systems, from almost entirely NHS to entirely private (Fig 6.3c). In even the most dedicated NHS practices, some treatment that was not otherwise available was offered to patients privately

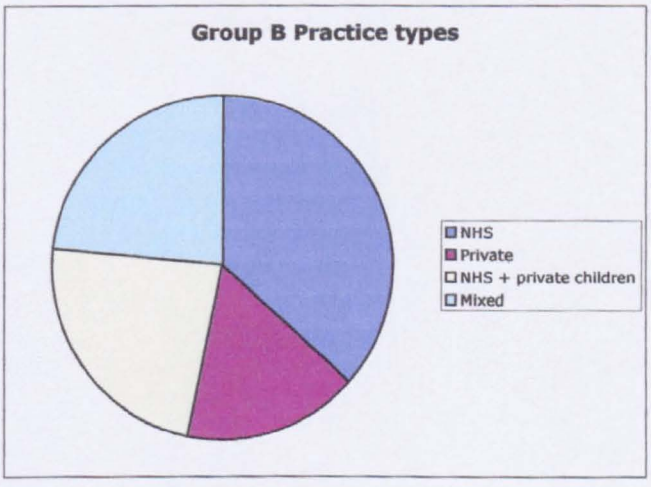
Figure 6.3 Group B sample characteristics



6.3a. Practice location



6.3b Position held in practice



6.3c Practice types

The interviews for this group varied from 20 to 70 minutes in length and were in many cases limited by the time available to the practitioner between patients or in their lunch break. 28 of the interviews were carried out at the participant's workplace, with the remaining 2 conducted at a neutral venue after a course or meeting. They were conducted between October 2008 and February 2009, and were interpreted in the context of the global financial crisis of October 2008 and deepening recession in subsequent months. This undoubtedly altered some of the responses relating to the ways in which individual practices and the profession might develop in the future.

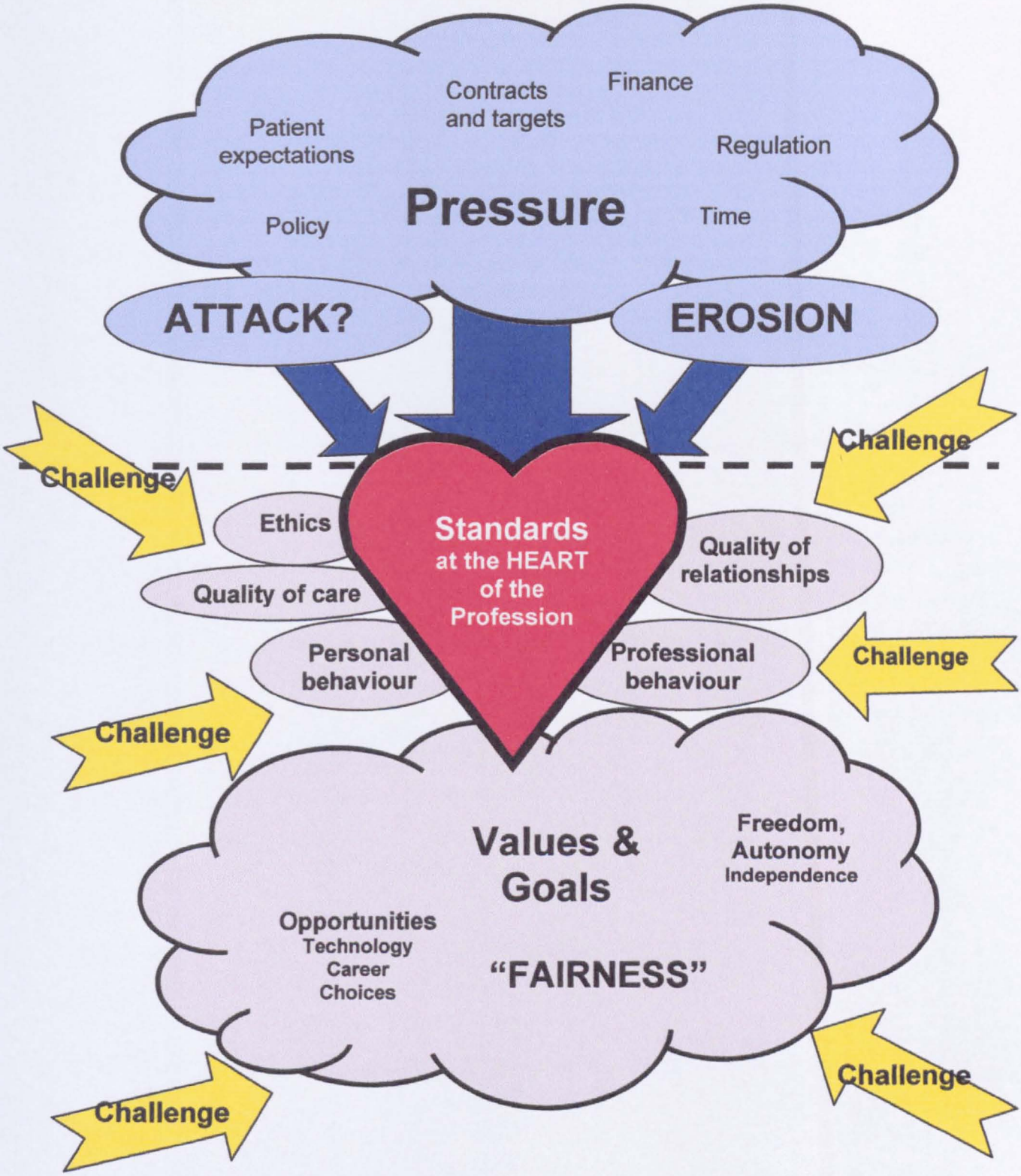
The data were subject to continual ongoing analysis during the research period, so that new issues could be included in subsequent interviews. The scripts underwent content analysis and thematic analysis by the methods already outlined and fieldnotes made during the interview period were incorporated into the analysis. The underlying themes which emerged as being of importance for this group are reported in section 6.4 below. In the following sections, direct quotations have been assigned to the appropriate participant, and those who were Vocational Trainees are distinguishable by a V added to their identifier (for example B24V).

6.5 Thematic Analysis of Group B: the frontline workers

The main themes which emerged from analysis of the data from this practitioner group are illustrated in Figure 6.4, with the profession being established around a core of standards lying at the heart of the profession, by which the profession is defined and which dictate the principles upon which its practice is based in areas such as ethics, personal and professional behaviour, the quality of care provided, and the relationships into which the profession enters. These standards, which are set by the profession, are an integral part of its value system and contribute to its collective goals, in terms of its aspirations for the future and the direction in which it continues to develop.

A wide range of opportunities is identified for the profession, in terms of its close association with technological advances, as well as the societal changes which have extended its potential to provide services in the private sector. The autonomy and independence of being a member of this particular profession are highly valued, and the freedom to make decisions and determine one's own future is considered an essential element of professionalism by this group, and one which they feel has been most severely challenged by recent government policy.

Figure 6.4 Diagrammatic representation of the themes relating to the concept of 'a profession' as perceived by members of the dental profession at the present time



There is a perception that the standards and values of the profession have become more vulnerable and perhaps exposed to erosion and attack by external forces over the past decade, and that measures need to be taken by the professionals collectively

and individually to safeguard their own high standards and commitment to the provision of quality of service, in bringing these standards back into the heart of the profession and thereby protecting them more effectively. While the majority considered recent government policy changes to have been a challenge, some regarded them as a direct attack on the profession, and there was a general perception that the profession is increasingly subjected to high degrees of pressure from a number of external sources, including societal, economic, political and organisational factors.

In Figure 6.4 the vulnerability of the profession's standards has been illustrated as being exposed at the current time, and the perception is that the profession needs to take action to rectify this situation to safeguard them from further erosion and challenge. This was a major theme for this group, who were extremely firm on their beliefs regarding professionalism and its effect on the values and goals of the profession. In accordance with Group A, they believed that the appropriate value set was instilled at an early stage, and that training at dental school and beyond allowed the development of professional standards in those who were responsive to such a process of socialisation. Implicit in this package of professionalism was an appropriate ethical stance and codes of conduct which would ensure the delivery of care of the highest personal quality. The status of individuals and of the professional collective was closely linked to behaviour, which in turn heavily influenced the nature of professional relationships with clients and contractors, and wider society.

While autonomy was not explicitly referred to, the concepts of freedom and independence were openly acknowledged of being of prime importance in virtually every aspect of a professional's work, and in this group in particular the retention of control over one's practice or business was central to their perceived continued success, with again an implicit and deep-rooted distrust of central government and low opinion of other government agencies and of corporates who did not share the same set of professional values. Membership of the professional community was by virtue of registration, which was regarded as a highly valued privilege, and there was a strong sense of 'belonging', even though the profession was recognised as being disparate and comprising a group of very independent individuals.

The opportunities afforded the profession by the most recent policy changes were acknowledged by this group, who generally viewed government intervention as a challenge which would not defeat them. Many welcomed the changes it had brought, and had risen to the challenge of becoming more business-orientated and independent by leaving the state-funded systems, acknowledging the increased risk of their

dependency on demand and a stable economy. This was however considered a risk worth taking in view of the retention of control and independence, and the process of individual decision-making in this respect appeared to support the balance of interests postulated in Figure 6.2. The vast impact of technological advances on materials and technique was again acknowledged as being of enormous benefit to the further development of the profession. The future was viewed as uncertain and in many ways still dependent on government policy, but the wider range of opportunities had created a profession in which the vast majority held very positive views of the future. Concerns over the impact of the introduction of the DCPs appeared to have been ill-founded, offering the prospect of greater opportunities for specialisation and leadership, and a more fulfilling role for the dentist.

A strong theme of fairness emerged throughout the fieldwork, data collection and analysis, especially in terms of the ways in which government and local agencies had treated the profession generally and its individual members, with expectations on both sides of the relationships being apparently disappointed. This sense of fairness appeared to extend to a 'fairness by proxy', with indignation strongly expressed when it was perceived that systems were unfair in their treatment of third parties, such as patients and the public. This was expressed by a number of participants, and could form part of the justification for their own indignation at their own unfair treatment, or could truly be part of their deep-seated altruistic sense of justice for society.

Each of the main themes identified will now be presented in the context of the analysis of the data, in order to illustrate the justification of their inclusion as a major issue emerging from the analysis and interpretation.

6.5.1 Standards of Professionalism

The characteristic which was most commonly associated with the concept of being a professional by this participant group was the possession and maintenance of high personal standards, not only in the treatment of patients but extending beyond the workplace into everyday life: "It's a way of life" (B6); "Something deep within you" (B10). The maintenance of high professional standards appeared to be a key issue in upholding the value system of the profession and distinguishing it from other non-professional organizations. This deep-rooted code of behaviour might thus be regarded as one of the main differences between a profession and a trade, and examples were cited of what might be deemed unacceptable behaviour for a professional, including sleeping with patients, getting drunk in public and taking drugs.

The existence of an 'unwritten code' of acceptable behaviour was acknowledged, in addition to the explicit rules laid down publicly for the profession through the GDC:

> *"The GDC expects it to be a way of life, and whilst it accepts that the modern way of living is quite different to what it was 40 or 50 years ago, there are still certain parameters out there beyond which professionalism is not expected to go. And it's never been laid down in black-and-white, but that's all part and parcel of the service." B6*

The interview data repeatedly supported Group B participants' own commitment to acting primarily in the best interests of their clients or patients, and putting others needs before self. There was a powerful commitment across all ages groups to 'doing the right thing' and 'to the best of your ability':

> *"Honesty is doing the right thing, even when people don't know you're doing the right thing. It comes from the person." B29*

Group B stressed that there were other personal, professional, ethical and financial considerations in providing a caring service:

> *"The treatment that will be delivered will be what that patient requires, not what the mortgage of the dentist requires, not anything else..." B30*

> *"You don't get any extra [payment] for that, you don't get anything for that at all. You do it because you care." B11*

This again highlighted the balance of interests illustrated in Figure 6.2 that needed to be considered by an individual in developing and providing a professional service, and the potential conflicts which might arise between personal and professional interests:

> *"Certainly in healthcare, and I suspect in the other professions, you do a caring job for other people and you hope to make a reasonable living out of it." B9*

> *"I do always what is in the best interests of the patient as far as circumstances, regulations and finances allow." B23*

Professional commitment was thought to be intimately related to the provision of an ethical service, taking responsibility for decisions and actions in order to generate trust and mutual respect from the client group as part of a reciprocal relationship. One participant spoke of a duty in providing the best service possible for patients, with clear recognition of the need to respect patients' needs, rights and wishes. There was evidence that the professionals were adopting the rhetoric of business and marketing, with one participant who had clearly attended a marketing course talking of 'meeting or exceeding patient expectations' in terms of quality and service (B25). It was generally accepted that patients' expectations were increasing with improved awareness and availability of information, and social pressures.

Behaviour was seen to be closely linked with the profession's standing and social status in the community, described by one as "a swank factor" (B5). Some felt that

dentistry had always been regarded as a more minor profession compared to medicine and law, and was more on a par with the new model professions such as accountancy. Another thought that a generalised loss of status had become more widespread across the professions in the UK:

> *" Well, dentists, we don't have it. Doctors, no. Lawyers, no. I think we've all just about got the same status now as a journalist or not far off." B17*

A degree of privilege for professionals was acknowledged by participants, in return for the responsibilities that were assumed, and a high value was placed on collective status, in upholding the good name of the profession and not bringing the profession into disrepute. The need for continued learning and development throughout a professional career was thought important by the practitioners, though this might have been in response to the present compulsory measurement of hours spent in Continuing Professional Development for continued registration. Many participants did however appear to possess an inherent desire to update knowledge and continuously improve techniques:

> *"I try to provide the best quality care that I can honestly deliver. I never feel that you stop learning, you're always trying to better yourself every day and you're always building on that." B21*

It was also deemed important to acknowledge the limits of one's own expertise and skills, with an onus on the professional to learn from experience for the future good of their patients. There was a perceived need by the practitioners in Group B to act in an unbiased manner and to possess an implicit understanding of the values associated with the professional community. A high degree of expertise in both knowledge and skills was thought to positively correlate with a high level of professionalism. It was important though for the individual to interpret and apply these standards and values as deemed appropriate by the profession, with a strong emphasis on conforming to the profession's collective standards, thereby providing the basis of a shared sense of what might be considered 'best' for both the patients and the profession:

> *"It means having a set of standards to which you work consistently, no matter what the clinical circumstances, combined with some form of ethics or framework of values." B17*

> *"I think the vast majority of the profession have shared values and aspirations, it's just how each individual goes about it." B21*

These shared values appeared to constitute the 'invisible glue' that bonds members of the profession together, and could be envisioned as a particular mindset encompassing a broad range of behaviours and standards deemed appropriate for and by the profession.

Stereotypical views were still perceived in the public perception of the profession, with disappointment voiced by a recently qualified participant that many people still appear to adopt the disparaging view of a financially motivated 'money-grabbing' dentist with high earnings and associated lifestyle. Younger professionals also reported that patients still expected to see an older male and, as young white females, they felt under even greater pressure to establish and maintain a relationship of trust. As in Group A, the professionalism of the service was deemed to be entirely independent of its funding, whether NHS or private, and was required of the whole care team, not only of the dentist.

The adoption of a more patient-centred approach in healthcare has brought new challenges to the professionals concerned in terms of re-negotiating the patient/professional relationship on an individual basis. This might include the renegotiation of decision-making powers, with a requirement for improved inter-personal communication skills and time on the part of the professional, sometimes proving to be a challenge:

> *" If you think of a legal professional: you don't ask questions of them, they have all the answers. And it used to be the same with dentistry and medicine, that the final say was always with the clinician. Whereas that's gone in our fields because it's more patient-centred and the patients have more say. It's good if people understand what you're talking about. I mean, I'm quite happy talking to patients, so I don't have a problem with offering them choices. And I'd prefer them to make choices..... a lot of the younger patients, you know, they're used to it being all about them and, particularly with teenagers, it doesn't matter what you tell them, it's usually wrong." B13*

In agreement with Group A, many participants felt that their desire to become a professional was deep-rooted and within them even before they went to university, and while not inherent, was heavily influenced from an early age by role models and family values. They felt this meant that they were already of the correct mind-set to take on board the professional principles which were taught to them during their training and in their subsequent professional development. This was expressed as an aspiration to high standards and an inherent desire to care for people, to make a difference and to do what was right for other people in being fair and honest. The development of professionalism was believed to be multifactorial from childhood continuously throughout a professional career.

There was some doubt as to whether it is possible to develop all individuals to become professionals, and a widespread feeling prevailed that only someone who already has a suitable value set and the will to be a professional is amenable to this type of process. Further still, there was some doubt in many minds as to whether one can

actually be taught to be a professional or whether this state can only be achieved through experiential learning from those around you in your formative years, at university and beyond. There was a very strong sense across all age groups that it is an inherent property of the individual who needs to be 'the right sort of person' to be able to take on board the professional principles required:

> *"It's a quality within you." B6*
>
> *"It's in my nature...something in your heart that makes you a professional. You can't teach people that who haven't got it." B7*
>
> *"I think you've either got it or you haven't." B10*
>
> *"You can give them a framework but you can't make them do it." B11*
>
> *"It's a zeal within yourself." B12*
>
> *"It's something you don't even think about.... It's an attitude rather than a way of working." B13*
>
> *"There is a certain type of person who is more caring, who makes a better professional. Something in you that makes you think about the reasons why you picked to do dentistry in the first place." B18V*
>
> *"It's your upbringing, it's the standards that you set yourself within the way that you live your life." B20*
>
> *"They have to have an initial interest to start off with .....maybe a certain understanding, of appreciating other people's values and appreciating other people, and understanding that you have to act in a certain way..." B22V*
>
> *"Core values about fairness, pride, helping people, stuff like that." B28*

Many participants reported that they had experienced a strong drive from family and their expectations, especially in those who were educated in the 1960s and 1970s who became the first in their family to go to university. Others talked of ethical, social and religious values which they felt had played a large part in shaping them as professionals, as well as personality traits which gave them drive, determination, and the willingness to work hard. Role models from outside the family were also deemed important in forming aspirations to become a professional and in the recognition at an early age of professional behaviour as being fair and honest.

While many had parents who were professionals, a larger proportion did not, and it was recognised that many parents of the post-war era did not have the opportunity to reach their full potential in a work sense, but still maintained very strong principles and values. One participant described their non-professional parents as providing:

"...an ethical framework to hang things on....you've got to have all that before you hit university, haven't you?" B17

There was no shame that these values might be considered traditional or old-fashioned. It was also acknowledged that children of professional parents did not all necessarily gain the same sets of values, as observed in differences between siblings. The requirement for this underlying set of values was recognised by one participant in terms of the need to stay "on the straight and narrow" and maintain the correct personal balance in terms of ethical and other professional considerations:

"It's very easy to cheat in dentistry. Very easy to cheat, and you've got to sleep at night." B25

A strong element of self-selection appeared to be evident, with many participants referring directly to their vocational calling and desire to be in a caring profession working with people. Some felt that too many were now coming into the profession driven purely by potential financial gain, and not because they shared the underlying professional ethic of caring (B8):

"There's two sorts of dentists I think. There's those that I call plodders like me, the jobbing dentists, those who get on with the job, do it, and like it. And there's those who want to run lots of surgeries, and run it from a distance and be like a lecturer and wonder around, with loads of auxiliaries, packing the money in and shunting them in and out like sheep." B8

The Socialisation Process

Experiences differed widely across graduates from different university dental schools but the process of becoming a professional was felt by some to start on the first day that you saw a patient as a student, at which point you gained an understanding of "the full extent of what the job entails" (B6) and you realised that "it's a whole different ballgame" (B19V) from purely academic-based knowledge acquisition. Formal teaching of certain aspects of professionalism, such as codes of behavioural standards, socialisation skills and ethics could clearly set the standards so that students "knew what to aim for", although taught courses in subjects such as jurisprudence and ethics were regarded by many as unnecessary and common-sense.

The limitations of didactic teaching were recognised and it was thought that the really important elements of professionalism were "absorbed by osmosis" rather than by being written down (B17). The symbols of the profession were still of considerable importance to a number of participants, including the younger practitioners, who felt that dress-code, titles and formality were extremely important:

"There was quite an old-fashioned attitude towards us. And you were reminded everyone was called Mr XXXX. It doesn't happen now, but we had to wear a tie. The blokes had to wear a shirt and tie and trousers and stuff, and the girls had to be dressed to a certain standard. And if you hadn't shaved you got sent back.

And I know the whole world has moved on since then, hey, we're over it, it's okay. But that was very much drummed into you from the first year right through to the fifth year. And I think it was a good thing, because I think you do need to behave in a certain way, yes." B28 (qualified 1986)

In some universities, ethics and other lectures were delivered to the dental and medical students together, and this appeared to lend weight to their importance and seriousness, especially in terms of professional behaviour outside of the workplace. One participant reflected on her self-imposed decision as an undergraduate to give up smoking, which she regarded as part of her continued development as a professional:

"It was a process, an ongoing process; it is still ongoing. But there are elements too where I was decisive. And I said, no, I can't smoke now, because this is the image you have to portray, and this is the behaviour. I didn't think it was appropriate." B20 (qualified 1995)

For some this assumption of a professional persona did not occur until they had completed their post-graduate year of vocational training in practice. The development of one's own opinions, standards and priorities, and of mutual respect for others in the profession was considered by some to be a post-qualification process of developing a sense of responsibility and standards that one set for oneself. A nurturing environment was required for ongoing professional development, together with the opportunity for comparison to permit constant reappraisal of one's own professional standards and values through peer review.

Role models before, during and after university education were deemed especially important, and these might be in the form of family, friends, members of staff, other students and other members of the professional team. One participant felt he had been heavily influenced in his choice of career by television doctors in the 1970s in both dramas and documentaries, and considered them to have acted as influential role models in this respect. It was reported that students 'looked up to' lecturers and teachers at dental school, and many talked of role models as inspirational individuals, respected highly in terms of both their behaviour and opinion:

"He did everything to the nth degree, because he said if you don't know what's good while you're a student, you won't know what to go out there and try to aspire to. So he was a good role model." B29

"They kind of instilled into you this idea of professionalism, and how you should behave and think." B21

Young and old

Some of the older more experienced practitioners felt that the younger VTs did not share the same work ethic as the older professionals, and lacked a sense of duty:

"If I'm off sick, I feel guilty, and I don't think they've got any of that." B10

It was also thought that dental students were now so heavily into the technical aspects of care that they neglected to develop appropriate professional skills - "They forget to use the patient's name sometimes" (B17) - and a feeling that in the past the inculcation of professional values and ethical issues was given greater priority. There was a perception that the more recently qualified professionals were much more commercially aware, but more relaxed in their approach to professionalism. By some they were perceived as being more professional, and it was thought they had a more serious time while they were training than previous generations.

It appeared that individuals in Group B deemed themselves to be a member of the profession through formal registration with the GDC and not by membership of a professional association. A small minority of the participants did not currently belong to any professional associations, but still reported that they felt part of the profession. It was thought to be important to maintain contact with other professionals, and there was widespread recognition that the profession was divided and fragmented, perhaps more so since the recent contract changes which had increased competition between care providers[78]. Professional bodies were fundamentally very important to the profession as dentists were very independent by nature, and needed the opportunity to maintain contact with others in the profession. Dentists were likened by one participant to 'privateers', never agreeing on anything, and needing something to keep them together (B28).

The GDC was now regarded, with some apparent regret, as a body outside of the profession and in some respects deemed wanting in their decision-making and unhelpful to the profession:

> *"They need to bite the bullet and be more clear." B16*

Although most in Group B thought it was probably necessary to increase lay membership in order to maintain public favour, this met with very mixed reactions which were perhaps more honestly expressed than those in Group A:

> *"I think if you're going to have a General Dental Council then the majority of members should be dental." B17*

> *"I do think we need lay people on there. You know we can't all just look to be sticking together and letting people off." B10*

[78] The April 2006 contract values were set differently for each individual practitioner or practice, who were in effect competing with each other on cost. This competitive tendering continues as the basis of allocation for additional contract UDAs which have become available through increased funding.

There were concerns regarding the degree of appropriate knowledge of the lay members, with a potential dilution of standards and sceptical concern over ways in which individual members were selected or appointed:

> *"If your face fits you will get in there, if your face doesn't, you won't...and there's obviously got to be a political agenda for them to want to do these things." B11*

The general perception was that the GDC had moved from being part of the profession to being outside it, and while the reasons behind this change were understood, it was felt to be regrettable that such drastic change had been brought about as a consequence of the actions of a few who did not represent the vast majority of responsible healthcare professionals, especially as they had largely been in the medicine and nursing and not in the dental profession.

The GDC were clearly regarded as a governing body concerned with maintaining professional rather than clinical standards and with policing the profession, and in some respects had now become proactive to the point of overwhelming the profession with regulations, with an implicit lack of trust underlying its motives:

> *"What you seem to get swamped by now is a load of regulations coming through, and you're thinking, hang on a minute, if it's in your heart and you're doing the job properly, you don't need all this coming at you... overregulated I think. Perhaps not well enough policed, but overregulated." B7*

There was however recognition that some professionals only work to the lowest common denominator and so the need for regulation was understood. The GDC was now viewed as a political body, its members deemed to be "minions of the Department of Health" (B2), and was thought by some to be letting the profession down. It was thought that in the interests of patients, the GDC should stand up to the government and the Department of Health:

> *" There is a perception that perhaps the government is running [the GDC] now. I do see that if things don't go the way that the government wants, they sometimes make changes to enforce their way. So sometimes there is probably a valid view that dentists now are not in control of their profession and where they're going, but I think it is very much that there is an agenda in the hands of the government." B29*

Some participants, most notably the new graduates, considered the GDC to be a source of general information and helpful with queries when things go wrong or in an ethical dilemma, although this appeared to be based on the information they were given as part of their VT training and not on practical first-hand experience. The changes in the GDC appeared to have had little impact on the vast majority of professionals in their day-to-day practice. One participant who was involved directly with GDC committees felt that it did indeed represent dentists as well as patients, in upholding the good name of the profession:

"I hope it represents the profession. I feel it represents me, but there are certain people in the profession who feel that they are not treated as well as they should be. They sometimes feel that the GDC is out to get them, if you will, but if you sat on the [fitness to practice] panel you would see that it is very fair." B29

While previously the GDC would have been talked of reverentially as the governing body of the profession and thus treated with respect by all in it, there was now a shift towards regarding it with a degree of distrust and in some cases open suspicion of its motives, which were perceived to be increasingly political, rather than unbiased and for the greater good of society.

Dealing with poor performance in the profession

There was a broad range of perceptions of what actually constituted unprofessional conduct and how it should be dealt with:

"I always feel very sad for the people who fall foul of the rules because, like anything else, you don't know why they've fallen foul of the rules. I think all of us at some stage have fallen foul of a tiny rule. But does that matter, if the overall effect is good?" B8

"I think we have a natural instinct to say 'Yes, this is OK, and no, that isn't', and exactly where you would draw the line on certain things... I think for me it's anything you do, if it benefits your patient, I think you're most of the way there in my eyes, even if you weren't perfect." B16

There was antipathy for those who let the profession down, and a wish for better policing, although a reluctance to be involved directly in the process. There was a perception that it is actually very difficult to get struck off and that a great deal of poor dentistry went unchecked or unrecognised by the GDC, to the detriment of the profession.

There appeared to be an inherent view that one professional should not criticise the work of another, as this was regarded as a direct challenge to the principle of respecting another professional's judgement, especially when the full facts of the circumstances in which the work was carried out were not known. Many reported that these unwritten rules had been drummed into them at Dental School, although they described extremely poor standards of dentistry they had seen which had been executed by their professional colleagues:

" It's terrifying some of it, it's awful." B9

" A patient comes in with a story and your heart breaks, it does." B10

"I had a case in just last week, a new patient, and I think it was the worst dentistry ever seen in my life. I was so gob-smacked, and I kept asking her 'Have you seen a dentist recently?' 'Yes.' And it was a private one and the work was just appalling. And I'm thinking, should I report this dentist or not?

But then it goes back to your dental school days where we were told that you do not put down another dentist's work. You do not mention another dentist's work to your patient. You just don't do it. And it's kind of a dilemma. It's very difficult to know what to do. ... it was pretty bad stuff, and I was a bit upset that he had obviously taken money off her to do that treatment, and she had got into this state where she needs quite a number of teeth out." B20

Despite the rhetoric, whistle-blowing was thought not to work effectively in practice, though some felt it was becoming more accepted by the profession. Part of the reluctance to take action was the acknowledgement that everyone makes mistakes and that some things just don't work out as intended. This view was expressed by both experienced and newly qualified dentists:

"We all have bad days. I'm not slagging them off." B10

*"**Riskwise** magazine comes through from the Medical Protection Society[79], and some of it - you can see the guy there. It's Friday afternoon, and he sees somebody as a favour. He's rushed off his feet and he's done his best. .... one of them was in trouble for not giving an estimate for his treatment plan - a revised estimate - and he got slated for that. Ridiculous, absolutely ludicrous. You know, that sort of stuff comes out, and I look at that and I absolutely despair. And I think, that is when the lunatics are running the asylum, you know, that is just crazy. You look at some of those and think, there but for the grace of God... (laughs)." B9*

"Yes, but sometimes you're not in a position to judge anybody else, you don't know what you would be doing at that moment on that patient when they went to see that dentist." B24V

There was concern that dentists did not want to get a reputation for making judgments on other dentists' work as this might affect their professional standing, and this view was again shared by both older and younger practitioners:

"...sometimes it's easier just to say nothing, isn't it....That's the fault of dental school because they really did drum into us how unprofessional it was to criticise another person's work." B20

Another young graduate thought that something would have to be "very, very bad" for her to report it. The majority of participants came across as surprisingly humble and conscientious when assessing their own competence:

" I'm not saying I'm the best clinician in the world...I'm bog-standard. My carving of amalgams is not as beautiful as some other peoples'. If the RDO came in and looked, he'd say 'She is average'. But I can't leave things untreated." B10

"Well all I know is that I try, and at least I go to bed at night and sleep thinking I've tried my best. Somewhere down the road there may be mistakes you've made and you think, well that's the way life is, but yes you do become concerned.... and you just worry what the fallout is...." B20

[79] The indemnity bodies circulate their members with quarterly magazines such as 'Riskwise" which contain educational articles relating to legal aspects of practice such as consent, and stories of poor practice and cases which have caused problems.

Ethics played a very strong part in professional practice with a need to admit one's own mistakes and to be honest with the patient and others. It was thought that the vast majority do act professionally, and many dentists felt that if the GDC wanted to know who the bad dentists were, they should ask the other dentists in the locality:

> *"Yes, there is a rogue, probably one rogue in every district and everybody knows who they are. Generally that's what happens. Sorry, that's probably a bit controversial for your tape, isn't it? The policemen know all the bent solicitors, don't they? "B9*

> *"If you ask any dentists on any patch there will be certain names that crop up time and time again, and you'll see patterns of treatment, you'll see treatment where you are led to believe by the patient that such and such has been done, and there's just too many.... sometimes you think there's no smoke without fire...." B20*

There was some disquiet regarding the potentially unethical ways in which some practices operated:

> *"I know that there are practices out there where it's not convenient to change what's going on because they are making a lot of money. There's a hell of a lot of that going on, there really is, and it's very, very difficult to be able to work out how... you know it anecdotally but you can't prove it. How do the PCTs or the GDC police that?" B28*

Disappointment was expressed that monitoring through the previous RDO inspections had been abandoned with the introduction of the new contract, as the profession appeared to welcome the opportunity to be publicly scrutinized in order to prove that its high standards were being maintained. Strangely, there appeared to be a belief in some divine intervention which would ensure that bad practitioners would be found out without the need for the participant to take action, perhaps alleviating anxieties over their own inaction:

> *"I've always thought that if they're doing this bad work then somebody who's got a bit of power will find out about this and something will happen to them..... But I don't know, sometimes some dentists do slip through the net. Maybe it's just too big a thing to completely govern and to make sure everybody is absolutely safe." B26*

Corporates and some highly business-orientated practices were seen to be encouraging poor standards of professional practice by encouraging high volume/low cost contracts, thereby forcing down the quality of treatment that could be delivered. The corporates in particular were perceived as operating 'sweatshops' and being poorly run with minimal ethical standards. PCTs were seen to be colluding in respect of allowing these lower quality standards in order to meet their own target requirements for providing access to dental services:

> *"There are six boxes of complaints [at the PCT], but it's ticking the boxes to provide the service and so they are not bothered. And it does irritate a lot of dentists. .....". B10*

"Complaints are coming out left, right, and centre but nothing is being done about it because it's not expedient, because it is filling the hole in provision of NHS practice. It's about the numbers and not about the quality." B28

Poor professional judgment was also deemed to bring the profession into disrepute, where practitioners were carrying out work that was not in the best interests of the patient, such as cosmetic procedures which would compromise the patient's oral health. There seemed to be a fear that that you could inadvertently find yourself summonsed before the GDC as the rules in many areas were unclear or inconsistent, and in this respect the profession welcomed firm guidance which was less likely to leave them open to claims of negligence or malpractice.

Peer pressure was thought to be very powerful in maintaining professional standards[80]. While patients were not always regarded as the best judge of the technical standards of care, there was still a belief that they could be relied upon to speak up if things were not right:

"I believe that patients can smell a rat." B28

"...and I think at the end of the day, most dentists have to think about their reputation and the proof of the pudding is in how busy a dentist you are and how popular you are, and personal recommendation from patient to patient. And there's nothing more heartwarming to a dentist as when a patient comes to see you saying you've been recommended by xxx.... that's what I really like. That's the real icing on the cake." B26

Thus a strong belief in upholding a set of standards and values was expressed by these members of the profession, which appears keen to maintain its standing and public trust while publicly demonstrating its quality standards. It has though hidden its intolerance of poor practice from public view by failing to take open action against those it knows to be failing, and this seems related to an extremely deep-rooted professional code of protection which has been perpetuated through generations within the profession, as well as fear that one's own personal and genuine mistakes might come to light with serious consequences for one's future practice. However, it is a profession which recognizes that some aspects of its professionalism have been challenged by changes in society and its expectations, particularly by issues relating to funding and government policy.

[80] Single-handed practitioners appeared to have been branded as automatically being more at risk of performing poorly, although many actually made much more effort than other practitioners to keep abreast of current practice and engage with their peers.

6.5.2 Challenge to Autonomy, Independence and Freedom

Only one participant in Group B referred directly to autonomy in decision making as a defining characteristic of a profession, although many responses from this group referred to this issue indirectly. The expansion of independent privately-funded practice was seen to provide a happier environment for patients and dental staff, and many decisions to enter this field of practice were apparently based on the desire to maintain and improve quality standards, though this may have been the publicly acceptable argument to justify a personal decision made on the basis of the balance of interests in Figure 6.2. It was clear that there was no perceived link between professionalism and the system of funding or remuneration. The quality of treatment in practices was perceived to have improved because of the increased investment by the dental professionals in technology, materials and new techniques. One private practitioner described the freedom that she now enjoyed:

> *"[On the NHS] I just couldn't do what I want to do, to provide adequate treatment to adults. I mean, just look here, I've got nice equipment and you need to earn the money to put nice equipment in. I mean it's about £20,000 just in that cupboard there.... And we don't think twice about spending or going on courses. If we want something for the practice for two or three thousand, we just buy it. And it's lovely to be able to offer your patients a full range of treatments, and that's why we went down that road." B21*

There was a general perception that the NHS contract was restricting and undermining professional judgment in dictating the range of treatments which could be provided. Higher standards of care were thought to be possible in private practice, enabling the professional to maintain standards without the necessity to cut costs. Many were reconciled to the fact that's if they didn't charge fees then their practices would not be financially viable. A number of the older professionals who had worked extensively within the NHS were not particularly comfortable with the financial aspects of practice, and some of the inexperienced younger graduates also expressed concern at dealing with money. Money had however previously been a part of NHS practice for many years:

> *"When I went into practice in 1985 we didn't have a till, we had a cardboard box, because the maximum patient charge had just come in and I think it was £17." B30*

Some had found it easier than anticipated to make the transition to privately-funded practice from the NHS state-funded system. It was also thought that the presence of direct fees in healthcare provision encouraged patients to view their treatments differently in terms of value for money, and to return only if they were happy, acting as a direct and welcome form of quality control. Many dentists were happy to regard themselves as businessmen, competing for customers in an open market and being judged on the quality of their work. This was seen to raise professional standards and

to increase the likelihood of the "dodgy practitioners" being identified. One participant viewed his practice as "a business run on professional principles", and talked of the requirement for a fine balance between being a health professional and running a successful business (B28).

It was felt that allowing advertising from the 1990s had made a huge, perhaps negative, impact on the profession:

> *" It moved the mindset from being totally professional to being partly commercial. And I think we're sliding in that direction rather rapidly, because now 'the smile' is being sold to the population, regardless of what needs to be done to produce it." B17*

Many could not reconcile themselves with this change to a commercial mindset from a professional perspective, and thought some dentists had misjudged their balance of interests, and were too far removed from being the healthcare professionals they had trained to be:

> *"I think the element of what is beneficial to the patients has virtually disappeared... I think it's forced [the professionals] to react negatively in a professional sense, because it is driving them to a more commercial service. ....it means you are being forced more or less to make a choice between money and patient health....I like to sleep at night." B17*

A privately-funded system was seen as more of a test of an individual's professional values, requiring both their expertise and ethical framework to meet the patients' needs while upholding the values of the profession. There was a strong sense that professional satisfaction was derived from patient satisfaction, and doing something well gave more satisfaction than money. Many statements indicated that money was not the main motivator, though it had to be an essential part of running a business:

> *"When we set our practice up, we set it up to look after people, make enough money to look after my family and we ran it as a business. But the money was not the driving factor other than that we needed to make some to make it work. I could have made considerably more money than I have, but to do it I'd have to turn into somebody I don't like. Been there, seen that, done that and I decided no. Whether that's 'professional' or not I've no idea." B17*

There was a general statement from private practitioners that their financial reward was no greater than that of their NHS colleagues, but they achieved more job satisfaction from offering a broader range of higher quality treatments. They were less time pressured, had less paperwork and were more in control of their own future, and enjoyed a much improved lifestyle as a consequence.

While some in Group B viewed change simply as change, and nothing more sinister or confrontational, other participants felt that government policy constituted a direct threat to the profession and that they were indeed under attack. There was a feeling of

disappointment and anger that irreplaceable commitment to the NHS on the part of many members of the profession had been lost, and that it was necessary to protect and defend what one had worked for and built up:

> *"Everything we have worked for and invested in for 20 years will be gone". B15*

> *"I think I felt a little bit let down by the NHS, which maybe a lot of dentists did ... you felt like the government and political bodies don't really understand how the profession works." B21*

> *"I think we are an inconvenience, we needed to be controlled and financially we've been controlled. The government hasn't been prepared to listen to anything, and successive governments over the past 20 years have been looking to get rid of dentistry, because we are trouble. And they want to do it without losing face, and haven't managed a way yet. And this has been another way." B13*

There was acknowledgment that if the government provided funding for the service then it would be unrealistic to expect them not to intervene in the running of the professional service. Thus a clear advantage of private practice was the distancing from direct government intervention[81]. Regulation and control over the profession imposed by external agencies was perceived to have increased considerably, with an implicit undercurrent of distrust:

> *"The government would rather like to regulate everything under the sun, including Christ, you know....they're very controlling." B28*

There was a perceived danger of too much legislation and too many protocols, with anger at the degree of intrusion:

> *"You can go too far and then people get disillusioned because you can't get on with caring for the patients." B29*

> *"Nobody is going to tell me how to run my business. Not when my home is acting as collateral on the practice loans. ...We financed it, we went and got the money. We put our home on the line as collateral, and I'm not having anybody telling me what to do with it at all. Nobody else would. If you go and ask a teacher 'well you put your mortgage on the line so that you can still keep your job', it's not going to happen, is it? To hell with that." B17*

> *"Dentists have always been autonomous, they have been independent. And we've worked in the health service, and now I think we might be able to do something other than that." B25*

One participant thought that the government would work to keep the doctors happy, but with dentists it could "let them go", and felt that the profession was being disposed of (B21). Another participant, anticipating further imposed controls and restrictions, felt that some dentists had been rather naïve in their expectations of the new contract.

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[81] One participant reported that she would not be able to pass her practice on to her children who were training as dentists if it remained in the NHS, and this had played a part in her decision to change to privately funded work.

The newly introduced registration of dental nurses had met with a mixed reception. Some regarded it as "an absolute nightmare" (B13) in terms of increased costs and time commitments for CPD, adding to the strain on a small business. It was more generally felt that registration was a positive step for the nurses who had perhaps previously been undervalued. Two practitioners in Group B talked of the hierarchical structure which had been developed in their practice to accommodate the new professional roles in the team, and described how professional their staff had now become in their approach to service provision. One participant who supported the general concept of DCPs, regarded their introduction as part of the general dumbing down of society and joked:

> *"...if the cleaner starts doing the fillings, you know....." B8*

In dealing with the challenges to the profession, some thought was given to appropriate leadership although this aspect of the profession appears to have caused much less concern than in medicine, perhaps because of the smaller size of the dental profession, and its more independent relationship with government. Many thought that the leader should be the CDO but felt that the position, as a government appointment, had now become overly politicised, and was excessively influenced by the government's wishes for NHS services. It was felt that this had been exposed by the April 2006 contract:

> *"I think the role of the chief dental officer used to be more as a representative of the profession, but certainly over the last couple of years he's been telling us what the government wants and is not prepared to listen to what the profession says at all." B13*

Most of the new graduates did not know who held the current role of CDO, nor the remit of this position[82]. The CDO was seen by older practitioners to be in a powerful position as a bridge between the profession and the government, but was not felt to be a representative or spokesperson for the profession and many wished the post to be more independent of government as it had been previously.

The general feeling was that there was no leader in the dental profession, but there was a need for a strong single voice for the profession. Some thought that the British Dental Association should lead the profession[83]. It was acknowledged by some that it would be difficult to have a single leader as the profession was so disparate and it was felt more appropriate to have various leaders in different situations:

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[82] Some of the new graduates were rather confused on this issue: *"I know there is someone. I think I actually met him. I did actually meet him... I'm sure that along with his little crowd, he sort of makes the regulations up and monitors things and that's why he's given that position, I don't know". B12V*

[83] If this was the case, it was suggested that Chair of the BDA would by default act in the leadership role, ideally heading a team in which all the voices of the different parts of the profession would be listened to and heard.

"There are too many individuals with arguments between them. One would do one thing, another one would do something different." B24V

It was felt to be important to encourage all the different groups and professional bodies to talk to each other, and the value of local leaders as role models and 'opinion formers' was not to be underestimated (B16). This was seen to be of increasing importance in the context of the perceived government policy of 'divide and rule', and local leadership might become more important as dentists experienced different problems in different areas, as PCTs were allowed the freedom to negotiate local terms of contracts. The need for dentists to develop leadership skills in their own practices was acknowledged in their developing role at the head of a healthcare team.

Several individuals were thought to have 'the charisma factor', being regarded as national leaders in advancing clinical practice or in holding senior positions within the profession which commanded respect, although there was a perceived lack of positive role models in the profession generally. One newly qualified dentist felt that it was not appropriate for a profession to have a leader, as everyone is essentially deemed to be equal in a collegial system.

6.5.3 Fairness

Part of the drive to regulate general dental practice through the restrictions of the new contract were thought to be in response to practitioners abusing the previous funding systems, which themselves had been flawed in many respects with unfair expectations of the profession:

" And I was thinking, well I'm trained to be a professional. The income wasn't fantastic, I was seeing 50 patients a day, ... it was like bang, bang, bang. I mean, I used to cry over the computer some days, and think 'this is not right'." B21

"We were all working hard and then a year or so later they cut the fee scale. And we were pedaling as fast as we could, we couldn't pedal any faster. Enough is enough. Where do you stop? So we went down the private route in 1994." B27

Dissatisfaction was subsequently expressed at the way in which new policy in had been implemented by the PCTs in April 2006, the lack of perceived fairness, and breach of the psychological contract in terms of:

- the way the new contracts had been introduced and managed
- the unfair demands placed upon the professionals in terms of unreasonable expectations
- the restrictions to their clinical practice as a consequence of the imposed funding conditions
- the unfair competition in the tendering process and use of historical data

- the frustration at losing clinical freedom and in not being able to treat NHS patients where contracts were denied
- the restrictions placed on their abilities to develop their own practices in a business sense, with the loss of goodwill associated with the business
- the feeling that they were not listened to, and that local and national negotiations were not conducted fairly.
- The way in which the contracts and funding systems were introduced without proper piloting or evaluation, when the professionals themselves are expected to engage in evidence-based decision making and practice.

While some PCT managers could be regarded as being very professional, it was appreciated that they had a different set of values to the healthcare professionals they worked with, needing to achieve cost-effective volume targets rather than quality in patient care. For some, however, the pain and suffering through the change process had resulted in perceived rewards, with more security in relationships with government agencies:

> *"I think the best thing that's happened to dentistry is the new contract. Absolutely the best thing, because it's made things much clearer. It is very clear about what the government wants from dentistry... You are either an NHS dentist or you're a private dentist, and that's it. End of story." B28*

Others were less enamoured with the way in which they had been treated:

> *" I don't think the government has got much respect for us to be honest. The contract was imposed, which I don't like. Like it was imposed in the 90s. It doesn't matter which government is in, they don't give enough respect to dentists....we are always at the back end of something and I think we deserve a little more respect, because I think we are a good profession." B25*

The dentists' sense of fairness appears to extend beyond their own personal sphere of concern and they express their indignation on behalf of their patients also:

> *"I think it's quite unfair. People I have in who are having minimal work are paying exactly the same as somebody who needs a lot of root canal treatments, a lot of fillings, because they haven't looked after their teeth in the past 10 years. So I just find that unfair." B18V*

The April 2006 contract was regarded as a great challenge by some and as unacceptable by others, who were extremely angry and deeply resentful of its implications in terms of public health and its immediate and unjust effects on the professionals and patients concerned:

> *"..appalling, absolutely appalling, don't even...I feel like throwing things. It's completely inequitable...It's completely wrong...They said it was a preventative programme. Like **** it's a preventative programme, it's a negligence programme. It's encouraging people to be negligent, and it shouldn't. And I bet there are lots of guys out there who are tearing their hair out trying to do it properly." B9*

> *"It's an absolute shambles. I think the core thinking is completely wrong.... It's just absolutely crazy." B16*

"I think is appalling. It is abysmal, and it is completely destroying any professionalism within the business. It is constructed such that it ticks all the financial boxes for the central government auditors. It does not allow you to operate professionally. It doesn't allow you to operate ethically at all in any shape or form." B17

It was considered to be ill thought out, inadequately piloted, and implemented as a last resort. It had changed working patterns in order to meet annual targets, and there was a definite concern and uncertainty about the new system of targets and contracting arrangements. Refusal of PCTs to increase contract volumes had angered dentists when at the same time the press was reporting a shortage of NHS care and the profession was being portrayed as uncaring and inadequate. One participant related their indignation at the disrespect they experienced when giving a presentation to the PCT in a bid to increase the amount of NHS work they were contracted to carry out:

"It was like we had to jump through hoops... it was a bit like the Dragon's Den, going in front of a desk with seven of them... I did get the impression that some of those people interviewing us didn't really have an idea about how general dental practice works, and a couple of them were dentists. ....I just felt that it wasn't right,.... you know, I feel they should be looking at quality rather than cost, and I just thought it was wrong." B26

There was a feeling that dentists had been placed in an unjust and untested situation. There was a perceived loss of control over the workplace and clinical practice, and restrictions in some areas of clinical decision-making. A system that did not reward extra work with extra payment was perceived as unjust. It was acknowledged that the reported changes in treatment patterns after the introduction of the new contract did not reflect well on the profession and were not acceptable to the majority who felt that a practice should be able to manage the losses as well as the profits:

"Why should your practicing profile suddenly alter? I find that very difficult to square up." B9

Some reported that it had made no difference to their clinical treatments, and that they were committed to doing what was right for their patients, even if they lost money[84]. Others had wanted to stay in the NHS but could not make the contract financially viable in their practice, and had instead opted to take a salaried position employed by the PCT, in which they saw that the staff felt 'unloved', were less dedicated to their work, and "no-one seems to care that much" (B16). It was perceived that there was now little or no incentive to expand or 'to do anything extra' in an NHS practice. The way in

[84] Another described this as a need to 'iron out' the fees across the patients, and many related a situation where private treatments were required to subsidise the loss on some NHS treatments. However, even the most dedicated of NHS professionals felt that there was a need to change the way in which some aspects of the practice worked through adapting to the new systems:
"You've got to manage your [appointment] book, and you've got to get rid of your wasters." (B10)
"The money side of it is just a joke, it's a farce... but what else can you do? That's the system we've got, so you have to adapt to what you are given. There's the system you've got to work in. Therefore, you make the system work. I don't particularly like it but it's what we've got to do, isn't it?" B11

which work was being measured under the new contracting arrangements was perceived as being inappropriate and unfair, and the previous contract was deemed to be better in this respect, as well as allowing the professional more freedom and flexibility to meet patient needs:

> *"...there were certain things where I pulled my weight and I did more than I needed to do for somebody, because it made me feel better. And the old system let me work that way..." B7*

There was also a perception that it was unfair to expect professionals to work at a loss or lower their income to an unacceptably low level:

> *"They couldn't say that the new contract was unprofessional because apparently if you're 'a professional', you should just make £10,000 a year and do the new contract exactly as it says. But you know, I'm not so professional that I am going to work for £10,000 a year, and have the hassle of employing six people like I do, and have patients coming in moaning at you every day about something or saying how much they hate dentists or whatever. You know. There is a line where you have got to say 'I am not prepared as a professional....'. You cannot be professional for £10,000. Sorry, you can't, that's just not right. There's got to be some form of at least reasonable remuneration." B9*

This was clearly an exaggeration to make the point. The NHS contract was seen to be viable by many in Group B only if you had 'the right sort of patients' in your practice (B25), and otherwise it was thought to be virtually impossible to manage financially if you continued acting ethically and professionally.

6.5.4 Opportunities and the future

Many participants in Group B voiced concern regarding the direction in which government policy might force the profession to develop in terms of deskilling its members, or further reducing the scope of practice through contractual restrictions related to funding:

> *"I worry about the future. I worry whether they just want to get rid of [the NHS] all together and make it a basic service. I hope not." B10*

Others were more optimistic:

> *"I see quite an exciting time coming up ahead in dentistry to be honest with you, I think we're leaving a bad time behind us, but I would say that very little of this in the future will be provided by the state." B28*

It was acknowledged that dentistry can become very boring, and for some nearing the end of their career it was more difficult to sustain an interest, especially when social trends and contract changes had made practice less stimulating and more repetitive. Some felt that public funding would cease entirely and that a core service is essentially already being provided. The more widespread private funding of services was regarded as being very positive for the profession, in terms of retaining control of

quality standards and clinical decision-making, and also in terms of being able to provide the complex range of treatments that many patients who retained an aging dentition would need. One of the VTs was upset at the changes she was seeing in terms of more private care:

> *"... I think that's really sad... I don't know whether it's going to be the people or the dentists who maybe have to go to the government bodies and say 'Enough is enough'. I think there needs to be some change, because I think the way it's going, it just doesn't seem to be doing the public any good." B22V*

The internet was seen to be beneficial for patients, in informing them of expected standards. It was observed that social changes meant that younger patients didn't grant respect as readily as the older patients, and some participants felt that the public perception of dentistry was based on an unfair bias perpetuated by the media:

> *" Sometimes I feel as if we're becoming sort of rather homogenised ... They just lump you together, you know. And if there's a misdemeanour, they automatically assume you've all done it, rather than an individual being pinpointed out - I think we need to be careful about that." B8*

It was felt that patients "were highly to susceptible to the government propaganda that dentists are greedy money-grabbing salesmen" (B23):

> *"That's how people still see it. And if you go along and say 'I make £35,000 a year or whatever' they go 'No, I don't believe you'. I've never made huge amounts of money, but I've always decided that I'd rather go away and spend time with my family than work ridiculously hard." B17*

The changed relationship of trust between patients and professionals was observed:

> *"The times have changed now. You look 20 years ago. If someone said they were a doctor or a dentist, people just trusted you, didn't they? Trusted your opinion. Now there are so many horror stories about this and that, I think they've got to learn to trust you. And you've got to learn to trust them to turn up and pay the bills as well." B10*

One participant in Group B felt that patients now were divided between those who were mainly in the older age groups, who trust professionals and regard them as highly ethical and professional in their treatment of them, and those younger, more cynical patients who don't trust anything a professional says, and who are constantly getting second opinions and complaining about their former dentist. A professional who had worked in the same community-based village practice for the last 30 years had noticed how it has evolved as a consequence of the patients changing from traditional locals to people who had moved out to a rural area from the city, who had different expectations and placed less value on a personal service.

Improved technology allowing a much wider range of high quality treatments had been a major boost to the profession, opening up a new range of treatments for a public that was more demanding as a consequence of social changes and media and peer

pressure. The profession was seen to possess many strengths to enable it to cope with change, including its diversity, adaptability and its relative independence from state control. There were now many more women in the profession and more practitioners of ethnic origin, especially in the younger age groups:

> *"So the kids coming in [to dentistry] now are from different social backgrounds or different ethnic backgrounds, different attitudes, different everything. It's just very, very different and they are better for it, much better for it, I think." B11*

There was a perception that whatever system was implemented, dentists would make it work, and there might be a substantial degree of variation as to how individuals might work across the system:

> *"If you put clever people into a system, then expect them to operate it cleverly." B17*

Despite feeling forced into making a decision to leave the NHS, retrospectively this was regarded by many as "the best thing we ever did" (B3)[85].

As in Group A, there appeared to be a general view that the profession in the future would be divided into two distinct professional groups based on the funding of their services and consequently the range of services they would provide. However, the nature of the two groups might take a number of forms. The majority thought there would be a large group of professionals operating in a privately funded system of care delivery, with a smaller group of salaried professionals providing state-funded care. Larger polyclinic practices were expected to supersede many existing smaller practices.

It was generally thought that overall there would be less state-funded dentistry in the future, and that this reduced core service would be delivered through Dental Access Centres rather than practices, providing only emergency care and pain relief[86]. One experienced NHS practitioner who had been qualified for more then 25 years, already felt her standards were dropping and that she was already becoming deskilled: "it's very disheartening really" (B15). Some hoped that there would be a core service which provided basic care to a high standard, instead of the current situation where practitioners were cutting corners with a consequent reduction in quality standards:

> *"I think we do things really well in the NHS and where it goes wrong is where we're trying to do fancy stuff cheaply, and that's not going to work." B16*

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[85] Some of those facing bankruptcy were upset at their patients' attitude in response to their decision to become independent:
"I would love is to still be an NHS dentist for the moral side of it, because NHS dentists seem to be held in a totally different regard to the private dentists. ..... private patients just see 'money' instead of 'maintaining standards' and 'striving to do the best for the patients'. So that's a little bit upsetting sometimes." (B20)

[86] Some envisaged that those working in Dental Access Centres would be a poorly paid salaried service with low levels of motivation and turnover, requiring them to be employed in higher numbers.

"I think there should be a basic standard of care - I think solicitors are so widely varying in their approach and skills, I think if dentistry gets that bad that would not be a good thing to be honest....I think they should just admit that the government cannot afford to fund dentistry. Come clean about it, stop getting the dentists to take the rap for it, provide a good solid core service, pay salaried dentists to provide it and stop shilly-shallying about." B30

It was recognised that there was a chance that NHS dentistry could become more boring and repetitive if clinical freedom was restricted:

"I think they will become very stressed with just rolling out the same old stuff. I don't know if I could do that. And whether they will leave in their droves because they are stressed with a boring old firefighting, because that's what inevitably you may end up doing...." B29.

It was anticipated that the younger dentists entering the profession would be more adept at the 'selling' that might be required, being more money-orientated and that they might not want to work so hard, anticipating a rather different balance of interests from what had gone before:

"They won't put up with the garbage that we've had to put up with." B9

"I know that if I was starting out as a new associate in an NHS practice, I couldn't earn sufficient to finance my overdraft which I'd accumulated as a student without doing unethical treatment planning... you'd have to tread between the cracks in the system to allow you to earn sufficiently." B17

While private practice was not necessarily less professional, it was deemed more open to unprofessional practices, being virtually free of formal quality checks and much more reliant on individual professional standards[87]. Worries were evident at the influx of foreign dentists and their perceived impact on lowering standards in the profession. One VT feared that if she embarked upon a career of NHS salaried positions she would never be able to gain the wider range of skills required for a job in a good independent general practice.

Some saw a clear distinction developing within the profession on the basis of the care provided, between 'family dentistry' and the cosmetic 'dental spa' 'beautician-type' of practices, with more dentists offering cosmetic dentistry and 'super private dentists' who charged 'huge fees' (B4)[88].

Uncertainty and insecurity was seen to be worse in NHS practice, with the PCTs varying widely in their approaches to practitioners and contracting:

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[87] Regulation of the private sector is being implemented in 2010.

[88] Many felt that the economic climate wouldn't affect dentistry excessively and it appeared that people were still apparently prepared to pay for non-essential treatments such as Botox injections, perhaps as an alternative to a foreign holiday. Others thought that the economic situation would indeed have a substantial impact on the private market and that some practices might struggle to remain solvent.

"You can't plan longer then 5 minutes, there's no way you can plan..... We want to expand our NHS practice but they won't let us...they don't want to play ball. They can't play ball. But they are also run by accountants. It's number crunchers and accountants who tick the boxes and keep the money. It's frightening. Health care with a price. I don't think so." B11

Despite the uncertainty over future career options, many of the VTs were looking to work in the salaried services to reduce the immediate time pressure of working to targets and to eliminate the need to ask patients directly for money[89]. All of the VTs who participated intended remaining in the NHS and some were already planning to undertake further postgraduate training. It was acknowledged that the dental profession continues to be a good profession for women with a high degree of flexibility. An increase in the number of women in the profession is perceived to have led to a more caring but less productive profession, and so meeting targets might become more challenging. It was perceived that women were generally less interested in the competitive and business side of the practice, and that this would have an unknown impact for the future.

It was anticipated that differences between the profession and the Department of Health would become more apparent, in terms of their lack of shared goals and values. Differences were also likely to become more apparent between the profession and the corporates, who were predicted to increase their market share exponentially, running practices purely as businesses:

"I think it's going to become just a business and I think that's sad". B8

"I don't think it can continue in the state that it is in. Unless you get these big corporates bringing in overseas dentists, and just slinging out loads of dentistry, which is not ideal."B20

While most participants feared the consequences of more involvement of the corporates, others saw that they could fulfil a valid role if they acted appropriately.

Technically the profession offered an extensive range of opportunities to carry out more varied work, with the welcome potential to allow increased freedom to set ones own standards in the future in privately funded practice. Freedom was widely valued, with the acknowledgement that additional freedom brought additional responsibilities. There would be more opportunity for specialisation in practice outside of the current hospital services, although it was felt that there would always be a role for the generalist, with networking between professionals becoming more important.

[89] One VT was finding it very hard work in general practice, and another said she would be 'very relieved' to be in a salaried post.

The vast majority of participants thought that dentistry was a good profession and would recommend it as a career. There were concerns that the altruistic element had become less important to those entering the profession. Generally the practitioners in this group enjoyed "the people part of it" and valued building long term relationships with patients and their families:

> *" I love the 'making things right for the people' part of it, and I've got a lovely bunch of appreciative patients. I've trained them up well!" B9*

Many enjoyed their work, but would not recommend it their children, and would choose a different career if they had the chance again. Some of the negative issues were related to the increased administrative burden and the high stress levels experienced in dentistry. The few participants who wouldn't recommend the profession were concerned about the uncertainty for the future, the exhaustion, and the reduction in training standards:

> *" I don't enjoy dentistry any more...it is all so uncertain, which when you've given so much to it - I just feel demoralised by it all at the moment. But that's not to say it's always like that. If you get on the right channel, it can be satisfying, very satisfying. So it's just the way things have gone at the moment. I wouldn't recommend it. I haven't advised my children to go into it." B15*

> *"I think what grates on me is that I don't have a life any more.....I'm getting tired." B23*

> *"It's an academic engineering job.....and I worry that the young kids who are being trained now are not being taught the basic engineering principles...They fix the job because WonderGlue does whatever WonderGlue is supposed to do, they don't know why WonderGlue does that. They don't look at why things fail. They just do it because they do it. Something seems to be missing in their training." B11*

Young dentists were generally held in high regard and there was an upbeat feeling about the future of the profession:

> *"The future of the profession is in good hands." B11*

> *"I feel really positive about it at the moment and I've really enjoyed everything I've done." B14V*

> *"I think it's a fantastic profession, provided you're aware of the pitfalls." B17*

There was now a much wider range of opportunities and choice of how one could work, and for some the break with NHS dentistry forced by the new contract had improved the potential of a very positive future:

> *"I'm talking as a guy who wants to run a high quality customer-led dental practice. For me it's brilliant....and for the profession as a whole. Yes. Because I believe it's not possible to do ethically correct dentistry in NHS dental practice. Full stop. End of story." B28*

6.5.5 Summary of Group B analysis

The data generated from Group B appeared to be much more honest and personal, based purely on the professional's own personal experience rather than rhetoric or political correctness. It might thus be assumed to reflect more fully the grassroots response of the profession to the issues raised, and portrayed a more honest view of the profession at the present time. However there were areas where the indignation of the participant clearly went beyond their own personal interests and it would appear that most members of the profession take a great degree of interest in the associated politics, presumably out of necessity in having to deal with its consequences.

The deep rooted values and beliefs of the profession appear to span the age range from newly qualified to retirement, and this is perhaps associated with the relative small size of the profession, but also with the success of socialisation in the dental schools, inculcating the traditional set of professional values, reinforced by peers and fellow professionals throughout a practising career. Alternatively it might be assumed that the sample may have been self-selected to a degree that those who did not hold these views and practised outside of the norms of the profession did not engage as a participant of the study. The degree of agreement between the professionals, both within this practitioner group and with the leaders in Group A, is surprising, given the degree of self-acclaimed diversity and disparity within the profession.

The major themes illustrated demonstrate the depth of feeling with regard to upholding the standards of the profession, and yet the reaction to poorly performing professionals is paradoxical. While privately claiming to deride them, the professionals themselves appear unable to act publicly in assisting with their identification, and wish to blame this shortcoming on their successful socialisation which taught them not to 'shop' other professionals. Behind this appears to be the fear of being found out and the risk of personal shaming for minor mistakes or errors of judgement that may have been made in good faith, linked a perception that the GDC does not now fully understand the profession and the means by which it delivers its professional services. The distrust and perceptions of unfair treatment (which had previously been related to central government and now to PCTs) appeared to have spread to include the GDC, which is now perceived as a government-manipulated body. Many of the practitioners showed great pride in their practices and the facilities which they had built up, as well as in their reputation with patients and the wider community, and the quality of their care. Their ambitions seemed to be to survive and thrive despite the challenges presented to them, and to emerge with their pride intact as an improved and more independent version of what had gone before.

6.6 Reflective Summary of Analysis

The participants in both groups A and B demonstrated an enthusiastic willingness to participate in the study, and a genuine interest in the subject matter and findings. It was interesting to note that some of the leaders referred to dentists as 'people' throughout their interviews, for example "people think they are hard done by". This might reflect the close-knit feeling of professionals in that they subconsciously regard their own community as the population, with outsiders not recognised as part of that world. It might also reflect the paternalistic assumption of the 'royal we' in regarding "the people' as my or our people, in other words, those that I feel responsible for.

The honesty and openness of the interviewees was at times quite astounding and humbling, reflecting the trust they automatically placed in one of their own profession, whom they knew would act ethically and not place them or the profession in a compromising situation. It was quite clear that they would not have been so open with a lay researcher. Recognising that the interpretation of the data will be altered by the fact that I am a member of the profession, the advantages of this situation were key to the depth and richness of the data that was collected. As such I felt extremely privileged to be in a position to carry out such a unique piece of work, with an onus on me to uphold the expectations of my fellow professionals in handling the data in a proper but fair manner. This to me personally was much more powerful than any ethical approval or other formal permission.

I learnt first-hand much of what was going on at the very top of the profession, and armed with this unique insight, I was sometimes taken aback that individuals in leadership roles in one part of the profession were not aware of what others in another part were saying or doing. In some instances they appeared to be blatantly out of touch with what was happening 'at the front line'. The economic crisis in October 2008 clearly altered some of the responses in interviews after that time (A8 to A10, and B11 to B30), especially in relation to the future of the profession and the attitudes of practitioners towards maintaining their ties with the NHS. During the entire set of interviews a number of issues emerged which were added to subsequent interview outlines, including the issues of leadership, revalidation, and the potential de-skilling of the state-funded members of the profession.

There was clearly much agreement between the two groups, but the practitioners in Group B were much more open and spontaneous, and had clearly not considered some of the issues previously. The most notable difference in their responses was the belief by Group A that the new contract did not affect the way in which professional

practice was undertaken, whereas many in Group B made it clear that the contract undermined their professionalism and in some cases encouraged or even forced unethical practice to ensure survival of a practice from a business point of view. All were keen to engage in the research and to be informed of its findings, and most demonstrated that it had been a therapeutic experience to have someone listen to their views and seemingly care about their issues. This does perhaps evidence the essentially isolated nature of the work carried out in this particular profession. A small number of the participants were subsequently encountered through other activities and two of these reported that they had reflected upon some of the issues raised in their interview, discussed them with other members of the profession, and found this very helpful. As part of the ongoing analysis of data, I discussed some of the findings informally and separately with three other participants from Group B in order to clarify certain issues, and again they all demonstrated a deep a sense of engagement with the process, being very willing to usefully contribute and sincerely interested in the outcome of the study.

6.7 Summary

Analysis of the interview data and fieldnotes for the groups of 'Leaders' and 'Frontline workers' has demonstrated an overlap of the themes emerging from the data of these two groups. Both were extremely concerned with the values and standards shared and upheld by the profession, with a strong altruistic element and the drive to do one's best. Similarly the challenges to autonomy and independence were of concern to both groups, although power *per se* does not appear to be a great issue for this particular professional community, which is interested in its own rather specialised domain, acknowledging that it has little influence beyond into wider society. It is impossible to consider the future of the profession without reference to the funding of services and this has clearly been a key issue for the profession, due to the imposition of policy which had radically changed the ways in which the profession provides it's services over the past three years. There is no consensus regarding the decision to move from state- to privately-funded systems and a balance of interests must be weighed by each individual professional, to determine the impact of the decision on their patients, practice, self, professional and wider society, in order for them to make their individual choice in this matter.

Members of the profession express open emotion at their experiences in many of their professional relationships: their anger and indignation at being treated unfairly, disrespectfully and dishonestly by government and its agencies; despair at their fellow professionals who conduct themselves poorly; and disappointment at the way in which

the public appear to believe the distorted media portrayal of the profession and its work. While there is a nostalgic sense of regret by some that things aren't as they used to be, there is also a sense of anticipation in others, with a belief that the worst is over and that the profession is now full of opportunity and potentially has a great future ahead of it, especially in terms of technological advances and growing demand for services.

In this chapter the analysis of the data has provided a rich insight into the attitudes, emotions and deeply held values of the profession through the themes identified for each of the groups, In the following chapter the implications of these findings will be discussed in the context of the research questions, addressing the three key areas relating to the contemporary social construct of 'a professional', the ways in which the profession has reacted and adapted to change, and the way in which the profession continues to develop in the future.

Chapter 7: Discussion

Chapter 7 Discussion

7.1 Introduction

The findings reported in the preceding chapter have highlighted the complex web of issues which are perceived as being of importance to the profession of dentistry in its present social, economic and political context, and have demonstrated the ways in which this community have reacted to the changes that they have encountered. This particular profession has responded to a unique set of contextual circumstances during the period in which this study has been undertaken which were not anticipated at the start of the study, and the importance of contexualising the professionalisation process as advised by Johnson (1972), Freidson (1986), Torstendahl (1990a), Ackroyd (1996) and others is supported.

However, this does not preclude the extension of the concepts which are developed here to the wider field of study, and the perceptions and responses of the dental profession will now be discussed in terms of their relevance to the literature already reviewed in the broader field of the professions and their management. Proposals will be made as to the way in which existing theoretical models might be supported, refuted and extended through these findings. The initial section of this chapter will consider the findings in respect of the construct of 'a profession', its implications for identity, and in relation to established theoretical viewpoints on the professionalisation process. This will be developed further to examine more specifically the ways in which power, control and autonomy affect and are affected by the behaviour of the professions, in terms of their internal and external organisation and their relationships. This theme will be developed further with specific reference the professions who enter into a contracting relationship with a mediator such as the state, and the factors affecting their responses in view of their perceptions of unfair treatment at the hands of their patrons and clients.

In the final section the findings will be considered with reference to allegations of de-professionalisation and proletarianisation in the professions at the present time, especially in view of the fact that the dental profession appears currently to be thriving. Contrary to the majority of professions at this time, it may well be at the zenith of its professionalisation, when analysed through the comparative models of professionalisation proposed in the sociological literature.

The underlying assumption of this research has been that the social construct of 'a profession' remains valid in contemporary society in the UK, and that dentistry is still regarded as such. This particular study has focused on this social construct as viewed

by those within the profession, and by virtue of its sampling strategy has engaged with a self-selected sample who, it might be assumed, have something to say on the matter. It has also been undertaken by an individual from within the profession itself, which may have altered responses in the data collection process, and though this might be towards greater honesty and openness, it may have led to the adoption of a certain stance or argument in some circumstances. In either case, it might be assumed that the responses are different to those which might have been gained in an interview with a lay person and this was discussed in Chapter 5. The selection of the group of 'leaders and policy makers' was limited to those who are or have been members of the profession itself, and was necessarily restricted by the discrete nature of the profession and the small number of posts justifying the assumed title of leader or policymaker in this respect. A strong sense of justice pervaded the interviews, both in their content and the aura of the personal encounter at the time. The volume of rich data generated has proved difficult to handle in terms of selection for inclusion in this thesis.

It is reiterated that the data generated is not intended to represent the views of the profession, but to provide deeper understanding of the issues which might temper and direct the responses of the profession at a time of immense change and opportunity, and certainly at a unique contextual point in its further development as a profession. The future direction in terms of government policy – and it must be accepted that government policy remains the overarching influence in the future of the healthcare professions in the UK at the present - for this and other professions is as yet unknown, but it is hoped that this present study might better inform the theoretical standpoints with respect to the further development of the professions, and more practically find direct application in the management of further change affecting the professions, both internally and externally. The extent to which the dental profession might serve as a model for other healthcare professions might also be considered, in view of the strong likelihood that healthcare services may increasingly be delivered through a mix of state and privately funded systems in the future, regardless of the political party in power.

7.2 The concept of a professional and the professionalisation process

There can be no doubt that, as Burrage (1990), Ackroyd (1996) and others have purported, the concept of 'a profession' is still relevant in modern society, and that many of the traditional characteristics of the learned professions form the basis of the current social construct, at least from the professionals' own perspective. While the clergy formed the template on which other the professions might have developed (Carr-Saunders and Wilson 1933), it could be argued that it might no longer be regarded as worthy of the present contemporary construct of a profession that appears to include

elements of client satisfaction, entrepreneurship and successful commercialism (Dent and Whitehead 2003). One group of successful professions, including those in healthcare, have been closely tied with scientific and technological advances over the past two centuries, and dentistry at least now appears to be closely related to further developments in this respect. It could be argued that professions such as law and accountancy developed in a different type of professional grouping, with their knowledge and skills in the main unrelated to technological advances (Siegrist, 1990). The findings of this study clearly demonstrate that there is a clear move towards commercial aspects of practice in dentistry, and this has clearly been an element of public sector government policy over the past two decades (Hanlon 1998).

Fig 7.1 A professionalisation map of the main professional groups in the UK from the 18th to the 21st centuries.

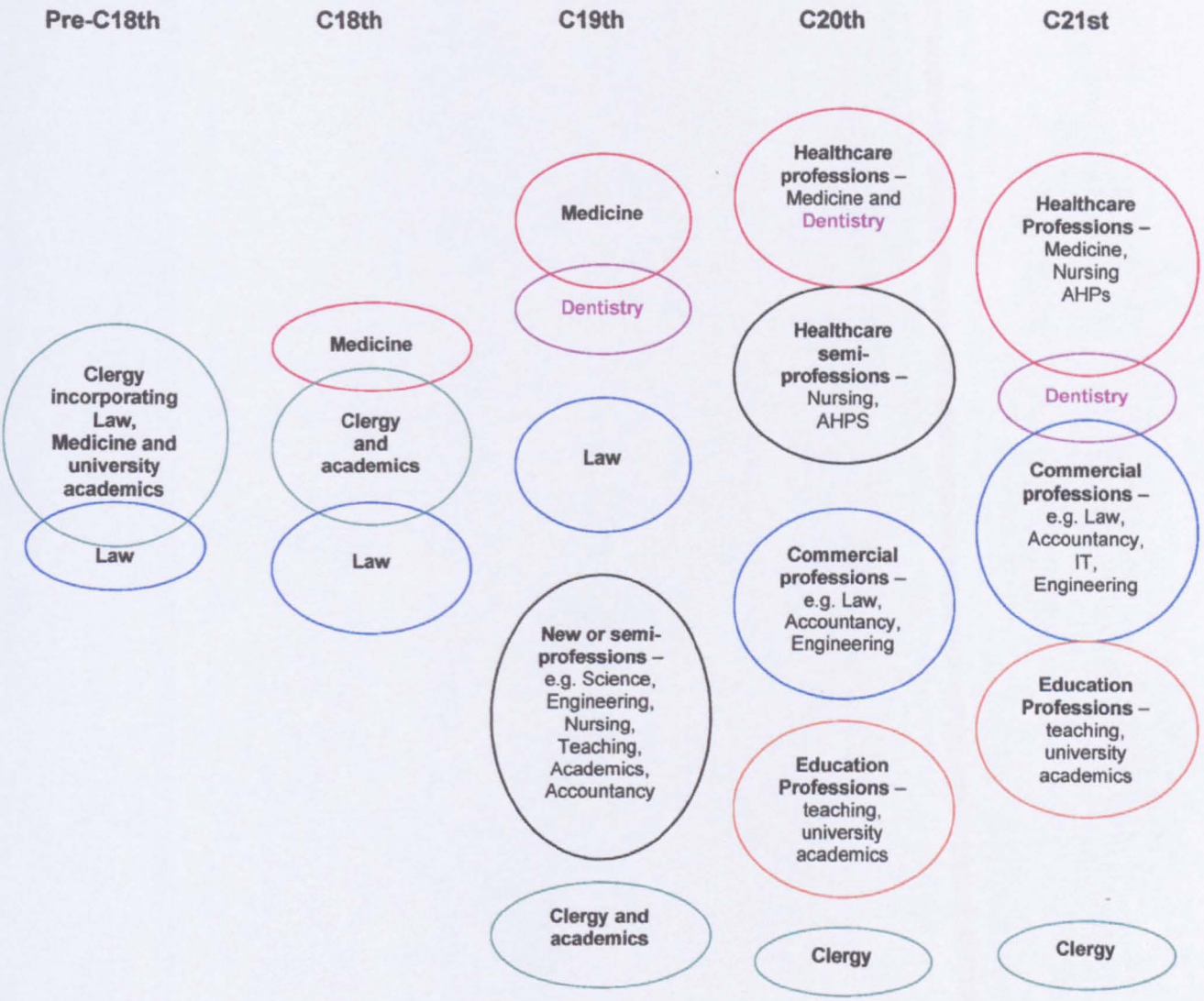


Figure 7.1 represents a 'professionalisation map' giving an impression of the development of the UK professions over the past five centuries, based on the

historiographical and sociological literature considered in this thesis, together with its findings. It is intended to be illustrative and to provide an overview rather than being all encompassing across all the professions. The professions of law and medicine developed from within the clergy and by the 19th century became established in their own rights, independent of the universities. The new or semi-professions began to become established in the 19th century and during the mid-20th century, with the advent of the Welfare State, a number of differentiated professional groups appear to have developed in the areas of the commercial sector, the healthcare sector, and academia, subsuming the majority of the new or semi-professions.

Increasingly the clergy appear to have become marginalised and are difficult to classify into these categories, though perhaps lying nearer to academia than to the other two groups. In the 21st century there appears to have been a reversal of the trend of differentiation between the professions, as they again become closer through an increasingly commercial aspect to their practice, almost universally applied across both private and public sectors. This in no way implies that a professional can cross into another group, merely that the approaches of the professions have become more closely aligned. The healthcare professions have expanded to include many which were previously regarded as only semi-professions, and the majority of healthcare services remain as part of the welfare system, albeit with a more business-orientated approach to service delivery. However dentistry, which had previously allied itself with medicine, has now in many respects set itself upon a new course of development to become a more commercially orientated independent profession, operating more in line with lawyers and accountants in the way in which it delivers its professional services. Again, it is difficult to place the clergy in relation to this apparent commercialism of the professions.

Larson (1977) felt that the concept of professionalism was still strong in the 1970s but that it had little practical application, becoming more of an illusion to be aspired to (Murphy 1990). The findings of this current study would however indicate that the principles of professionalism are retained in the healthcare professions, with their practical application integral to the continued relevance of the social construct developed through their professional practice. The findings indicate that there might be some type of 'magic mix' of elements at any one point in time that make a profession (or a developing occupation) viable in terms of the current social construct of 'a profession'. For dentistry this 'magic mix' of factors contributing to its current success, as judged in terms of its continued success and growth in our society, appear to reside in the persistence of a contemporary social construct of a profession, albeit changing

dynamically and constantly evolving; the dental profession's ability to adapt rapidly to change by virtue of its relative freedom, particularly in choice of contracting relationships (which most particularly are not tied in to state control); its entrepreneurial ability to remake and extend its boundaries to absorb new fields of practice; its retention of the role of diagnostician at the head of a clinical team, ensuring its continued legal monopoly status; the increased levels of demand for its services driven by media pressures and social trends; and its close association with high levels of specialisation, practical skills and most particularly advanced technology, which have allowed the development of new areas of practice and increased the barriers of entry.

The healthcare professions now appear to be at the heart of the contemporary construct of professionals in the UK, although it has become clear through the term of this current study that the healthcare professions themselves have become more developed, differentiated and perhaps internally divided over a period of 5 years as a direct consequence of government policy, in part intended to achieve this aim. Perhaps the time has come for independent free-standing professionals (Ackroyd 1996) who can freely engage in innovative and entrepreneurial behaviour in the market place to assume the dominant form in the professional model once again, while the institutional and bureaucratised professionals (Harries-Jenkins 1970; Murphy 1990) of the 20th century are in decline in terms of their power and status. If the professionalisation process is viewed as being cyclical rather than linear (Siegrist 1990) then the medical profession may be experiencing a period of decline while the dental profession is currently enjoying a position at the peak of its cycle.

It is thus argued that the social construct of a profession might now embody the 'magic mix' of elements so successfully combined in and demonstrated by the dental profession in the past 5 years, and the impact of this change in construct will be discussed in terms of the implications for individual and collective identity within the profession. This has wider implications in terms of the organisation of the profession, and the relationships between professionals, both internally and externally, especially for those in newly created professions and roles, and in positions of apparent or potential power. There are also longer-term implications related to the teaching and measurement of the changing construct of 'a profession' and of professionalism across healthcare, which are likely to play a key part in the future assessment of a healthcare professional's right to practice in the UK, consequent to the intense current interest of regulatory bodies to this area due to public pressures.

7.2.1 The changing construct of 'a profession'

While the trait theorists are now considered outdated, there must still be considered some merit in identifying the characteristics evident in the contemporary professions as postulated by Murphy (1990), in order to sustain the practice of identifying the elements that continue to differentiate them from other occupational groups. The profession of a strong sense of altruism in the study group is noteworthy, maintaining this as a traditional defining feature of the professions (Parsons 1951). The claims of strong vocational and altruistic tendencies in the healthcare professions might however be viewed in two lights. It might be regarded as part of the language and tradition of a highly socialised group who wish to preserve their status and elite position in society through a self-interested public confession of dedication to the common good and the service of others, with an element of political manipulation in appearing to take the side of patients and society in arguments with government. A contrary interpretation would be that this is indeed a true expression of values, and that a substantial number of health professionals do still experience the 'something within you' vocational calling to help others, which had moved them to enter these professions initially. The reality may be somewhere between the two, and such a black and white interpretation is clearly far too simplistic when this element of professionalism cannot be viewed in isolation from the complex range of elements contributing to the social construct, related to the expectations of status and reward which are clearly still prevalent in the balance of interests for any individual.

This strongly expressed altruistic element might be expected to change in response to general societal pressures and trends and to vary across different age groups, making it all the more difficult to determine with any accuracy its contribution to the whole. While there are reports that new recruits to nursing in particular may be less dedicated in their caring role given the increased academic component in their training to degree standard, this may infact be due to other factors which have reduced morale generally in the NHS[90], and this does not necessarily preclude the existence of a group of committed and highly educated practitioners who espouse the more traditional values of the professions as well as embracing the newer model features. Heed must however be taken of warnings not to generalise across the professions (Prest, 1987a; Siegrist 1990), and perhaps this should be extended to individuals within a profession: individual professionals have been shown to exhibit a wide range of distinctive

[90] It is reported that less than half of nurses would recommend nursing as a career in a survey commissioned by the Royal College of Nursing in 2007, with morale at a 10 year low and 28% saying they would leave their job if they could (RCN 2007).

characteristics, and this diversity within a profession may well be a key strength that allows a profession to adapt successfully.

As Dent and Whitehead (2003) suggested, the social and cultural assumptions associated with the term 'professional' are now subject to question and may well prove to be a loss in terms of the anchor status that the professions once held in society. The dental profession had until 2006 largely escaped the managerialism and 'culture of performativity' of the NHS, and its subsequent response to the imposition of measurement and bureaucratic control has been to engage in "new identity formation" (Dent and Whitehead 2003) in which the profession is perceived not only as a healthcare provider but as the provider of further privately-funded services judged to be of value in society. Continuing Dent and Whitehead's argument through, the identification of an individual within this new professional identity is closely allied to the newly established discourse that signifies 'what a dentist is' in contemporary society. Thus the individual must take up and be inculcated by discourses which are relevant to the present, and this has clear implications for professionals of different age groups who's own construct of a 'professional' may not match that of contemporary society. Views of other professionals within the community may also be at variance with their own perceptions.

The construct of 'a professional' to the younger participants in the study is based on an information set and experiences which differ from those of an older practitioner, and though their elders considered them to be more commercially minded, this was not borne out in the sample group, although the differences in training and expectations between the older and younger groups were evident. It might be argued that perhaps the practitioners with more of a commercial view were less likely to have volunteered to be part of this study. The modern construct of 'a profession' is no less powerful in the eyes of these younger practitioners but it is different, and cannot be matched with the construct of 20 or 30 years before which appears to be still prevalent in the minds of many of the older practitioners. It seems likely that each is striving to meet their own expectations of what they perceive to be ' a professional', and to find a client group in which their identity as a professional can be mutually verified. This is an area that would warrant further study in dentistry where the professionals uniquely have such a high degree of freedom in choosing how to undertake their professional practice and select their preferred client group.

This identifies the importance for a profession to ensure that the current construct be effectively communicated internally across its membership, in order for it to reinforce

the social construct and to act effectively as a unified body which can retain its power and status in society. As Dent and Whitehead (2003) observe, to construct and retain identity the individuals must engage in dominant truths about how a professional should be, although these truths are not fixed and are subject to influence and change. It would then follow that for a profession to maintain its status and position of power and authority it must continue to reflect the current body of knowledge that allows its subject position to be distinguishable, visible, and thereby reified in contemporary society. Failure to adapt and interact with 'the other', which in this case is contemporary society outside of the profession, will inevitably lead to loss of professional status and identity. In this respect the dental profession appears to be in the process of successfully transforming itself in accordance with the changing demands of society, perhaps because of their close interaction with the public in their day-to-day practice, affording the opportunity to continually interact closely with society and maintain an up-to-date perspective through the very nature of their work. It is thus important that the leaders in the profession maintain their closeness to society if they are to effectively understand and represent the profession in its current contemporary form.

It is assumed through this argument that power and status will remain a defining element of the professions in the future and that they will continue to value and defend these elements in order to preserve their standing in society. The successful teaching of professionalism will depend upon the successful interpretation of the dynamic evolving construct of 'a professional', and indeed may shape it to some considerable degree. Thus traditional ideas of full-time commitment (Olesen and Whittaker 1970) and dedication to the profession outside of the workplace (Harries-Jenkins 1970; Johnson 1972; RCP 2005) have already altered, as have codes of dress and behaviour, in tune with changing societal trends. Previously unwritten codes which existed only as implicit understandings between those within the community have now become more explicit codes of conduct, published in response to the demand for increased public accountability and regulation. This is perhaps another reflection of the increased bureaucratisation and rationality of Weber, and of stronger societal control. It need not necessarily be viewed as a weakening of the profession, but as strengthening its position as a trusted establishment in society. Indeed many in the dental profession welcomed this increased transparency and explicit accountability, which gives the profession a chance to prove its high standards and to dissociate itself from the rogues in other professions.

The impact of the changed construct of 'a professional' has undoubtedly had an impact on individual identity in a profession such as dentistry where the vast majority of

members are still free-standing independent professionals. This independence contradicts the trends outlined by Burrage (1990), Ackroyd (1996) and others of the increased bureaucratisation of the professions in the 20th century by their increased employment in large organizations in both the private and public sectors. In this respect then dentistry is certainly different, although it may recently have been placed in a position where this bureaucratised control seemed unavoidable, had it not been for the demand for its services outside of the state-funded system and its rapid adaptability to a new set of rules in the market. This again sets them apart from the majority of healthcare professions in the UK at the present time who are closely tied to the NHS and have little scope for practice outside of the systems dictated by government. The exit of practitioners from the state funded system clearly exposes them to higher personal risk and vulnerability in terms of the economic downturn, and of future policy decisions which might alter their legal status as sole providers of dental services, risks which they were prepared to take on as individual practitioners.

In addition to its continued legal monopoly status, a further strength of the dental profession lies in its high degree of specialisation and close links with developing technology. Much of this technology resides in the field of materials rather than in expensive technical equipment, and whereas medics were seen to be dependent on large scale organisations to provide their expensive technology (Murphy 1990), this has not been the case in dentistry where equipment and materials to carry out up-to-date techniques are affordable in independent practice. This again has endorsed the freedoms enjoyed, it would seem almost exclusively, by the dental profession. The technological advances have also in many cases generated the increased demand for services, in terms of cosmetic procedures which have become established as the norm in our modern society, and the demand for which does not appear to have declined in the short-term despite the economic downturn (Brook 2009: personal communication)[91].

The application of theoretical knowledge is thus securely safeguarded in dentistry by virtue of the difficulty in learning and executing the highly skilled procedures required to deliver its practice, as well as tight legal restrictions on practice. It is also the case that it is virtually impossible to carry out dental procedures without the necessary equipment, requiring a considerable initial outlay of capital, in contrast to many other healthcare services and practices which can be carried out with the minimum of technical equipment. The legal changes in dentistry to date have also safeguarded the

[91] It is perceived that disposable income which might previously have been spent on holidays is now being spent on self and home.

diagnostic role of the dentist, deemed of paramount importance by Abbott (1988), while allowing routine and mundane tasks to be devolved. This increased opportunity for specialisation should not be confused with proletarianisation (Murphy 1990) and will be discussed further in Section 7.6 in terms of its relation to allegations of de-professionalisation.

In dentistry, the threat from other professional groups in taking over the field of practice appears minimal, though vulnerable to further changes in legislation. There can be no doubt that the involvement of the professionals themselves in the associated decision-making and policy development has been of paramount importance in maintaining their power and status in this respect. The DCPs are not educated to the same high levels as the dentists themselves, and are thus incapable of the holistic overview and practical application of theoretical knowledge that is deemed to be required of a true professional (Burrage 1990). The title 'professional' has thus been bestowed by government upon these newly established groups (who were previously referred to as auxiliaries, assistants, therapists and technicians), despite their lack of higher education and credentials, in much the same way as the title of 'Consultant' has been bestowed upon nurses and AHPs who, while being university educated to degree level, have not undergone the higher accredited training required by the professionally-based Royal Colleges for a medical or dental professional to assume the same prestigious title.

The legal profession has undergone some considerable change in respect to the delegation of areas of its work to practitioners in specific fields who may not practice as members of the profession, but in areas of social services. Law however remains a more intellectual area of practice and an holistic overview and high degree of learning remain key to its practice. Medicine, providing a more practically based service, has undoubtedly been destabilised by the establishment of the new AHP and nursing professions, all of which are educated to degree level, with their own professional bodies, registration and regulation. This may well reflect Abbott's (1988) view of a system of interdependent professions that develop in accordance with their own internal structures but in relation to one another. This current change in healthcare thus reflects the negotiated changes in relations and fields of practice between these traditional and newly established professions, albeit as a result of imposed external government policy, and may enable them to shift their boundaries accordingly to re-establish their own fields of practice, as postulated by Fournier (2000). This would appear to give the medical profession the opportunity to specialise and delegate if its members are allowed the freedom to do so.

The generation of new knowledge has been regarded as a hallmark of the traditional professions, and this is an area where the construct may have altered, given the need for funding of more elaborate research in areas pertaining to medicine in particular. The rationalisation of evidence-based decision-making in clinical practice, although not widely extended to management decision-making, has had a clear impact on the delivery and development of healthcare services, not least in rationing and defining the services to be provided. While the academic strongholds continue to generate new knowledge and techniques in all the healthcare professions, they are restricted by the funding available and increasingly new scientific interests, including drugs and materials, are being developed through commercially funded research, heavily influencing the direction of future developments in their own field. Again, the more intellectual professions such as the law and clergy still retain their academic base in the universities, perhaps heavily directed by state funding of research monies. However in the technological and science-based professions such as dentistry much research is now carried out in clinical practice, which is perceived by the profession to be its cutting edge. This would appear to retain control of the developments more closely within the profession which continues to generate much of its own new knowledge internally (Abbot 1988), thereby theoretically retaining more control of its own future path of development, albeit with a bias from private funding.

Recruitment into the professions in the UK is still heavily guarded by the universities, who are state controlled but must now act with commercial interests to generate sufficient incomes and remain viable. This study supports the findings of Brand et al (1996), Kulich et al (1998), and Crossley and Mubarik (2002), that a certain type of self-selected individual applies for a degree course such as dentistry, based on a high degree of independence, an altruistic leaning, a desire to carry out work of a highly technical but practical nature, and the expectation of status and reward all appear to remain relevant. The fears expressed within the profession regarding the inappropriate means by which recruits have been assessed purely on academic grounds demonstrate how this concern has led to a change in recruitment strategies in the new dental schools to include an evaluation of personal values. The inclusion of an assessment of professionalism in the revalidation requirements for dentists indicates that the importance of these more traditional values (or the public demonstration of these values) is perhaps once again increasing. This may be in direct conflict with the universities' organisational goals whose recruitment strategies may be aimed towards meeting targets and quotas, for example in terms of income, diversity and academic achievement.

It is notable that the increased development of postgraduate qualifications in the healthcare professions in the UK has largely been kept within the professions in the Royal Colleges through a series of diplomas, memberships and fellowships, continuing the strong tradition of professions in the UK to stand outside of direct control of the state and the universities (Burrage 1990). Only relatively recently have the universities entered this market, having recognised its financial worth. These additional postgraduate qualifications have raised the potential for the development of increasingly hierarchical structures within the healthcare professions, which may not necessarily be related to career progress or remuneration, for example in general practice. Increasing opportunities for specialisation may reflect circumstances of increased fragmentation as outlined by Johnson (1972) and others, and in dentistry this may well become evident through the commercial interests which some independent specialty practitioners will choose to serve, producing structural change within the profession as some members are able to more fully detach themselves from the state funded systems, changing its internal dynamics still further. The trend towards the capitalisation of mental labour and human services, in which small scale profitable practices are swallowed up by private and public bureaucracies (Murphy 1990) as is being seen with the growth of the corporates in dentistry, may then be halted, as privately funded professionals retain their independence to determine the future direction of their practices. The critical issue for a profession in this respect will thus be the proportion of its practitioners that are able to retain their independence from state control.

7.2.2 The role of the individual

Having established that the social construct of 'a profession' is a dynamic phenomena, the impact of the changing construct on the individual members of a profession can be considered, although it may be difficult to differentiate between the degree to which the profession influences the construct, and vice versa. Public expectations in terms of accountability, trust and respect have impacted greatly on the established professions in the last 20 years, and the present study demonstrates that their reactions have been tempered by their degree of state control and the scale of public interest in their services. Thus in medicine where there is high state control of professionals and the public interest is high due to the potentially severe personal consequences of malpractice, then tight regulation and increased bureaucratic scrutiny has been implemented. In dentistry and law where the professionals are less tightly bound by state control and where the public interest is not so engaged[92] then regulation has

[92] The majority of cases of unprofessional conduct in law and dentistry have far less serious consequences than in medicine, often being fraudulent in nature rather than of direct danger to a client.

been much less rigorous and less intrusive in everyday practice. However, the present study demonstrates that new schemes of service delivery have in some cases markedly changed the relation between a professional and their client, especially in terms of the longevity of the professional relationships which might be established, and this is presumed to have an impact on the identity of the professional in terms of the 'self' constructed as a consequence of social interaction.

The work of Stryker and Burke (2000) has shown the intimate link between the process of self-verification and the construction of identity through social structures. The adoption of a new identity in the group studied appears to have been driven by both internal and external factors, as described by Dent and Whitehead, (2003). As already argued, implicit in the need to conform to newly established institutional norms is the need to adequately share within the professional community the perception of the new identity, in order to strengthen the collective identity, reinforce the construct, and avoid the emotional response of a mismatch between role and expectations described by Stryker and Burke (2000). Burke would argue that behaviour is directed towards altering the current situation to bring self-relevant meanings into agreement with the identity standard in a process of self-verification, in order to match meanings in the standard with meanings in the situation. The difficulty of matching the meanings of a standard which is rapidly changing are evident, and in the present study there appears to be a minor degree of mismatch between the perceptions of the leaders and policymakers[93] and the frontline GDPs, in terms of the identity standard. If the public perception of this particular profession is based on media coverage initiated by the leaders and policymakers, and it does not match with the identity standard held by the practitioner who they visit for their treatment, then Stryker and Burke (2000) would predict a negative emotional response of stress and conflict and reduced commitment to that identity on the part of the professional. This failure to confirm one's self is also likely to trigger sensemaking and further attempts at redefinition of identity (Weick 1976).

The use of symbols, jargon and titles which formed a traditional role in the negotiation of professional identity has reduced considerably, and the demarcation between professionals and non-professionals becomes more difficult to determine, such as the loss of white coats for hospital doctors, decreased use of formal titles, and the decreased use of jargon and technical language to enable clients to engage in decision-making. Identity is dependent on interaction and the identity of others, and

[93] 40% of Group A were no longer practising in general dental practice.

how they respond to identity claims (Weick 1976; Stryker and Burke 2000), and it would thus follow that in a professional sense an individual needs to find a client group that 'works' for them, where identities are mutually verified, leading to increased commitment to that identity and the increased likelihood of the individual being accorded status, respect and esteem (Stryker and Burke 2000). This in turn would lead to self-verification and the increased likelihood of according status, respect and esteem to those who assist in self-verification. In terms of relations with clients, the behaviour of the dental professionals studied appears to have moved them towards a situation where they have established a client group with which they can establish such relationships of mutual benefit, and perhaps the more entrepreneurial are more able to accomplish this transition to a new identity standard. Of those who expressed negative emotions about their professional life (Stryker and Burke 2000), it is likely that these have arisen through clinging to traditional identity standards which are not mutually verified by the contemporary client group or contractor. Most notably the unhappiest dentist interviewed was in the most restrictive contractual relationship with a PCT which allowed virtually no leeway to effect any change to the client relationship. This created a severe mismatch between self-relevant meanings and the identity standard, resulting in failure to meet self-generated ideal standards and with no scope to alter the situation in order to bring perceived self-relevant meanings into agreement with those held in the identity standard. Increasing organisational and societal control will undoubtedly impact upon this situation for professionals.

There is thus pressure on professionals to adapt to new identity standards, to conform to role expectations and conceptualised identities developed both within the professional group and by client groups in society. The idea of increased commitment to an identity through increasing connectedness in that role (Stryker and Burke 2000) has implications in both these areas. Firstly, there is an important need to ensure that members of a profession remain connected as a professional group to increase salience of the professional identity, and this seems more likely to present a challenge in an open networked structure such as the dental profession, where professionals are free-standing self-employed practitioners, rather than if they were organised in a hierarchical bureaucracy. Secondly, there is a need to ensure that professional/client relationships can be established in such a way that mutual verification of identity can be effected. This requires longer-term relationships to be established between practitioner and client (or patient) through which social role identities can be verified and modified.

Where this is not possible through contracted delivery of services in which only short term relationships are possible, it is likely that there will be a reversion to default collective level identities based on stereotypes relating to social categories and group membership (Sluss and Ashforth 2007) with an increased chance of failure of self- and mutual verification of the identity. If salience and commitment are related to inter-connectedness with others both within and outwith the profession, then it is likely that poor connectivity with the client group may require a compensatory increase in connectivity within the professional community to ensure individual commitment to the professional identity. It was clear from a number of responses that the professionals valued highly the personal service element of their work in terms of satisfaction and reward, and this may be related to the mutual verification of identity. However, the reduced distance between client and practitioner alters the basis of trust to a more personal level, despite the inherent societal controls which are now based on distrust and conformity. The inherent assumption that all professionals are unworthy to practice until they can prove otherwise, which underlies the recent introduction of revalidation, inevitably alters the role identity and social construct. 'Guilty until proven innocent' is the way in which society now chooses to regard the professions.

It might be assumed that a slightly different type of individual might now be attracted to a career in dentistry, drawn to the independence and high levels of practical skill, as well as the opportunity to exercise entrepreneurial and commercial skills in developing a career. Contrary to Ackroyd's (1996) observation that 19th century professions were in competition with the entrepreneurial class, the dental profession now seems to afford extensive opportunity for entrepreneurial and innovative thinking, due to its independence from state funded systems, close alliance with technological advances and high demand for its services, in agreement with Dent and Whitehead's (2003) view of a new professional model and Hanlon's view of the success of the 'commercialised professions' (Hanlon 1998). This might be expected to influence recruitment patterns in the future and may need to be incorporated into recruitment strategies for the profession in order to preserve an appropriate mix of altruistic and innovative tendencies. As the findings demonstrate, this is a profession which encompasses a diverse range of practitioners and its survival and adaptability are likely to be closely related to this diversity. Whether strategies are under state-control or under the control of the profession may have a large bearing on the future character of the profession. Its entrepreneurial nature can only be fully realised in a climate of relative freedom to effect change, an area in which the medical profession appears to have experienced much greater restriction of its innovative and entrepreneurial thinking under the tight constraints of state managed and funded systems.

7.2.3 The role of the professional bodies

Stryker's work has endorsed the need for connectedness in a professional community and the need for social structures through which identity can be constructed and verified (Stryker and Burke 2000) and it would be natural to assume that one of the main roles of the professional bodies is to provide this interconnectedness within the profession and to negotiate its newly evolving identity in the wider social context. However, it was evident in the study group that membership of the profession, and thereby its rights to status and professional autonomy, was deemed to be granted solely through registration and not through belonging or subscribing to any other professional body. Thus Carr-Saunders and Wilson's (1933) strong advocacy of the need for a formal association is perhaps partly met through registration with the GDC, but the need for membership of a professional organisation or association representing the needs of the profession itself is not supported, though it is perhaps the existence of the group that is important rather than membership of it.

The barriers to achieving registration are maintained through high levels of credentialism and the subsequent further challenge of maintaining registration through CPD requirements and imminent revalidation. These were held by the majority to be appropriate measures in the current social context, even though they had been externally imposed, and a degree of policing and governance was welcomed in order to prove that the vast majority in the profession upheld high personal and professional standards. However, resistance to externally imposed change and suspicion of inappropriate externally enforced scrutiny was evident, with dissatisfaction when external interests, in terms of government policy and corporate organisational goals, did not concur with those of the profession.

The intolerance of poor standards was centred on the belief of the existence of a shared value system which all within the profession should subscribe to, and a wish to eliminate those who might bring the profession into disrepute. Thus, even amongst a community of fiercely independent practitioners who do not have one single professional body to which they all subscribe, there was a surprisingly strong collective sense of shared values and of belonging to a professional community which bestowed much more status and power than a unconnected network of independent practitioners (Goode 1969; Freidson 1986).

There appeared to be a clear understanding and some regret that the regulatory body (the GDC) was no longer part of the profession, it having previously been identified as

one of the bastions of the professional institution and a public representation of the profession's right to self-regulation. Representation of interests within the professional associations appeared to be important to the professionals concerned, but, as already noted, surprisingly little attention was directed towards leadership of the profession *per se*. This was in complete contrast to the medics who had raised this concern to such a level that national roadshows and presentations had been arranged to engage the profession on this subject. It might be inferred that perhaps because medics are more institutionalised and thus more subject to state intervention, they have a tendency to behave more defensively as a collective and to rely on formalised structures and authority figures. Freestanding professions (Ackroyd 1996) such as dentistry, with virtually no hierarchical structure, may place a different importance on networked ties to their profession in terms of 'belonging', and may think more in terms of their own corner of the world and the opportunities afforded to them as individuals, rather than from the perspective of the profession as a whole. This may place them in a better position for their continued development in the post-bureaucratic world of flexible networked organizations, where interaction and personal connection assume increased importance through the interaction of interpersonal role relationships. In support of a symbolic interactionalist approach, this relies on the agency of individuals, rather than organisationally defined roles, for the social construction and enactment of roles (Sluss and Ashforth 2007). The majority of dental professionals in the study group appear to have successfully met the challenge to re-establish their identities (Barry et al 2003) during the study period. Their new identities, either as a free-standing private practitioner, a closely controlled NHS contractor, or a mixture of the two, appear to have been successfully self- and mutually- verified with their chosen client groups.

The diversity already noted in dentistry was reflected in the range of professional bodies, many of which had adapted and changed to adopt new contemporary roles, not least the Royal Colleges who have in part maintained their strength through the determination and examination of postgraduate qualifications in the professions. This is mirrored across healthcare where the Royal Colleges have undergone transition to a more educational role which safeguards to some degree the shared body of 'recipe' knowledge (Berger and Luckman 1967) within the professional institutional domain, to ensure that the actors within the collectivity continue to generate and transmit their objectified stock of common knowledge to successive generations. The incorporation of generalists as well as specialists into the Royal College faculties undoubtedly strengthens the role of this institution within the profession.

The unity and consequent strength in the dental profession appeared to arise however from a universal distrust of government, and it might be postulated that this antagonism and potential threat to the power and control structures of a profession is the element that stimulates it (on a collective and individual basis) to constantly formulate new strategies to defend and extend the boundaries of practice described by Abbott (1988), Fournier (2000) and others. Ackroyd's (1996) belief that professional organisation is a persistent phenomenon by virtue of its ability to adapt and its evolutionary capacity to change its character will in turn be related to the speed of its response and the diversity of its resources, directly influencing its survival. Here the smaller professions may be able to respond more rapidly but do not have the breadth of resources to call upon to ensure their continued power and status. Conversely a large profession such as medicine may have a wide range of resources at its disposal but lack the co-ordination or cohesive approach required to respond to the challenge quickly enough. The main concern of the dental profession appears to be in maintaining power only within the profession, and perhaps over government in the determination of future policy. It's strongest collective desire appears however to be the retention of control over its day-to-day working and clinical practice.

Low levels of hierarchy in a profession inevitably allow more potential flexibility in its form, and this networked form appears to strengthen collegiality, more so than in those working in formalised structures of organizations, even where those structures have been reorganised around the expert groups such as in medicine, as described by Ackroyd (1996). As already noted, the recognition of this networked form arising from a disparate group of practitioners brings into question the role of leadership in such a collegiate group. The difference between the rhetoric of the leaders and the perspective of the frontline workers was surprisingly minimal in the study group, with an underlying unity expressly aimed at wanting the best for the profession and its patients. While the frontline workers felt that the leaders and policymakers were in some respects out of touch with reality, the differences appeared to lie in concepts of the profession, arising both from personal differences of opinion as well as some leaders being distanced from the social reality of frontline work. There was however a marked difference in the frontline workers' attitude towards the leaders and policy makers within the profession, as opposed to the government appointed Chief Dental Officer, which was regarded purely as a government role and no longer of the profession itself. This seems to imply that it is possible for members of a profession to be ostracised by the profession by virtue of their external alliances. A degree of nostalgia and regret was attached to this observation by many, as the CDO position appeared to have been previously regarded as the leadership and figurehead role within the profession.

Leadership within professional groups appears to be complicated by collegial relations and high levels of individual autonomy, as well as the independence and diversity of the study group in this particular case, and appears to be an under-researched area which might warrant further useful study.

As predicted by Johnson (1972), in times of low power and control by professionals and high levels of localisation and mediation there would be strong trade union type of activity by the professional bodies, and this is borne out by the perceived militant stance of the BDA especially in terms of its 'battles' with government and strategic positioning in negotiations reported by participants. There was no consensus on whether it was appropriate for a profession to engage in behaviour befitting a trade union, and this appeared to rest with individual personal judgement.

The increasing proportion of women in the dental profession reflects the situation in medicine and law, with over 50% female recruitment at undergraduate level. While it might be assumed that this will in some way undermine the profession's status as has been observed in other professions (Miller et al 2002), the present opportunities for individuals in the dental profession to determine their own means of practice and client base mean that it does not conform to the 'organisational' context of genderisation previously reported, and in such a networked form based on human interaction and personal skills, women may actually thrive. It is possible to be a highly successful dental professional and retain the role of frontline carer, meeting the needs of women who are motivated through relational competencies (Maier 1999; Perrott 2002). Women leaders acknowledged that they had to behave more like men to succeed in their roles, and that many women would not want to take on the extra work of being involved in dental politics. This area again merits further consideration in future research studies.

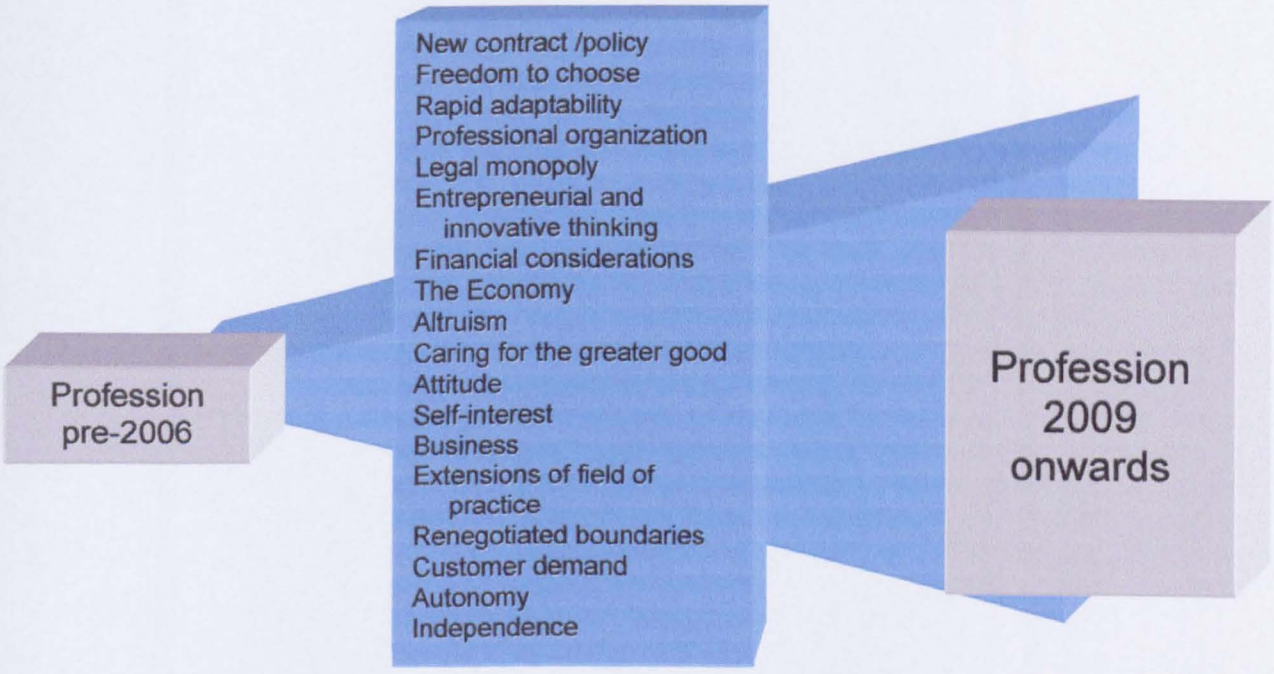
7.2.4 The professionalisation process

The professionalisation process is no longer regarded as linear in nature (Prest 1987a; Murphy 1990; Ackroyd 1996) and is certainly contextually unique (Freidson 1986; Burrage 1990). While we would not choose to compare between professions the actual stages in the process as proscribed so discretely by Willensky (1964), we can still usefully compare behaviours of a profession in response to change, which might indicate the degree of influence by individuals and different personalities in various roles within the profession. Aside of the debate as to the exact nature of professionalisation and its end point (Siegrist 1990), in the present study a wide range of factors appear to have influenced the recent course of the developmental process of the profession under study (see Figure 7.2). Many of these are inherited from the

tradition of the professions, such as legal monopoly, altruism, autonomy and freedom from control. Others have arisen through unique contextual circumstances, from which the profession has emerged, surprising even itself, in a position of apparent strength.

As already intimated, the dental profession at this time does not fit neatly into a conventional typology previously outlined in the literature. It is not one of the three traditional professions.. Nor did it arise as a new model profession in close association with an established organisational structure in the 20th century (Ackroyd 1996). The healthcare professions may now represent a dominant form of the social construct of a profession in our current society, but again dentistry does not fit into any of the existing typologies – it is unique and has developed through a set of contextually exclusive circumstances to its present form. This endorses the need for all professions to be considered in their own right, for while they share some characteristics and features of development, the differences between them will allow the continued survival and success of some and not others.

Figure 7.2 Factors contributing to the transformation of the dental profession



Dentistry has been allowed to effectively utilise and embrace the elements shown in Figure 7.2 and to largely incorporate the appropriate mix of new characteristics into its newly negotiated identity which has been successfully conveyed to society and incorporated into the contemporary social construct. The limitations to this process appear to have arisen in the counter-messaging from government which has raised

public expectations to an unachievable and/or unsustainable level, resulting in conflict between the role expectations of patients and the identity standard of the practitioner.

Government policy has allowed the dental profession to react differently from other healthcare professions by granting it the freedom to chose its contracting arrangements, allowing the mixing of private and state funded services, while technology and increased demand for services have afforded these professionals a realistic option to leave the state funded system either partly or entirely (Dancer and Taylor 2007). The importance of the funding system in terms of the contracting relationships of the professionals concerned, and the power balances in these relationships (Johnson 1972), remains key to the reactions of the profession when challenged by government policy. The differences in the response of this particular profession appear to lie with the balance of interests which are experienced by an independent, as opposed to an employed, professional.

Figure 7.3 Balance of interests for dental professionals

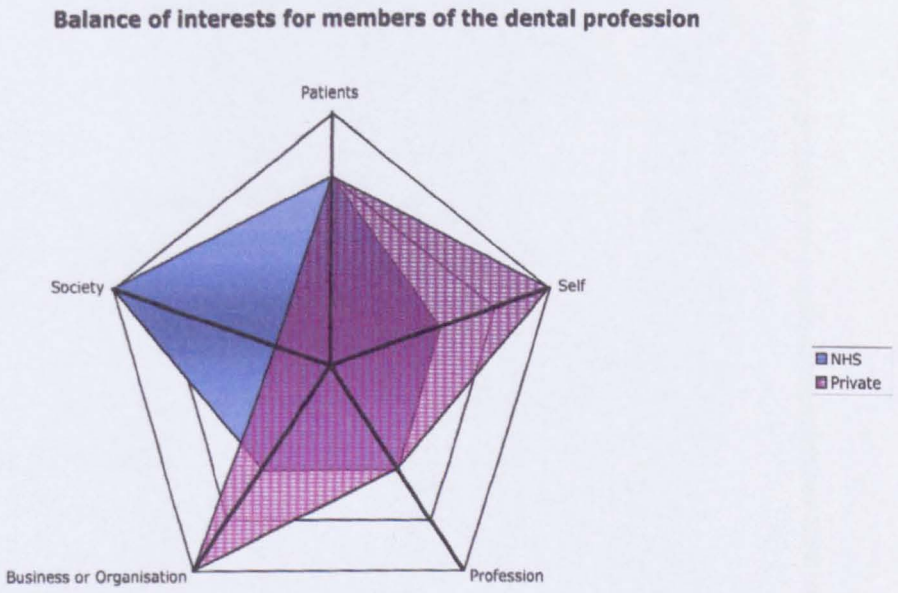


Figure 7.3 thus represents the balance of interests which might be considered in an individual professional's response to challenge in varying circumstances of employment and dependence on the state. No attempt is made at exact quantification in this figure which is representative only, although further work in this field might address this aim more specifically. The example given might indicate the relative importance of the business (including staff) and self-interest (including health, happiness and life outside of work) to a private practitioner, while a state-funded

practitioner tied into a comparatively restrictive NHS contract might value stability and their contribution to society above their own self-interest. Both groups of practitioners argue their commitment to their patients in different respects, either through quality of care in the private sector, or access to services in the NHS, and these correspond to the polarising arguments encountered in current policy discussions. The importance of funding in this balance is intimately related to the retention of autonomy, and the desire to control one's future and safeguard those for which one has responsibility. In this respect for a professional, their established patient base might be viewed as an extended family, taking priority over the general population with the moral justification of looking after one's own and acting in their best interests. The interests of the profession as a whole will not include this range of personal elements, and thus the goals of individuals and the profession must necessarily differ. As already noted, this particular profession has a high interest in maintaining its independence and control within the profession, and this is strongly reflected in the individual responses to change.

The balance of interests between the individual and collective are partly influenced by a professional's unique reputational status and standing, in both society and the professional community, whether they are employed or freestanding. This is closely allied to membership of a community demonstrating high standards, in terms of establishing and retaining trust and status, especially in the face of public challenge to the authority and authenticity of their professional status (Dent and Whitehead 2003). Further regulation has been welcomed by the majority, who can see the opportunities it affords to enhance status, but considered by others to be an affront to their standing. Individual choices are also driven by the stability of funding streams, the balance of power and responsibility in the contracting relationships developed, and the individual need to retain control and autonomy in professional practice. Thus individual's decisions are influenced by the leaders and policymakers within the profession, who may advise in terms of the collective benefit to the profession, and who are also largely responsible for the shift in jurisdiction of the profession, affecting in turn other professionals surrounding the field of practice (Abbott 1988). It could be argued that DCPs do not constitute 'a profession' for the reasons discussed previously and so the dental profession itself, as the sole competent diagnostician and legal prescriber of treatment, has retained the right to exclusive practice in its field. At the same time the profession has also extended its field of practice through market forces which have allowed it to shift its boundaries rather than remove them (Fournier 2000), into areas presenting new possibilities, such as tooth whitening and other cosmetic enhancements.

The profession's strategy for retaining independence and reducing external controls is a clear resistance to the imposition of the rationalisation and bureaucracy, described by Siegrist (1990) as being inherent in the professionalisation process, and by Harrison and McDonald (2002) as being an essential element of the NPM project. Again by virtue of a unique historiographical and sociological context, dentistry has not been subsumed into the state-controlled workforce in the healthcare professions, and only in the most recent NHS contract of April 2006 has there been an attempt, albeit incomplete, to bring them under a system of formal rationalisation, in which the optimal treatment choices are based on rules and targets rather than on patient need. As argued by Harrison and MacDonald (2003) dentists themselves argue for the continuation of a substantive system based on social action and values, and their adherance to arguments pertaining to quality is based on the unquantifiable content of service, in conflict with the formal rational viewpoint of contracting PCTs. While professionals by nature have been regarded as having a low propensity to take risks, they appear to have demonstrated that when appropriately challenged or forced to take action, they are capable of transforming their profession in ways which have proved extremely beneficial on an individual as well as collective level with a degree of self-interest and manipulation of the circumstances to ensure their own survival (Ben-David 1963; Freidson 1986). There is clear evidence in the findings of the profession's ability to rise to a challenge and make the system work for them, even if it involves bending the rules (Economist Intelligence Unit 2009), which may in turn be related to behaviour which is directed towards altering the current situation to bring self-relevant meanings into agreement with the identity standard in a process of self-verification (Burke 1997). Routinisation is not a foreign concept in dentistry where much of the work is repetitive, and there is also evidence that the dental professionals have embraced the opportunities to improve their own work patterns (by incorporating the DCPs into their work schedule), improve their own work satisfaction, develop their own status in a leadership role, and extend their own fields of practice and specialise as a consequence.

Prest (1987a) described the differences in pace and direction of the changes observed in the professions as they undergo periods of growth and regression, and the dental profession appears to have both changed direction and pace in its recent rapid adaptation and development. Corfield (1995) stressed the importance of the demand for professional services as an essential element in the further growth and development of the professions, in addition to their established monopoly of practice (Larson 1977), and again the dental profession has successfully safeguarded its

monopoly status while enjoying a period of increased demand for its wider range of services. The lack of a predetermined project plan for this particular profession is reflected in the contrast between the current fieldwork and responses gained in studies carried out only a few years earlier in a similar sample group of frontline practitioners, at a time before policy had been made explicit and when uncertainty over the future was considerable. This demonstrated a predominance of negative emotion and dissatisfaction, and a pessimistic view of the profession's potential future (Dancer and Taylor 2007; Harris et al 2010) which was felt to be outside of the control of the professionals concerned.

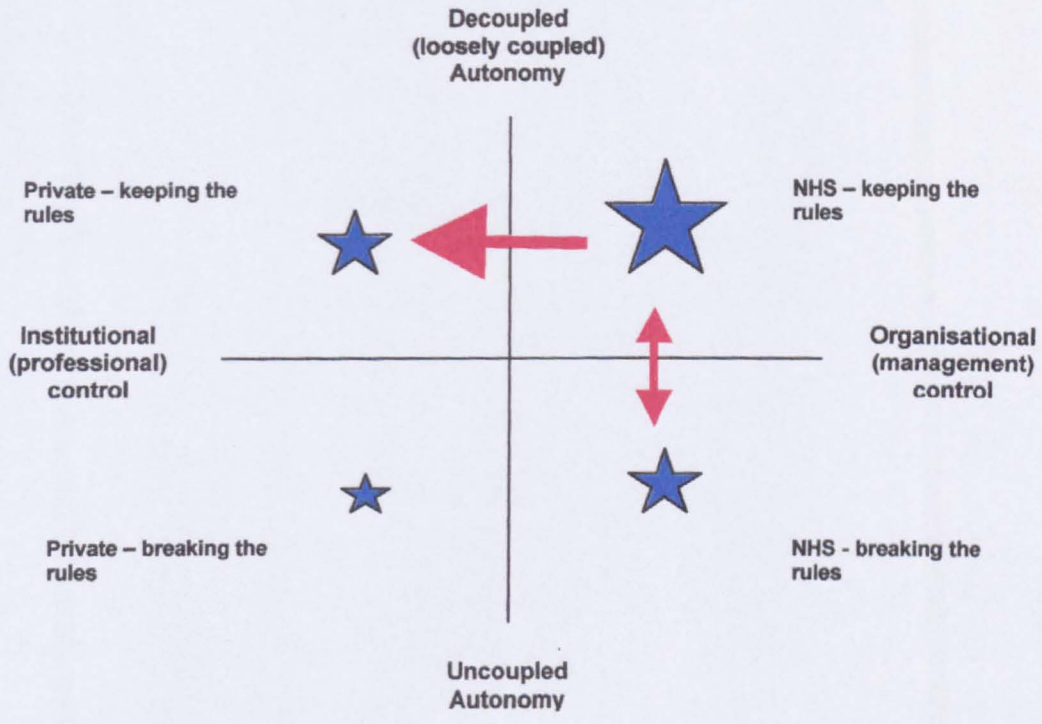
7.3 Autonomy, Power and Control

The dental profession thus appears to have maintained its position of autonomy and independence through responding to the opportunities presented, often reluctantly in the first instance, and fully exercising the considerable degree of freedom it enjoys to make choices with regards to its future direction. Beckman (1990) considered the degrees of freedom in work to be central to professionalisation. Mele (1995) equated autonomy with freedom, and it is the range of choices and freedoms in this profession which appears to allow entrepreneurial independent practitioners to co-exist with those who prefer to be bound to the state in tightly controlled contracting relationships. It could be assumed that not all professions would adapt and react in the same way, and this will in some part reflect the personality types of those recruited and their successful acculturation into the profession during training and subsequent development (Olesen and Whittaker 1970). Constraints in terms of government policy and additional forms of control from both clients and society have contributed to the increased regulation generally experienced in society across all sectors, linked to raised public awareness and expectations of transparency. The balance of control is also linked to a shortage of manpower, certainly experienced in the dental profession in the last 10 years, allowing the profession to increase its influence over policy and its tariffs, especially in light of the increasing demand for its services (BDA 2007b).

In the context of the model developed by Dent (2003) relating to autonomy and control of the professions, additional control now appears to be exercised strongly from a third dimension, through society. The scope of this model might thus be limited in the current context, although in Figure 7.4 an attempt is made to classify the current situation in dentistry through the model proposed by Dent (2003), arising from the introduction of the NHS dental contract in April 2006.

This figure reflects that the majority of dental services are provided by professionals through the state-funded system in the top right-hand quadrant of the diagram[94], with tight organisational control imposed through a closely monitored PCT contract, despite the practitioners retaining independence in other respects. However, it is documented and supported in this present study, that a number of professionals 'bend the rules' in order to make the system work in their own practice, although the majority of their work is carried out by the rules. They are thus represented as slipping into and out of the lower right-hand quadrant, with their own internal practice being subject to 'corruption' which may be related to the financial aspects of the practice (Fournier 2000) and potentially bringing the profession into a degree of disrepute (Lewis 2007)[95]. The general trend however is to move increasingly towards the private sector (Silvester et al 2000) where at present there are extremely few controls other than those imposed by the profession, with most professionals operating within the standards deemed appropriate by the profession (in the top left quadrant) and only a small number operating in a manner that would be considered disreputable or fraudulent (in the lower left quadrant). It could however be argued that in many respects 'autonomy' and 'being subject to control' can be viewed as opposites, and that the types of autonomy and control in opposing quadrants of this figure could be experienced concurrently.

Figure 7.4 The current balances of autonomy and control in the dental profession based on the model proposed by Dent (2003)



[94] While 50% of income in dentistry is now derived from privately funded work, more than 75% of treatments are carried out through NHS services.

[95] This behaviour may range from fraudulent claims, to a change of clinical practice either through carrying out different treatment, or not carrying out certain treatments, because the fees are deemed inadequate. It would be argued that truly professional practice should not change as a result of funding.

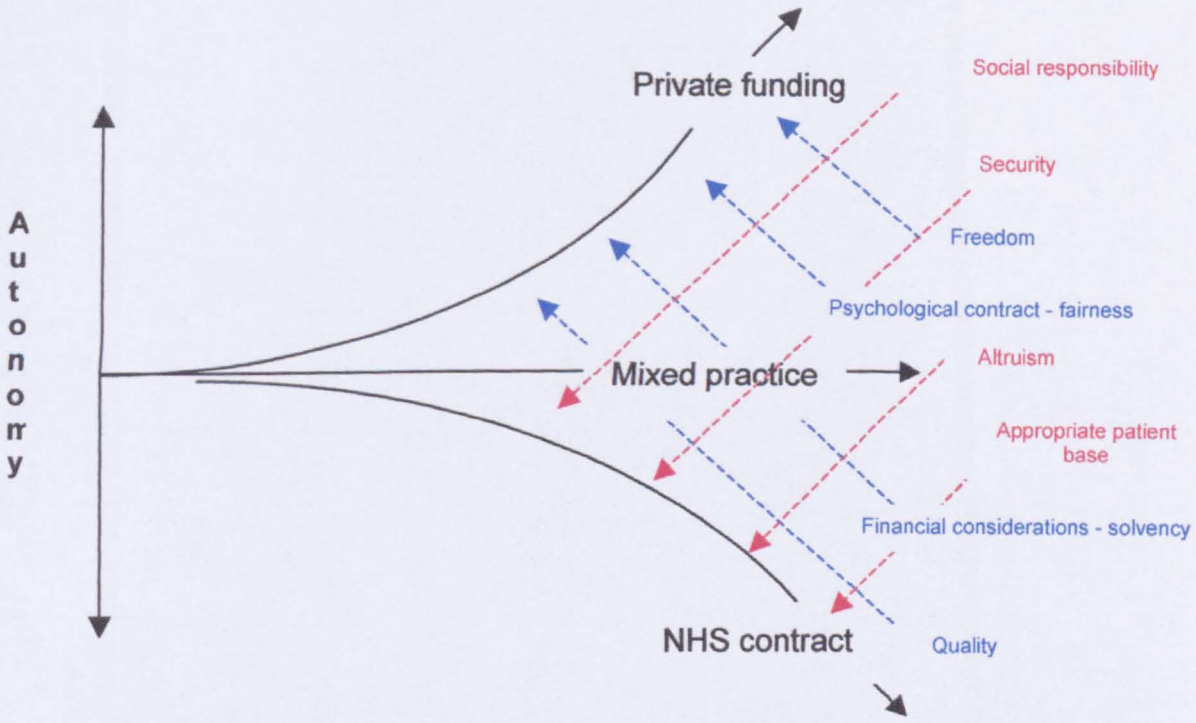
The dimension of 'societal regulation' is too important to be ignored in terms of the impact of legislation relating to health and safety, commercial and employment law, and a wide range of European laws which directly affect professional practice. Also included in this category would be the requirements for increased transparency and revalidation which have been demanded and developed by the public and regulatory bodies comprising lay members. In Figure 7.5 an attempt is thus made to represent the differences in the scope of influence of the three types of control outlined, namely professional, organisational and societal control, as experienced by a contemporary healthcare practitioner. While this figure is representative rather than quantitative in nature, it seeks to suggest that societal control is an increasingly important element in determining the behaviour of a professional, and that the degrees of professional and organisational control will vary significantly through the contracting relationships entered into, with increased organisational and societal control linked to state mediated contracts and working arrangements within corporate companies. It is notable that the GDC regulations are now regarded by those within the profession as an external form of control, and would thus be included as a form of societal control rather than as a professional control.

Figure 7.5 Control of healthcare professionals

Power is generally accepted as the ability to influence other people in terms of their thoughts, feelings and behaviours (Ash et al 2006) although Davies suggests that "it *produces* behaviour, including what many would deem desirable traits such as entrepreneurship" (Davies 2006:4, emphasis in the original). Abbott (1988) linked the power exercised by professionals with their ability to extend their jurisdiction and expand the cognitive domain of the professional field to annex new areas of work through the generation of abstract knowledge. The extent to which healthcare

professions outside of dentistry are able to act in this way is likely to be limited by virtue of their ties to the state and the legally defined boundaries of practice. Abbott also described autonomy in terms of the freedom to make career choices and saw that this was restricted by the proscriptive career choices in medicine, more recently under even tighter control and scrutiny through the PMetB reorganisation of training posts for newly qualified doctors. While the professions in the UK were differentiated from their continental counterparts by their early independence from the state (Siegrist 1990), that independence appears to have been extensively eroded in the last decade by their subsumation into the state funded delivery systems which now tightly control them. Once again in dentistry, however, the choice remains for professionals to determine at least to a degree their individual balance between control and autonomy, based on their desire to experience personally acceptable levels of security, freedom and satisfaction in their work environment as illustrated in Figure 7.6.

Figure 7.6 Factors influencing autonomy and contracting relationships in the professional practice of dentistry



At this point it would be pertinent to question the degree to which funding itself influences professional conduct, or whether the funding systems attract certain professionals who select their field of practice based on other constraints within the system, such as the balance of interests already discussed (Fig 7.4). This becomes particularly relevant when the funding system allows increased opportunities for

specialism within the professional field, and potential degradation (Abbott 1988) of other aspects of the professional's work. This might add to the status of the professional who can consequently act in a leadership role developing increased levels of abstract knowledge setting him above the layman, as has been observed in computer related industries, and it might be assumed that in turn this will attract a different type of recruit to the profession, attracted by the revised conditions and characteristics currently perceived to be related to the contemporary form of the construct.

The contracts which professionals enter into with authority explicitly contain a degree of rationing which cannot be bypassed in a state funded system and which are generally in conflict with professional ideals (Harrison and McDonald 2003). This problem has been circumvented in the dental profession by allowing practitioners the freedom to offer a wider range of alternative treatments outside of the state funded system. The autonomy of the profession has been challenged by the restrictive terms of the NHS contract in April 2006, but the profession was simultaneously offered an increased opportunity to bypass the state system and responded by setting up, in a relatively short space of time, a substantive privately funded system of treatment delivery, allowing it to re-establish its professional autonomy. In this case the 'rationing' could also be viewed as acting in the professional's self interest, where only the motivated fee-paying patients who place a value on their dental treatment will be retained in a privately funded system.

The rapid response of the profession to change almost certainly enabled its survival and formed the basis of the present profession, which has a much stronger and more independent footing than its previous form. Other forms of bureaucratisation such as clinical governance have had little impact in day-to-day independent practice where quality control has always in theory been practised as a professional requirement, and where there is little infrastructure in place for monitoring at a local level, other than by remote statistical analysis. Policing of the profession through the re-introduction of RDO monitoring of treatment standards by the DPB in 2009 (DPB September 2009: personal communication) is welcomed by the profession, as predicted in the findings, as a positive step towards public recognition of high quality care standards and increasing detection of poor performers and rogues.

Why then has the government allowed this rather uncharacteristic set of circumstances to develop for the dental profession in the UK while it has developed even tighter controls over other healthcare professions? While status and autonomy in the medical

profession are perceived to be under threat and diminishing (Dent and Radcliffe 2003), why are the dental professionals being allowed further freedom and independence? It has to be assumed that the dental profession is seen as little threat to government in terms of its power in society, or, conversely, as more useful to the government in retaining its independent position in society. Despite being a quarter of the size of the medical profession and enjoying essentially the same negotiating powers with government, it does not deal with life and death issues and it would be sensible to assume that it does not hold such a strong position in the public consciousness as does the medical profession. While its annual budget is considerable (£2,204 million in England in 2005/06, BDA 2007b), it is as little consequence to that of the remaining healthcare professions in the provision of services across primary and secondary care, and, from a budgeting perspective, an increased volume of privately funded care relieves pressure on remaining state-funded services.

Davies (2006) discussed the issues relating to New Labour policy since its adoption of the concept of 'community' in place of 'society' and its aspirations to redistribute power to neighbourhood levels through 'double devolution' (p.1), although this is severely hampered by the lack of a coherent definition of what exactly constitutes a 'community'. He related this to the concept of 'governmentality', which he defined as techniques of governance existing both within and outside the state apparatus (Davies 2006). Davies discusses Marquand's argument that individuals acting in the public interest do not do so in their own financial interest, or to help out friends and family, but according to values of citizenship, equity and service (Marquand 2004:27). Davies thus argues that the professions mediate between the state and the citizen in the systems of governmentality as "intermediary expert bodies with a strong sense of the public interest" (Davies 2006:2) and reports Marquand's view that "New Labour has systematically set about dismantling such 'intermediate institutions', through a centralised system of target setting and auditing" (ibid:3).

Both Davies (2006) and Reed (1996) have discussed the ironic relationship between professionals and the systems of organisational monitoring and audit which they have developed and contribute to, that appear to be now directly contributing to their own demise. In healthcare this certainly appears to hold true in at least some cases, as the development of the monitoring systems has been led by the clinicians in specialties who initially required data for research studies, and the clinicians themselves generally in healthcare are required to return data to the organisation regarding every patient they examine or treat, thereby acting as an 'accomplice' to "the intrusion of government power into the private and local lives of citizens" (Davies 2006:3) and potentially

contributing to their own demise. Davies thus regards institutionalized expertise as the conduit of governmentality. However Reed identified three types of professions and argued that it is the organisational professionals, comprising the managers and administrators, who have contributed to the bureaucratic controls systems which constitute an attack on the independent professions, who are being attacked on the other flank by the entrepreneurial knowledge workers (such as financial, R&D, and IT consultants) who have been afforded increased opportunity to exploit the potential for advancement and socio-political enhancement (Reed 1996). In this sense the healthcare professions are being attacked by the managers and administrators on the one hand, and the R&D/IT/financial consultants on the other. In reality in healthcare systems it may be difficult to distinguish between the two forces.

There has long been the suspicion within the dental profession, endorsed in this current study, that recent governments have intended to remove dentistry from its welfare budget by stealth (BDA 2007b), and it would be easy to formulate an argument that supported this view in light of the above discussion of funding issues. But is this the only issue influencing this decision with its wide-ranging long term implications? Is there another explanation of why the dental profession is being allowed to act in such an independent manner in re-establishing itself as one of the few viable free-standing professions? A closer examination of the relationships inherent in this situation may expose some of its vulnerabilities and weaknesses in spite of its current apparent strengths.

7.4 Professional Relationships

As shown in Chapter 2 relating to the history of the professions, the professions were historically independent and partly or entirely self governing in the UK, through negotiated arrangements of self-regulation conferring a high degree of autonomy to the professionals and separating them from direct state control. The rise of the new professions during the 20th century was characteristically associated with their development within established organised structures, in which strategically powerful enclaves of experts developed, distinct from the managerial groups (Ackroyd 1996) and these equate to the 'Organisational professions' described by Reed (1996). The legal profession appeared to follow this model of corporatisation during the 20th century, and to a high degree the inception of the NHS incorporated many doctors into the institutionalised structures of the hospital systems, with support from a framework of administrative staff who were succeeded, with the advent of the NPM in the public sector of the 1980s, by management and rationalisation.

General practitioners in medicine and dentistry have both enjoyed the freedom of acting as independent contractors to the NHS, and have essentially existed as sole traders and partnerships in small businesses, frequently owning the premises in which they practice and employing their own staff. The NHS contracting for dentists and doctors has however been markedly different in terms of the item of service element which has dominated the dental system of contracting, with volume under the direct control of the dental professional who worked essentially in a system which reflected the collegiate system described by Johnson (1972) in terms of its power and control systems, but in which the state funded part of the cost. The doctors however became more closely tied to a capitation contract with the NHS, with regular payment per head of population under their care, tying them to a patronage relationship with the state.

While the introduction of the quasi-market in healthcare in the 1990s exposed medical GPs to budget holding and business planning in their gatekeeper role, the dental profession was already well versed in business decisions and the system that Larson (1977) would refer to as 'the logic of the market'. The freedoms enjoyed as a freestanding contractor were offset against the uncertainty over future fees levels which were set by government, but the dentists were well-placed to adapt to a more consumer-led market place and to compete openly for business. In terms of Johnson's (1972) typology of professional relationships, the collegiate contracting relationship in dentistry appears to have outlasted that in many other of the professions, though not in an entirely pure form, and it displayed the characteristics of a profession which enjoyed high levels of power in its relations with its clients, especially given the shortage of supply from the 1980s onwards which gave additional power to the providers. The influence of the state however was heavily felt when they interfered in the balance through cutting fee levels in 1992 (BDA 2007b), and a number of practitioners chose to exit from the state funded system at that point (Silvester et al 2000) in order to maintain their power in a direct privately funded collegiate relationship with their clients.

Those dental professionals who stayed within the state funded system were virtually forbidden to carry out private work in any volume by the regulations then in place set by government, and were partially tied into a controlled capitation scheme attempting to introduce a patronage relationship with the state in which regular payments were forthcoming, supplemented by item of service payments for piece work. Under this system the professionals still enjoyed a high degree of autonomy, being allowed to dictate their own working arrangements and develop their practices without any hindrance from the state. The new NHS contracting system in April 2006 on the one hand completely tied NHS practitioners into a closely controlled and targeted system of

service delivery in return for regular monthly payments, while also allowing much greater freedom to carry out privately funded care in parallel. This brought the dental profession much closer to the position of the medical GPs in a mediated relationship, except that they had a realistic option to exit the state funded system, either partially or totally[96].

It appears that the professionals in this current study did not in many cases wish to make a choice for their future practice at this particular point in time, nor did they necessarily understand the full implications of their decision at the time, given the lack of concrete information relating to the new government contracts before they were actually implemented. It is clear however that through this process the state has increased its power and control over some practices and has lost control over others. The reasons given for opting out of the state funded system reflected the desire to retain autonomy and control over the businesses which they had established, and a distrust of the government and local PCT contractors based on past experience. This supports the findings of other studies covering this same period of time (Dancer and Taylor 2007; Harris et al 2008; Harris et al 2010). The younger practitioners understandably did not have any historical grievances but were still concerned regarding the control systems that would impact on their future investment, both in capital and labour, were they to enter general practice. There was also evidence of an element of tradition passed to the next generation with regards to the distrust of government and its conspiracy to get dentistry out of the NHS.

In this profession then we have seen a relative increase in state control to a firmly mediated arrangement by Johnson's (1972) typology of relationships, in which we would expect to see a confusion of the client and mediator, given the high levels of power attributed to the mediator in terms of dictating the range of services to be supplied. The discrepancy between the commissioned services dictated by managers and the actual need for treatment perceived by the professionals is a cause of conflict, and Morrell (2003), a former Chair of the BMA, felt it the professional duty of all practising medical professionals to stand up against poor policy and administratively

[96] This created a new set of possible funding relationships to this group of professionals:
a. to work entirely within the NHS state funded scheme, working to an annual target of activity and receiving monthly payments, while being restricted in the expansion and succession arrangement of the practice, which consequently had no value as a 'going concern', the goodwill in terms of the patient list now being owned by the PCT with whom the contract was held.
b. To mix NHS and private care with a reduced state funded contract value with the restrictions as in a above, and to then have the freedom to expand the practice, employ additional staff, specialise and dictate working arrangements.
c. to exit the state funded system and work entirely in a privately funded system in which the practice retained its value and the professional retains the power to control the development of the practice and working conditions.

flawed contracts. In effect, a number of dental professionals did just this in leaving the state funded system or in reducing their commitment to it.

The corporates which have entered the dental market place where demand cannot be met otherwise, as would be predicted by Abbott (1988), have seemingly taken on the role of a private patron, being perceived as controlling the professionals providing its services in dictating the type of treatment to be delivered, their working conditions and their remuneration (Freidson 1986). This appears to constitute the strongest type of technical control over the professional domain and is currently the area of most rapid growth in the profession[97]. The control exercised by a corporate is virtually equivalent to that of an employer, and the antithesis of the free-standing professional which characterised the profession previously. It is these corporates, exercising such high degrees of power, who's commercial values appear the most removed from those of the profession itself, and these are thus perceived as the greatest threat to the future of the profession in terms of undermining its core standards and values. Freidson (1986) highlighted this problem of conflicting ethical values in the 1980s, and cited it as the reason why US corporations were not allowed to engage in medicine and healthcare. It would seem however that funding and its power implications may once again influence the future of the profession, as powerful patronage arrangements and demanding private clients did in times past.

In this more consumerist age, the importance of developing additional skills to create and maintain a client base becomes all the more important, as client expectations become more demanding of the professional service and the longevity of client relationships become curtailed by the increased value placed on efficiency and timeliness, rather than personal service. This increase in demand for human skills and communication is seen across all professions, especially in health care, as the 'sovereign' privately funded customer dictates their terms of engagement with whomsoever they select to provide their care. Those who have entered the private market include those with a more entrepreneurial flare for seizing opportunities, as well as those for whom there was no viable future financially for their business in the state funded system. The vast majority appeared extremely pleased with the outcome of their decision, and although they felt forced to make the decision at the time, realised that it had allowed them to retain their autonomy and control over their practice as well as to improve their work/life balance and work satisfaction.

[97] This appears to have arisen as a direct consequence of the loss of the financial value of 'goodwill' in practices tied to NHS contracts, leaving corporates as the only willing buyer.

The reluctance to submit to the control of the PCTs had been evident in earlier work (Dancer and Taylor 2007), and arose from a distrust of government in terms of policy, as well as with lack of confidence in local commissioners with little or no previous experience of dental contracting. While many decisions over future practice were justified on the basis of 'doing what was best for patients' in terms of continuity of care and maintaining quality of standards, the self-interest to defend one's position as head of a business that was a lifetime's work was also acknowledged, and if the practice collapsed then no treatment could be provided at all. Dental professionals have not been used to the immediate impact of the public sector mindset which it experienced in their contracting relations with the PCTs. It could be anticipated that the strong informal relationships which Ackroyd (1996) observed in professionals in their employing organisations might also be reflected in the actions of a co-ordinated networked community of professionals, who in the main effectively freed themselves on an individual basis of unwanted ties to the state funded system, while at the collective level ensured their continued position of power in terms of the retention of their legal responsibility of diagnosis, and in carefully restricting the duties of the DCPs who could work with them, but not in place of them.

The observed response of a profession to change can be usefully framed through the four tenets that Fournier (2000) describes in relation to the boundary work of the professions. Firstly their boundaries with the lay public must constantly be renegotiated, on an individual and collective basis, and this is likely to have the most influential effect on informing and indeed directing the social construct of a profession. In this respect the public face of the profession is in the hands of both the collective organised structures that relate to government and the media, who appear to have a disproportionate influence on public perception, as well as the individual members of the profession at the frontline who on a personal and business level represent the profession firsthand in the eyes of their patients and the local social structures within the community. In the healthcare professions where service is of a personal and intimate nature, and offered in circumstances associated with high levels of stress and emotion, the outcome of any single contact with a patient or their family can be of high impact in their estimation of the profession's reputation, as well as in their perception of the value attached to its services. While the relationship with patients is more often based on an established and longer lasting-relationship, this element of professional practice in healthcare is clearly altered by both social demands and government policy for instant access to care. Less value is now placed by many of the clients on this aspect of professional service, although the professionals themselves still value these professional/client relationships as a rewarding aspect of their care delivery, as

demonstrated in the findings. This is one element that may differentiate between those choosing to work in a system in which relationships continue to play a vital role in the overall professional service delivered and those who provide short-term access care. The relationship with the media has also changed extensively in many professions since the ban on advertising has been lifted in the last two decades, making the reputational aspect of the professions much more newsworthy as the profession can now legitimately engage with the press over points of dispute and allegations of poor practice and conduct, and this is also evident from the findings of this study.

Fournier's second area for renegotiation involves the boundaries between the profession and other professions around them. As already discussed, the dental profession has enjoyed an uncharacteristically high degree of independence as a profession which it has maintained through the 20th century at a time when the trend had been towards increased subsumation of professions into organised structures under state or corporate control. It's boundaries of practice however have recently been potentially challenged by legislation driven by government policy driving the establishment of a number of subsidiary 'professions' who's members may undertake much of the work previously guarded by the dental profession as being in its sole legal domain. While many anticipated the demise of the profession, the reality appears to be a strengthening of the position of the dental profession in that it has carefully negotiated a framework in which the DCPs can work in their field of practice, but only under the direction of a dentist who retains sole right to the role of diagnostician and the power to delegate work. This has undoubtedly been a strategic move by those at the head of the profession to defend its boundaries, and in so doing, maintaining and enhancing the power and control exercised by members of the profession. In this system, the work to be delegated is controlled entirely by the dentists for any particular patient, and allows the process of controlled degradation (Abbott 1988) to lie directly under the control of the profession, who may elevate their own status through specialisation and the delegation of mundane tasks. As Murphy (1990) warns, this is not be mistaken for proletarianisation, and this point will be discussed at more length in section 7.6.

The same situation is not reflected across healthcare where the apparently more proactive and militant medical profession has failed to defend its own boundaries of practice as successfully, in respect of government policy which has overtly redistributed power across a range of established and newly created professions which previously held a subordinate role to medicine. The crucial factor appears to be in the legitimate role of these new professions to engage in diagnostic practice, delegation, and the

control of resources, as well as the high levels of expertise they have rapidly established through university degree level education and an academic evidence base. The further establishment of a series of organisational structures which mirror those in medicine – registration, regulation, Royal Colleges and professional associations – have all, in a relatively short space of time spanning less than a decade, substantially reduced the power and status of the medical profession as a result of the implementation of New Labour Policy in the NHS Plan (2000).

The third area in which a profession might proactively enhance its status and position of power is through expanding their field of practice (Fournier 2000), and in this respect the healthcare professions are well-placed to provide 'lifestyle' services, the demand for which has increased with increasing social pressures and awareness related to appearance and wellbeing. In medicine this area has been the cause of some disquiet in terms of the acceptable boundaries of professional practice relating to cosmetic procedures, especially in view of increasing media interest in this field, with many established professionals decrying the commercial aspects of services in what are often regarded as fringe areas on the borders of the profession. This disquiet appears to originate from a number of elements. Firstly, the association of such practice with the commercialisation of professional services to which some members of the healthcare professions are fundamentally and morally opposed on the grounds of conflict with professional values relating particularly to altruism and acting in the public good. Reed (1996) felt that professional practice had traditionally distinguished itself from 'business' practice through the authoritative claim to 'disinterested universalism' in which the professions fulfil social needs rather than being 'tainted' with business practice (p.588), and the medical profession appears largely to reflect this sentiment. Secondly, and not entirely unrelated to this, are concerns regarding the public perception of the profession and its reputation, with the implication that those engaging in such fringe practices are more likely to bring the profession into disrepute. While the same arguments may hold in the other healthcare professions, the same degree of dedication to public health and reliance on the state-funded system might not have such a strong influence upon the direction in which the profession evolves, and certainly in nursing and the allied health professions such as physiotherapy, there is much less resistance to engaging in services funded and directed by the private sector, either through employment or on an independent basis.

The lack of ties to state funding in dentistry and the entrepreneurial flair for embracing opportunity have become evident in this study. However, the degree of individual influence on the decision to embark upon work outside of the normal range of

professional activities must again come back to a consideration of the balance of interests for all concerned, and the freedom which is enjoyed to act within a certain set of constraints imposed on an individual basis by a range of work/life issues at a particular point in time, as well as the value set of the individual. These were evident in the anxiety of those who needed clear guidance in terms of the bounds of practice and who felt let down by the GDC in its lack of decision-making in an area of high ambiguity. There appears to be some desire for an element of positive affirmation by proxy, which admonishes individual responsibility in decision-making in professionals whose conduct is to be increasingly judged against explicit guidelines and rules. The acceptance of Reed's (1996) 'tainted' association with business practice appears to be much less of an issue for many dental professionals, although some, including surprisingly the younger practitioners, were still uneasy with dealing directly with money, and preferred to delegate this to others in the practice.

The fourth area in which Fournier (2000) describes the boundary work of the professions is in their flexibility and there can be no doubt that the majority of healthcare professions are restricted in this respect by their close alliance with the structures of the NHS. While Ackroyd (1996) observed strong informal relationships arising between professionals employed in large organizations, their flexibility to adapt must be impaired by the structures in place to ensure their conformity to organisational values and strategies. When that organisation is state-funded and directly controlled by government policy, the power and control exercised by the professionals within it must be severely compromised. The freedom to adapt and act independently, as a community and on an individual basis, again appears to set the dental profession apart from all other healthcare professions at the present time, and has maintained it's professionals at the head of its field of practice. Other healthcare professions collectively perhaps conform more closely to the reticulated system of professional groups as envisaged by Abbott (1988), with the interface between them increasingly under the influence of government policy and negotiation.

The perceived value of dental services in society appears to be increasing if judged on demand. Its annual state-funded budget is not inconsequential in real terms, and the intention of recent policy was to bring the profession under much tighter state control through new contracting arrangements, though apparently allowing the exact opposite. By allowing the profession the freedom to choose between a state- and privately-funded system of delivery, and perhaps more importantly to allow them to mix the two funding streams, the state appears to have given this profession the lifeline needed to allow its continued evolution as an independent profession in the UK. It is though

entirely at the mercy of further government legislation which might remove its diagnostic monopoly and sweep it off its pedestal of power within the profession.

What of the future? There is clear evidence that the government will drive down future costs of dental care by flooding the market with increased numbers of suppliers (BDA 2007b)[98], a policy employed in other healthcare professions where increased numbers of physiotherapy graduates have ultimately led to oversupply and unemployment. The decision to allow the devolution of funding with an increasing proportion of dental care to be sought from the private purse has perhaps been the single most liberating decision made by government in respect of this particular profession, and through comparison with medicine illustrates the impact that a stranglehold control of funding and imposed restriction of practice by bureaucracy and rationalisation can have on the development of a profession. This position however will only last for as long as the dentists remain at the head of the dental team of providers. In due course it could be envisaged that more work will be carried out by DCPs[99], and a further change in the law would allow them perhaps to run a practice without the need for a dentist at all. This would fail to recognise the difference between the skill of a trained craftsman and the applied knowledge of an educated professional (Harries-Jenkins 1970) and reflects the concerns expressed by Marquand that the government fails to recognise the need for greater authority for professional elites in a system of decentralised power in society (Davies 2006).

In this latter relationship of the profession with the state, not only in close contracting agreements but in general regulation and explicit requirements for standards of practice, the issue of 'fairness' is identified as being of utmost importance. In the healthcare professions in particular the extension of this 'fairness' argument is again enacted through a proxy position whereby the indignation is felt not only on behalf of the individual and professional community, but also on behalf of client groups and the public. While this might arise from individual values and sense of moral duty, there can be no doubt that its strength and potential power in terms of public bargaining cannot be underestimated in a context where the media and society in general are quick to grasp a story of conflict and favour the underdog, especially when the government is seen to be at fault. This strategy is clearly actively engaged by the healthcare professions, with the professional siding with their patients and clients, and opposed to bureaucratic control (Fournier 2000).

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[98] Through increased intake of undergraduate students in UK dental schools and opening two new dental schools in the past 5 years.

[99] Present GDC rules are infact lax enough to allow a dental nurse to be trained to carry out virtually procedure, as long as they have documentation of as yet undefined 'appropriate' training.

The strong ethos of 'fairness' in the professions would perhaps be expected in a group of experts professing strong moral values and resisting policies of control. Their high expectations of their own professional community is extended to others with which they relate, including the public, and although they can appreciate the differences in rationale behind decisions made by management and government (Harrison and MacDonald 2003), there is a strongly expressed perception of superiority in terms of ethical and moral stance over decisions affecting society. Perhaps, like the clergy before them, the profession may view itself as existing on a higher plane with superior knowledge and values (Johnson 1972; Freidson 1986). While this might be expected to be associated more strongly with the leaders and policymakers who enact and develop strategy at high level, it was infact more evident in frontline workers in the present study. It might be assumed that, by virtue of their practice, they enter into a greater number of professional relationships in the course of their professional practice, and perhaps have a more polarised view of their own individual interests, rather than an holistic and reasoned view of the wider profession in society.

7.5 Fairness

A profession's perceptions of fairness will undoubtedly have influenced its response to change, both at the individual and collective levels, particularly in respect of its behaviour as a consequence of the government policies implemented in the past decade. It might be assumed that professions have higher expectations of others, given their high standards of professional and personal conduct, and their ethical and moral strengths in terms of social justice. In the current sample, the desire 'to do one's best' in every aspect of life appeared to be an intrinsic value, and one which by extension might place a high value on this principle in others.

Whilst the management literature regarding the psychological contract has been applied across a range of employment situations (CIPD 2005), including those in NHS organisations (Cortvriend 2004; Fielden and Whiting 2007), it does not seem to have been extended to those in a more loosely constructed contracting arrangement where there is a degree of constraint on the freedom of the parties involved in terms of a restricted market and a limitation of the alternative partners with whom one might enter into a contracting relationship. In medicine and the majority of healthcare professions the contracts are almost exclusively held in state control by the NHS, although the number of private partners is increasing and this trend may continue despite an anticipated change of government. It is thus argued, by virtue of the restricted availability of potential contracting partners presented to the majority of primary

healthcare professionals, that the terms of the psychological contract can be extended to these contracting arrangements, where the professional is not a direct employee but under close control of the contract mediator, with little or no alternative choice of party with which to contract. In the current study, the profession has the freedom and independence to exhibit a wide range of violation behaviours, and this is an area which might provide further valuable insight into the response of expert groups to imposed change.

While Cortvriend (2004) studied violation responses in an NHS PCT merger situation, with evident differences in the context of the study groups, there are also clear similarities both in the situation and in the responses of the healthcare staff concerned. In the context of the present study there was a great deal of uncertainty regarding the contracting process and content of the contract itself, leading to high levels of stress, with poor perceptions of competencies in the PCT contracting managers. As in Cortvriend's study (2004), the negative perception of management style and lack of prior knowledge in this study led to a demoralised community, further damaged by the impact of their own violation behaviours in the form of exit, intention to quit, with concerns and lack of loyalty expressed to those outside of the profession, reduced commitment (to the NHS) and reduced organisational citizenship behaviours. The lack of trust in the organisation (Van der Heuval and Schalk 2009) expressed in the present study accords with the findings of Fielden and Whiting (2007), who found this to be a significant factor linked with the intention to leave, job satisfaction and commitment in their NHS-based study of AHPs. They also noted the discord between NHS agencies acting in an uncoordinated manner at a local (PCT) and national (DH) level, leading to perceived promises at one level being broken at another, and an increasing commitment towards an individual's career rather than of the organisational goals, both findings being supported by the present study. Kickul (2001) would advise that better communication be instituted in order that adequate justification and explanation of all determined decisions is apparent in the contracting relationship, which in the current context would amount to an increase in transparency and an extension of the principles of evidence-based decision-making, both to parties in the contracting process, and in the policymaking process on which it is based.

Van der Heuval and Schalk (2009) found that affective resistance was demonstrated by those who felt the psychological contract had been breached, resulting in the more negative feelings and resistance to change demonstrated in this present study. This is stronger in low trust situations, and in transformational rather than incremental change (Van der Heuval and Schalk 2009), and the context of this present study certainly

demonstrated this situation. Subsequent to this initial negative phase however, a notable proportion of the study group exhibited a more positive attitude to change, having exited at least in part from the main state-controlled systems, and consequently retaining control over the changes, as described by Guest and Conway (2002). In the present study this exit group remain part of the research sample as remaining part of the profession, while in conventional employee/employer research studies they are most often lost as they leave the organisation which is the focus of the study. Further opportunities to gain insight into continuing perceptions and behaviours are thus afforded in further study of these professional groups, based on their communities rather than their contracting arrangements as in the present study.

There was evidence in the findings to support the notion discussed by Cortvriend (2004) and Fielden and Whiting (2007) that health workers in particular are highly client-focused and so manage to concentrate on the 'patient' aspects of their work for reward, diminishing to some extent the negative aspects of the imposed change. The success of this might be diminished when the perception of feelings of fairness and justice are extended to sensing these issues on behalf of the patients also. The main difference between Cortvriend's work and the present study is the continual change that her study group of PCT workers had been subjected to, and it might be supposed that the dental profession would react rather differently and in some ways more violently to the changes imposed after a 15 year period of relative stability in its contracting relationships with government.

The present study extends the context of the claim that psychological contract breach leads to detrimental outcomes for the organisation (Kickul and Lester 2001) in proposing that a contracting organisation such as the NHS may act in an equivalent role of 'direct employer'. In the present study the detrimental outcomes culminated in exit, although, as discussed elsewhere, it could be argued that this may infact have been a desired outcome of the present contracting policies for dentistry. The other violation behaviours however are less easy to concede as desirable effects, and the dental profession appears to demonstrate the range of individual equity sensitivity behaviours found by Kickul and Lester (2001) linked to perceptions that mutual obligations had not been met, and a lack of respect and trust for contractors. Kickul and Lester (2001) found that 'entitleds', who are interested in furthering their own situation and maximising their own rewards, respond more negatively to breaches of the psychological contract involving tangible extrinsic outcomes such as pay and security. 'Benevolents' on the other hand place higher value on their relationship with their employer and react more negatively when promises of autonomy and control are

broken. The responses in the present study appear to reflect this full range of types and responses, endorsing the subjectivity of individual behaviour when the psychological contract is breached. It could however be the case that individual dental and other healthcare professionals might combine the types of entitleds and benevolents in their particular set of characteristics placing equal emphasis on good both intrinsic and extrinsic interests, placing them in the category of 'equity sensitives' based on the evidence of the present study.

7.6 Deprofessionalisation and proletarianisation

As already established, there is a clear difference between the proletarianisation of a profession and specialisation within it (Murphy 1990) and the two should not be confused. Analysis through Abbott's work (1988) indicates that the professions of medicine and dentistry have undergone a process of degradation as part of the internal division of labour, in which an upper truly professional group emerges over a lower subordinate group, which subsequently takes on the mundane tasks. This might be viewed as the opposite of proletarianisation, and a key distinction might be whether the profession has the power to control the work delegated to the subordinate group, and the degree to which the profession has been involved in the renegotiated boundary between higher and lower levels. It has already been noted that the professionalisation project in nursing appears to have been driven by the state and not the nursing profession (Dent 2003) and the same might also be said for the AHPs, all of whom are now trained to degree level to qualify for registration and who appear to consider themselves higher in the professional strata than the nursing and midwifery professionals. It could be argued that the higher groups may not be regarded as more professional *per se*, but that they retain more autonomy, and command more trust and respect from patients, public, and other professional groups. The lower group is then assumed to enjoy less autonomy, be more controlled and less skilled, consequently attracting lower levels of remuneration.

This would be borne out in the medical profession where, despite the similar titles of 'practitioner' and 'consultant', nurses and AHPs receive lower financial remuneration for their work which, it could be argued, lacks the holistic overview applied by the medical profession. So what value is now placed on the possession of this holistic overview from which an appropriate selection of applied knowledge can be selected for application to the immediate case in question, as opposed to a narrower specialist area of expertise? The fundamental difference between the medical profession and the other healthcare professions bordering their field appears to be the continued existence of a broad theoretical base of knowledge, far beyond the requirements for

everyday practice, upon which medical practice is based (Freidson 1986). The requirement for this holistic overview appears as if it might be the last bastion between the medics and the professions it has hitherto regarded as subordinate.

Allegations of the de-professionalisation of the professions have largely been grounded in medicine, in particular with respect to the imposition of systems of NPM in the bureaucratisation of the UK health services. Murphy (1990) argues that it is the rationalisation and bureaucratisation of the service and not proletarianisation and de-professionalisation *per se* that is cause for concern. Again, this particular aspect of control of the health professions has not been extended directly to dentistry, which has continued to enjoy freedom from state control and tight bureaucratic restrictions on its practice until relatively recently. It's legally protected monopoly and the expanding niche market for its services place it apart in many respects from mainstream healthcare.

Abbott (1988) attributed the advancement of jurisdiction of a profession to associated technological advances and the incorporation of professions into large scale organisations. While the former was intimately related to the rise of medicine in the 19th century and the maintenance of a substantial element of its expert power through the 20th century, its close association to the NHS - a form of large scale organization - has acted against its own interests since the aims and goals of the organisation have become politicised to the extent that they directly oppose in many cases the values, standards and underlying philosophy of care set by the profession itself. On the other hand, for dentistry the freedom from organisational constraint and its close association with advances in technology, especially in the form of affordable materials and improved technique, have again afforded the opportunity to exit at least in part from the state mediated systems of delivery and retain their professional autonomy. Abbott (1988) also felt that a profession needed to grow to meet increasing demand, otherwise it would be invaded by others who enter the field of practice to compete, often on cost, in undercutting the current value systems in contracted services. The entry of corporates and private providers into the UK healthcare systems have demonstrated the potential for those with aims and values other than of a professional nature to enter and potentially dominate the market for state funded services, largely by undercutting the cost of current contract values, while few if any quality measures are in place[100].

[100] It is however possible that the contracting PCTs may be naïve in assuming that, once these corporates have achieved a dominant monopoly position in the market themselves, they will continue to maintain such low contract pricing strategies, at that stage having essentially made themselves indispensable as quantity providers of NHS care.

Cottingham and Toy (2009) discussed the 'industrialisation' of the dental profession in terms of the division of labour and apparently ignored the potential control of this division of work by the profession itself, and the increased opportunity it afforded to specialise. The 'labour of division' as described by Fournier (2000) appears to be much more relevant to the professions as they stand today. The positive effects of offloading repetitive and mundane work is highly valued in terms of freeing time to carry out more advanced aspects of work, and to lead and co-ordinate as described by Abbott (1998). Again the crucial factor in this situation is that in dentistry it is the professional who controls the work and its delegation; no member of the team is able to carry out work that the dentist themselves has not been trained to carry out; and no other member of the team is educated to university level or equipped with the breadth of scope that affords an holistic overview of the patients' care and its delivery. The opportunity for entrepreneurial activities is rife in this set of circumstances and has been widely embraced by many in the profession, more so than in other areas of healthcare.

Dent (2003) indicated that financial constraints lead to the need for reconfiguration of services in the form of a division of labour, together with its sources and means of funding. While ideologically it would be hoped that funding would not influence the professionalism of the community or individuals within it, there is clear evidence of altered practice due to funding and contractual constraints in healthcare, potentially as part of violation behaviour or de-coupled autonomy, affecting the strategic development of the professions. It is argued that it is unrealistic to maintain the tenet that a profession should be free of state control, as proposed by Morrell (2003), if it is largely funded through public monies and serves a population that is politically influential in voting at government elections. Whether state or privately funded, it would also be unrealistic to assume the professions' immunity from the influence of the economic downturn of 2008/2009, given their increasing association with the provision of privately funded lifestyle treatments which are closely associated with levels of disposable income, and the anticipated severe cutbacks in publicly funded services in order to address the devastatingly high levels of public debt in the UK. While Trathen and Gallagher (2009) wished to draw an element of funding into the definition of a dental professional, it is not the funding *per se*, but the freedom to choose the source of funding that will influence the professionalism of dental practitioners in the future, and the further development of their profession.

Fournier (2000) gives a further useful outline of the three means by which a profession might under go de-professionalisation; firstly, through what is described as the

changing logic of the market which may lead to a corruption of professional practice along commercial rather than 'public interest' criteria, as also described by Reed (1996); the acceptance of this argument rests on the individual's view of whether a profession can operate ethically and maintain its professional values and standards of acting in the public interest, while being funded through a patronage arrangement. As we have seen, this was the historical arrangement of funding for professionals and it could be argued that they have never been free of such financial and remunerative biases to their service delivery. The question might then relate to the point at which a profession is deemed to have been sufficiently 'corrupted' by this financial element of its services to consider it 'de-professionalised'.

Secondly, Fournier considers the bureaucratic trend which brings about codification and commodification of professional knowledge (Ackroyd 1996). This is closely associated with the creation of a more hierarchically controlled occupational group within an organization which Reed (1996) linked with internal fragmentation and rationalisation leading to increased intra-group stratification and polarisation. Reed considered that this was part of a process in which the knowledge base of the independent traditional professions was being effectively "rationalised out of business" by the state and large corporates (Reed 1996:587). An element of this is evident in hospital medicine, but the GPs and certainly the GDPs have to a large extent escaped the structural elements of organisational encroachment on their practice, while still being subject to increased monitoring and bureaucratic controls through their contracts. The codification of knowledge in dentistry is difficult to achieve as the profession's knowledge base and the techniques it employs in order to apply its knowledge are so specialised that it is almost impossible to self-treat or improvise treatment. The diagnostic element is so exacting and dependent on specialist tests and radiographs that it does not readily compare with general medical practice, and is by definition already a specialist service in the field of medicine. Again, the unique combination of its use of advanced technology, very specific diagnostic skills, and high levels of specialised tacit manual skills appear to make it immune to many of the undermining influences and policy moves affecting the other healthcare professions.

Thirdly, Fournier (2000) considers the erosion of a professional monopoly by the logic of the market, with diffusion of expert knowledge to customers and the public who become empowered, with the potential to become 'sovereign customers' or 'proto-professional customers' (Dent 2003). While this is evident in the area of general medical practice in particular, the value of increased customer knowledge in dentistry has been acknowledged above as being of limited value due to the high degree of

technical expertise required in its application. The customer is then limited to seeking second or third opinions regarding dental treatment, and may thus assume the role of consumer more readily in this respect, in shopping around for the product they are satisfied with in the role of 'proto-professional customers as described by Dent (2003). This is not however the same as acquiring enough codified specialist knowledge to dispense with the services of the professionals themselves, which might contribute to a degree of deprofessionalisation. This present study supports the notion that clients who are better informed and educated actually seek more in the way of professional services, as they are more aware of their treatment needs and the possibilities available to them (Fournier,2000).

Ackroyd (1996) describes a process whereby a profession undergoes systematisation, as opposed to innovation, and considers that professions in the past experienced the former while entrepreneurs experienced the latter. In dentistry at least at the present time this is clearly not the case, where the profession has adapted through innovation and entrepreneurial approaches to take advantage of the opportunities afforded by remaining in the domain of small business, avoiding the now heavily entrenched hierarchical and bureaucratic structures which have so successfully ensnared the medical profession. The dental profession appears to be in the process of successfully adapting to Fournier's (2000) new 'logic of the market', in adopting commercial business practices without becoming tainted, and in successfully renegotiating relations with customers who are educated and empowered. It is thus argued that to remain viable, a profession must adapt to embrace the commercial aspects of practice and customer service, and engage in more entrepreneurial forms of behaviour, and that both of these contribute to the present social construct of 'a profession'. The antagonistic relationship of professionals with entrepreneurs in the past (Ackroyd 1996) has been replaced by a form in which professionals are required to be entrepreneurs, and in terms of Reed's (1996) typology, the dental profession appears to have successfully transformed itself from an 'independent' traditional type of profession to an entrepreneurial type, while the medical profession has been co-erced by government policy to remain under the control of the managers and administrators in the 'organisational' professions.

The increasing tendency for a certain section of the dental profession to become directly employed by both corporates and the state to provide basic services would appear to support Freidson's (1986) claim of proletarianisation by increasing employment of professionals in organizations, where they lose their freedom to choose what work to do and how to do it, with the potential to routinise and deskill their work.

He stressed however that the issue rested not on the employment status of the professional but on their ability to control their work, and pointed out that many professions in healthcare and other fields of practice had been employed from their beginnings. In the present study the restricted contracting situation of dentists in the state funded system reflects this loss of control, even though the professionals are not directly employed by the state, and their response in shifting towards independence demonstrates their wish to retain this technical autonomy. Freidson (1986) warns that self-employment does not always mean freedom, in that customers dictate to a large extent the services provided. The balance of control favours the profession when there is low supply and heavy demand, as has been the case for the last decade in dentistry, and the government moves to increase the number of dental professionals must be considered as a direct counter to this situation. Freidson also stressed the part that individual reputation must play in accruing 'career capital' during a professional's practising lifetime in order to be successful as an independent practitioner (Freidson 1986:125). This was borne out by the concerns of the more senior practitioners in the present study, who thought that the younger professionals had not fully appreciated the importance of building and individual reputation for success in private practice.

Murphy (1990) declared: "If professionals are undergoing proletarianization, it is a proletarianization very different from that of the proletariat" (p.74). He proposed two hypotheses of proletarianisation. Firstly, the 'strong' proletarianisation hypothesis states that "all professionals lost control of the overall goals and policy directions of their work and over their technical tasks and procedures" (p.72). This leads to deskilling and degradation of work, with a consequent decline in status and rewards in a process which equates to Taylorism. Murphy felt that this was refuted in view of the high technical authority maintained by professionals in organisations, and warned against mistaking specialisation in the division of labour for de-skilling, when professionals are freed from more mundane tasks to pursue more esoteric interests which bestow higher levels of autonomy. Secondly, Murphy (1990) describes the 'weak' proletarianisation hypothesis, in which a professional may suffer a degree of loss of technical autonomy (technical proletarianisation) or of ideological goals and purposes (ideological proletarianisation). He argued that professionals had lost a part of their ideological control and retained their technical autonomy, and considered that this amounted to bureaucratisation of the professions, affecting the organisation, control and reward systems of the professionals. It could be argued that the professions have never fully experienced true ideological control, given their high dependence on patrons and the state for the continued demand for their services.

The present study would appear to provide evidence of the further specialisation of the dental profession in relation to the potential to delegate mundane work tasks to DCPs, and it could be argued that any loss of ideological autonomy has been countered, at least to a degree, by the shift of the professionals to an independent position in which they retain more control of their ideological goals and purposes. There was however also concern of de-skilling in relation to the future development of the state-funded section of the profession, where NHS work would become heavily controlled by either a direct state or corporate employer, performed on a robotic production-line basis, with little scope to develop beyond basic technique and skills and with declining levels of reward. This would appear to equate to Murphy's (1990) strong level of proletarianisation. There were fears expressed that this section of the profession might in reality become a sub-set, carrying out only basic treatment.

Arguments of deprofessionalisation which are centred upon the 'professional' attitude of the practitioners and their quality standards are not necessarily supported in this case, if the individuals concerned continue to provide high quality services and conduct themselves appropriately, regardless of the procedures carried out. However, if professionalism rests on issues of autonomy and control then it could be argued that this sub-set may well be 'deprofessionalised' through their restrictive contracting and employment arrangements, subjecting them to increased levels of control through bureaucracy and rationalised management, which Murphy (1990) regarded as the real threat to the professions.

It would appear however that the majority of the profession at present intend to retain their independence and thus their control of both technical and ideological aspects of their practice. This would reflect a group strategy intended to realise high levels of autonomy and thereby retain professional status, as described by Beckman (1990). The profession has so far retained its involvement in defining new roles through legislation, and has thereby successfully safeguarded its own role and position of power to date. The private funding of services in dentistry will allow the continued development of a group of successful independent practitioners who are predicted by the profession to become the majority group, who will be able to afford to educate themselves and acquire further high-level specialist skills to provide the high standards and range of quality care which the public now demands. This group are already viewed by many within the profession as being at the top of the profession's hierarchy, in place of the hospital consultants and academics who would traditionally have been regarded in this position, reversing the hierarchies previously described by Freidson (1986), where the professional elite were the "authoritative custodians" of the

knowledge and skill of the profession, comprising the staff of the professional schools (p.82). Murphy (1990) felt that it was the monopoly over abstract utilitarian knowledge that set the professions apart from the dominant class and the proletariat, on the basis of knowledge and credentials. Thus the redefinition of roles within the dental profession which has occurred, as a response to the challenges presented by government policy, appears to be reinforcing and perhaps relocating the knowledge and skills-base more firmly within the profession, in order to successfully safeguard its basis of power, status and rewards, allowing it to retain control and autonomy, and remain in a privileged society of 'knowers' (Murphy 1990).

7.7 Summary

This discussion has illustrated the many issues which have arisen through the findings of this study, which although centred on the dental profession has brought to light a range of issues which have been applied across the broader scope of both healthcare and the wider professions. Through the literature a number of areas have been examined more closely in respect particularly of the continued relevance of the social construct of a profession in contemporary society, and the way in which this may have transformed to merge individual altruistic values with a more entrepreneurial and innovative way of providing professional services in the more commercially-based market systems which are now emerging from the state funded (and controlled) healthcare systems of the past 50 years.

The semi-ethnographic nature of this research led to the collection of an extensive range of data and findings, much of which could not be presented in the present thesis. Difficulty was thus experienced in determining the most appropriate sections of the findings to present in detail, and it is acknowledged that it has not been possible to include detailed findings and discussion of many other relevant issues, such as training and recruitment, the measurement of professionalism and influences of gender. Thus the elements of freedom and fairness have been taken as the basis of the latter section of the discussion, as the strongest issues emerging from analysis of the empirical work.

The impact of both the changing social construct and of government policy on the professions has led to a response at both individual and collective levels, and in a loosely networked profession such as dentistry it seems that the individual response may dominate in many respects. The casestudy has demonstrated that a profession may apparently successfully transform itself in a relatively short period of time in order to ensure its continued historical survival. This process of continued development would support the notion that the professionalisation process does not have an end-

point and that, as the social construct of a profession changes, then so must the professions. It is uncertain to what extent these processes run in parallel or influence each other, but it is clear that government policy has forced change upon the professions, especially in healthcare, and this has had a major impact on the present and future forms of these professions and the public perceptions of them. The importance of the individual response has been discussed in terms of the balance of interests to be considered by any individual professional in making key decisions, and the balances between autonomy and control considered in view of the increasing levels of societal controls which have been imposed in the last decade.

The responses of the profession under study were closely linked to issues of fairness and freedom, in terms of their perceptions of breaches to the psychological contract, and their wish to retain control and autonomy in their professional practice. The unique freedoms which have been granted this profession have allowed it to act in ways which are not possible elsewhere in healthcare, and have allowed a demonstration of its true reactions to the perceived threat to its core professional values and standards. The trend towards independence, the persistence of a strongly altruistic element of practice, and the commitment to high standards appear to demonstrate a desire to maintain the traditional values of the profession while moving it into a new era. The small size of the profession, its diversity, the entrepreneurial flare of the individuals attracted to such an autonomous profession, and its close association with technological advances may all have contributed to its success in allowing it to adapt so rapidly to the challenges presented. The immense changes affecting this profession were not anticipated at the start of the study in 2004, when dentistry appeared to be in a state of fairly severe depression with regards to its uncertain future. Although it is not possible to experiment in social science research, the opportunities presented through the course of this research provided almost experimental conditions in allowing the study of a group experiencing such radical and transformational imposed change. However, the findings of this study are unique to this profession at this point in time, and we would not expect that any other profession would have responded in exactly the same way given a similar set of circumstances.

The future circumstances of this and other professions are not clear or guaranteed, as in any other aspect of life. There is evidence of de-skilling and increased technocratic control in this profession, but there is more overwhelming evidence of a move towards independence and increased freedoms. Allegations of 'deprofessionalisation' on the grounds of loss of trust and respect cannot be upheld on the basis of this study which has gauged only the professionals' own views. However, it would be anticipated that if

the social construct of 'a profession' is dynamic then the relations of a profession with society will also change over time, and so a change in aspects of that relationship are just that, a change, and do not necessarily amount to a loss or diminution in the concept of 'professionalism'. Allegations of proletarianisation are more successfully upheld by the findings of this present study, and in the concerns expressed for its future, but having been recognised, it is certain that the profession may respond in such as way as to minimise the impact of this potential threat on the profession overall. It is perceived by the majority that the future of the profession lies primarily within the private sector and, being allowed by government to pursue that path, it intends to retain its freedoms, develop its specialisms, and extend its leadership roles.

In the following final chapter conclusions will be drawn from the overall findings of this work, together with their implications for the wider context of the field of study of the professions. Suggestions will be made as to the many ways in which this study could be extended through further research, and through additional areas of study which might further develop theory in this field, particularly in relation to the social construct of a profession, the psychological contract and issues of autonomy and control.

Chapter 8: Conclusions

Chapter 8 Conclusions

8.1 Introduction

In the previous chapter the findings from the research conducted for this thesis were discussed in the context of the existing literature in this field and a number of areas identified in which current theory might be adapted or extended as a consequence of these findings. These were particularly related to the areas of freedom and fairness, in terms of control and autonomy within the profession, and of fairness in the psychological contract.

The aims of this present study were stated in Chapter 1 as being:
Aim 1: To explore the social construct of 'a profession' in contemporary society
Aim 2: To explore the responses of the professions to change.

The social construct of a profession has been explored through the fieldwork for the casestudy group of the dental profession from the perspective of the professionals themselves, and the implications of these findings in the wider field of the professions has been discussed in the context of the existing literature. The responses of the dental profession to change have also been determined and discussed in the wider context. The aims of the research have thus been met and n the following section conclusions will be drawn in relation to the main research questions, and their implications discussed in terms of the contribution to knowledge, as well as indications for further work in this and related fields.

8.2 Conclusions

The conclusions of this thesis will be presented in terms of the research questions posed and answered during the study in respect of the perceived impact of recent change through government policy on UK health professionals. The preliminary study revealed concerns among healthcare professionals that the shift to NPM and the implementation of the NHS Plan (DH 2000) in particular had led to erosion of clinical autonomy, particularly in medicine and dentistry, increasing bureaucracy, and distrust of the autonomy and self-regulation traditionally enjoyed by healthcare professions. This was reciprocated with distrust of government and local management by the professionals themselves. The intention of this policy for many within these professions appeared to have been to undermine the power of the medical profession and to further rationalise services so that management rather than clinicians controlled the organisation and delivery services. The new roles introduced as a direct consequence of this policy were proving to be ambiguous and not necessarily empowering for the

professionals involved, which might well have been the original intention of the policymakers. High levels of uncertainty over the future role of the professions in healthcare, and the unsettling and threatening nature of the changes, had led to the adoption of a somewhat militant stance in the medical and dental professions, who felt compelled to defend and strengthen their professional domains, driven in part by the confusion of conflicting interests and priorities between healthcare and competitive commercial services. Recent policy has granted the dental profession more freedom and autonomy than other healthcare professions, particularly allowing a freedom of choice in its contracting arrangements for both privately- and state-funded services. This is due, it is supposed, to this profession's relatively low level of power in society, and the financial benefits to the state of increasingly privately-funded treatments.

It is thus concluded that government policy aimed at improving the quality and delivery of healthcare provision and services has led to a shift in the balance of power between the state and the healthcare professions, as well as between the healthcare professions, and that while some professions have now been ostensibly granted more power in their existing and newly created roles, this has not always been to the degree intended or necessarily to their benefit. There are clear differences in the ways in which different professions have responded to the change, dependent on their initial position of power and their ability and freedom to adapt rapidly to the imposed changes. It must also be concluded that the distinct differences of approach in terms of policies affecting the medical and dental services indicate that government regards these fields of practice as distinctly different types of services. It can also be deduced from the findings of the initial fieldwork that, across all the healthcare professions, recent government policy and its implementation has further alienated the clinical professionals from NHS management and government.

8.2.1 What does it mean to a dental professional to be a 'professional'?

The literature demonstrates the apparent defining characteristics of a profession and their historic derivation. Altruism and high levels of knowledge are reinforced by strong collective values and standards, incorporating codes of conduct for the professional community. Autonomy, power and control appear to have been closely linked to the status of the professions in society, and to their responses to past change, in terms of defending and redefining their boundaries of practice and successfully renegotiating their identity in the relevant social, economic and political context. The nature of the relationships entered into by the professions have been key to the establishment and maintenance of their status in society, and this becomes more relevant with increasing state mediation and control of public sector services in the 20th century.

It is concluded from the findings of the research for this thesis that the social construct of 'a profession' remains relevant in contemporary society from the perspective of the professionals, and it is clear that this is of practical application in day-today work, rather than existing as a theoretical construct as Larson (1977) suggested. To the professionals in this study, as members of a profession, it is evident that the construct has changed and will continue to evolve, as the professions in the past have had to change and respond to a changing social context throughout their development.

A study of the historical and sociological literature in Chapters 2 and 3 contributed to the overall aims of the thesis in that it allowed a much fuller interpretation of the construct, especially in that it identified its defining elements and their derivation, as well as how and why the professions have been able to successfully adjust to changes over time, and by so doing effectively defended their perceived rights to the position and status they had established and traditionally held in society. The dental profession has demonstrated in the findings reported in Chapter 6 that the key elements of altruism, the acquisition and application of high levels of theoretical knowledge, and the maintenance of high standards of practice remain at the heart of this particular profession, and as differentiating factors from other occupations. The vocational and caring elements of professionalism were convincingly demonstrated, together with the strong sense of 'something within you' in relation to personal and shared values. The maintenance of high standards of practice might be replicated in other occupations, and the major differentiating element for a profession thus appears to be the possession of high levels of theoretical knowledge, beyond that required in everyday practice, which allows the professional an holistic overview, together with the ability to select the appropriate application of that knowledge to effect the desired outcome. The freedom to make that choice is thus also a key element of the construct. It would seem that current policy wishes to challenge the professions on two counts: by defining a number of new 'professions' and roles, such as the DCPs in Dentistry, the government is seeking to undermine the professions by diminishing the importance of their high (i.e. degree level) level of education, through attempting to establish these new 'professions' around a skills base rather than a knowledge base. At the same time, they are restricting the professionals' right to select the appropriate application of knowledge through increased rationalisation, regulation and monitoring. This interpretation of the findings leads to the conclusion that government policy is seeking to alter the existing social construct of 'a profession' to reduce their power and status.

As discussed in Chapter 7, the implications of renegotiated new identities for the professions, in terms of verification and the avoidance of emotional response to a mismatch, make this an important area in which the profession needs to engage the public and its members to ensure unity and successful verification of new roles. The strength of collective identity is likely to allow more successful maintenance of the social construct and retention of the profession's status in society. Dent and Whitehead (2003) considered that entrepreneurship and innovation might have become part of the new contemporary definition of a professional, and although this present study confirms that possession of these traits may be beneficial to the survival of the profession and its individual members, they have become part of the general requirements of continued success in business and so are not seen to be distinguishing features of a professional *per se*.

8.2.2 How has the dental profession responded to recent change?

The current success of the dental profession's response to change appears to have been dependent on the 'magic mix' of factors identified, namely its small size, its entrepreneurial nature and its ability to adapt to change, its individual members' freedom to choose their contacting arrangements, its association with high levels of technological advancement, and increasingly high levels of demand for its services. It is acknowledged that not all of these are under the direct control of the profession and its continued success is ultimately dependent on its client base, as observed by Corfield (1995) in relation to the growth of the professions in the 19th century. The contextual elements that have allowed the profession to re-negotiate and extend its boundaries of practice have been key to its success.

In this thesis the dental profession's responses have been observed and analysed at both individual and collective levels, and it has been demonstrated that both clearly contribute to the overall direction and development of the profession. At a communal level, there is direct engagement with government in an effort to retain control of the profession's domain, and to preserve power within the profession, in the control of everyday practice and clinical decisions. At an individual level, the responses were seen to be determined through a consideration of the balance of interests - between self, the profession, the practice, the patients and wider society - which every individual practitioner has to weigh up in deciding their own course of action. The independent nature of the dental profession has been demonstrated, but so too has the strength of collegial feeling in a diverse and widely-networked community with little internal structure. The strength of the feeling of belonging to the professional community has been seen to be highly valued, and again contributes a defining element of the

professions which set them apart from many other occupations. The commercial and competitive elements of professional practice may be hard to assimilate into a model based on communal altruism for the common good, but the incorporation of commercial practice appears to be a general trend across the UK professions at this time, and perhaps marks a return to the privately-funded systems of the past revealed in the historical studies of professional services in Chapter 2. The evidence from this study demonstrates the importance of contextual influence on the responses and further development (or 'professionalisation') of the profession, and the uniqueness of this process for each profession at a particular point in time.

The responses of a profession to challenge are therefore heavily influenced by the strength of their professional identity, on both individual and collective levels. The implications of change on collective and individual identity have been examined in Chapters 3 and 7, in terms of resultant behaviours which seek to re-negotiate a new identity that all parties are able to verify, with the need to effectively communicate the new identity standard within the professional membership, as well as with the client group and wider society. The closeness of the dental profession to its public may well have contributed to its ability to gauge the views of society and react accordingly in a timely manner. The collective response depends upon these individual choices, which will also be influenced by the leaders and policymakers in the profession.

The questions of freedom and fairness that have concerned the professions have been highlighted in Chapters 6 and 7 of this thesis as the two main factors affecting the profession's response to change, and the reasons behind the importance of the these elements has been established in terms of their desire to remain autonomous in the face of increasing rationalisation, and their high standards of professional conduct which in turn raise their expectations of fairness in their professional relationships, particularly in contracting agreements and negotiations. The challenge implicit in the apparent distrust which underlies increasing societal control and regulation, including the introduction of revalidation, appears to have strengthened the resolve of the professions towards their own self-preservation. While the dental profession is admittedly diverse in its nature, diversity is not to be viewed as the antithesis of unity in this respect, but rather as a strength in the form of a multifaceted range of perspectives and skills that can be drawn upon when required. It thus appears that the strength of the professions lies in their individual members and their ability to both maintain and, when required, renegotiate their collective identity.

8.2.3 Has the dental profession been deprofessionalised or proletarianised by these changes?

In Chapter 4 a distinction was made between the potential deprofessionalisation and proletarianisation of a profession. If deprofessionalisation implies a lowering of standards and loss of strength in the professional community, then from the findings of this study there is no evidence of this in the dental profession. In dentistry there has certainly been a challenge to the autonomy of the professionals, who have countered by removing themselves from the state-funded systems of control. The wider policy of undermining professional status by denoting those who were previously of the 'semi-professions', including auxiliaries and technicians, as now belonging to a 'profession', presents a threat in the wider field of healthcare, especially where diagnostic powers have been devolved. As discussed in 8.3.1 above, it is the holistic overview with high levels of expert and theoretical knowledge that appears now to distinguish the true professions from those who are professional skilled workers.

De-skilling of the professions has led to allegations of proletarianisation, and in the dental profession there is evidence of this, through the potential development of a sub-set of the profession which carries out only basic state-funded care. This might however be viewed as controlled degradation (Abbott 1988) if it remains under the direct control of the profession, such that routine work can be appropriately devolved to other professionals such as DCPs, allowing increased specialisation of members of the actual dental profession itself in a leadership role at the head of a professional team. This again can be seen in a positive light for this particular profession, while the medical profession is being allowed no such equivalent freedom or power to control the devolution of its work. The reasons behind the different policy approaches to medicine and dentistry have been discussed in Chapter 7, and it can only be surmised that the freedoms allowed to the dental profession at this present time are related to a government intention to allow the profession to return to the private sector, reducing the requirements for state funding of dental care, and acknowledging that the profession wields *little weight (and so poses little* threat to government) outside of its own professional domain. Dentistry thus remains in a relatively stronger *position than* other healthcare professions in this respect, by virtue of its relative freedom from bureaucracy, rationalisation and state control. Its longer-term future, however, appears almost entirely dependent on its legal monopoly over diagnostic rights in its professional field of practice, and continued demand for its services through periods of economic instability.

8.3 Contribution to knowledge

The literature demonstrates that the dental profession has not been previously been the focus of a study of the professions in terms of the approach taken in this thesis, and the existing literature on this issue within the dental field comprises a small number of opinion pieces based on personal opinion rather than on empirical studies (Welie 2003a, 2003b, 2003c; Cottingham and Toy 2009; Trathen and Gallagher 2009). There is a tendency towards quantitative methods in the research that is undertaken in dentistry, being based on a precise scientific discipline which readily lends itself, both physically and culturally, to survey data collection and measurements to obtain finite facts and figures, rather than qualitative methods designed to deepen understanding. It is likely that the lack of substantive qualitative work in this area is also due to lack of funding for research in dentistry, as compared to the extensive work that is funded to be undertaken in medicine and other aspects of healthcare. It may also relate to the difficulty of reaching a group of professionals who are independent and not easily be accessed through a central organization. This present study thus contributes original research in this field.

In so doing, the study has provided evidence to demonstrate that Dentistry is different to all other professions, and does not fit into existing models of the traditional, semi- or new professions. This implies that existing theoretical models need to be modified and extended, and adds weight to the arguments that the professionalisation process is unique to each profession and heavily contextually dependent. It also highlights the need to extend current models of professionalisation and research studies to include the newly created professions in healthcare which have arisen as a consequence of the NHS Plan (DH 2000). Having demonstrated the differences between the medical/nursing/AHP system of professions and the dental/DCP system, it is important that the dental professional groups, which constitute a very different model of professional care delivery, continue to attract attention from researchers.

The unique context during the timeframe of this study has provided a novel insight into the reactions of a profession subjected to change. The distinct character of the profession and its freedoms from the state-funded system have provided a deeper understanding of the way in which professionals may act when unfettered by strict government bureaucracy. The semi-ethnographic nature of the research has provided a rich source of data for analysis, capturing in detail the frank expression of feelings, fears, and violation behaviours. Most notably, those who exited from the state-funded system remain part of the study group sample, which is centred on the profession itself and not an employing organisation. The thesis has extended current work in the areas

of autonomy and control, most of which has previously been based in an organisational context. The addition of societal controls to existing models of control reflects the increasing levels of control imposed upon professionals through legislation relating to health and safety, infection control, and employment. It also recognises the perceived transition of the regulating bodies (such as the GDC) from being a professional body that is part of the profession, to becoming a government body, which is external to the profession.

The findings of this thesis also extend our understanding of the concept of the psychological contract to include restricted contracting relationships as well as direct employment in organisations, with particular relevance to professionals who have high levels of personal standards and values, and thus expectations of others with whom they relate. There is clear evidence from this thesis that a strong sense of professional ethical responsibility and notions of fairness exist in healthcare professionals, which is extended to their patients and to wider society, and that their expectations of mutual respect and trust are perhaps higher than in other occupational groups. The freedom of this particular group to exhibit violation behaviours afforded the opportunity to observe how other professionals might act if not so closely tied to the state. This will provide policy-makers and management with further insight as to how professionals react to change and how best to manage change processes.

The findings provide substantive evidence that the professionalisation process for the healthcare professions continues in the 21st century, as demonstrated by a group who are relatively unconstrained by rationalisation who have been allowed the freedom to adapt and respond to challenge at both individual and collective levels. The social construct of a profession is evidently still viable in contemporary society from the perspective of the professionals who have negotiated a new identity in the past 4 years, and in the 21st century the elements of entrepreneurship, innovation, and commercialism appear to have become incorporated into the contemporary construct of a profession. It will be important for the professions and their members to update their own perceptions and to ensure this is effectively shared internally and with wider society in order to verify their identities and maintain their status as a profession in society. It has been demonstrated that altruism is retained as a key element in the contemporary construct of a profession by those in the healthcare sector, and this should perhaps be conveyed more effectively to the public, providing reassurance in underpinning their trust in these professions.

The identification of the 'magic mix' of success factors, brought to light through this work, which have contributed to the dental profession's apparent strength at the present time may be used to assist this and other professions in developing future strategies for their further successful development. It must be recognised that public demand for services is an essential element of success.

8.4 Recommendations for further research

A number of areas have been identified as worthy of further research as a consequence of the work conducted for this thesis:

Society's perception of the social construct of 'a profession': while the present study has concentrated on the perceptions of the profession itself, it would be useful to gauge public perception of the professions at the current time, to allow useful comparison, and to inform the development of further successful strategy by the professions to continue their renegotiation of identity in a way which meets the needs and demands of contemporary society.

Leadership in a collegial community: this study has raised questions in relation to the appropriate form of leadership for a collegial community, and of how leadership may need to be adapted in highly-networked professional communities, perhaps in terms of the distributed leadership described by Gronn (2002), Wilkinson (2007), and others.

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The psychological contract in contracting relationships: the extension of the principles of the psychological contract in this study to restricted contracting relationships, and the importance of the principles to healthcare professionals in particular, opens a new area of research into the restricted contracting relationships of professional groups who possess high expectations and high levels of autonomy, as well as the freedom to restore independence and exit the relationship.

The balance of interests of an individual professional: further exploration is warranted to shed further light on of the balance of interests which each individual considers in making their personal decisions for their own future, and the ways in which these decisions are made, especially with regard to the interaction between collective and individual decisions, and the contribution of each to the overall response of a profession to change.

The continued development of the dental profession in relation to DCPs: the potential for change engendered through the introduction by government of the newly created DCPs warrants ongoing study, especially in relation to changes in control and autonomy within professional practice, and the potentially dominant strength of financial power in the relationships which develop.

The 'genderisation' of the professions: while this is an area that has already attracted much attention as a field of research, the unique and discrete professional domain of dentistry affords further opportunity to explore the consequences of increasing numbers of women on remuneration, clinical and competitive practices, and their potential to fulfil leadership roles. This might be particularly pertinent given the potential degradation of part of the profession's work, which may attract certain subsets of professionals to engage in different fields of professional practice.

8.5 The Future

The Future

In June 2009 the government announced a further overhaul of NHS dental services in England after heavy criticism of the April 2006 contract, particularly by patient groups. An independent review of NHS dental care by Professor Jimmy Steele made recommendations to return to the previous system of patient registration so that professionals could again care for their own list of patients in a longer-term professional/patient relationship, with further proposed changes to the funding systems and quality outcome measures to monitor the standards of the professional service provided for patients. Pilots of the new proposals are currently being undertaken.

One of the stimuli for this independent review was the difficulty of access to care by patients caused by the reduced number of dental professionals providing NHS care. This was directly due to the number of dentists who left the state funded system to practice independently as a consequence of previous government intervention in the April 2006 contract. Thus the profession itself, through the actions of its individual members in an attempt to retain their independence and core values, has had a direct impact on its own potential future, and while the profession's own voice may not have been heard, that of its patients certainly had been. The sustained demand for the profession's services is clearly a vital element in the continued success of a profession in justifying and maintaining its place in contemporary social structure, as supported in this thesis.

During the period of this study the social construct of a profession will have changed and, despite a substantial shift in the public perception of 'a professional', the dentists appear to have succeeded in maintaining their identity as a profession. It is clear that the profession itself must change in accord with the generally accepted new meaning of a professional, but that it can also to an extent influence this meaning, so that its own changing identity and professional role will accord with and be verified by the new identity standard prevalent in society. The social trend towards a consumerist approach for service delivery has allowed dentistry to develop as a profession in a more independent and commercial model, greatly assisted by an accompanying shift in public perception that private treatment is no longer only for the rich. The clinical and highly operative nature of dental treatment (and its close association with pain) place it more firmly in the more highly-valued domain of clinical healthcare than other commercialised health professions such as pharmacy and optical services, and it continues to provide care for patients (rather than 'clients') on a highly personal basis.

The present study in some respects endorses Hanlon's thesis that those who embrace the new 'commercialised' professionalism will benefit most from policy and socio-economic changes (Hanlon 1998). The profession's adherence to and defence of its high quality standards and shared values, its flexibility and relatively small size, and its lack of ambition in terms of influencing society outside of its own domain have all contributed to its continued 'success' as a profession. By these means and through a very unique set of contextual circumstances it has transformed into a more independent and commercially-viable health profession, and by adopting a strategy that has prompted patients to put pressure on government, it may in the future again be allowed to operate in circumstances that strengthen and potentially safeguard its professional/patient relationships.

As the evolution of the professions is contextually dependent, it is unlikely that other professions would ever find themselves in such a unique set of circumstances as the dental profession has experienced in the last 5 years. So what lessons might be learned from this study for other healthcare professions experiencing a state of flux and uncertainty?

- **Retain or gain independence from state systems.**
  The independence of the dental professionals from the NHS state funded systems has been key to their survival as a collective profession and on an individual practice basis. While the medics are heavily entrenched in the NHS systems, a number of GPs are becoming more commercial and independent in their approach to care delivery, and the newer Allied Health Professions have a

clear opportunity to develop their practice independently outside of the state-funded structures.

- **Be willing to change and adapt to new social and economic conditions.** The relatively small size and entrepreneurial nature of the dental profession has allowed it to adapt more readily to challenging policy implementation, and it could be argued that perhaps the medical profession has grown too large and might benefit in terms of increased flexibility from internal division which is initiated by the profession itself. It is evident that the construct and consequent status of a profession in contemporary society is based on its historical development, and while the medics enjoy this strength, perhaps the newer 'professions' will need to acquire more history and tradition to be accepted on an equitable basis with the more traditional professions.
- **Devise a way to make the systems work for you.** The dental profession has shown tenacity in its opportunistic approach to adapting the newly imposed systems and using new technology to its advantage. The dental profession has perhaps learnt from experience that it cannot directly change the policy imposed upon it, but it can work it to its own advantage, and aims to gain the support of its patients with whom it is intimately connected and in whom it recognises a powerful lobby group through which it can effectively influence government. Professions might then look to their own relationships with their patients and actively seek to adopt strategies which provide mutual advantage for both patient and professional communities in order to ultimately maximise benefits for the profession.
- **Retain control of professional goals and standards, and of the degradation of professional skills.** The dental profession to date has retained much control over the degradation of its skills and, most importantly, through legal protection has retained the sole diagnostic role in the provision of its services. This is key to the profession's present maintenance of professional status and, it could be argued, is probably the most vulnerable area for its potential demise. Its willing cooperation to participate in revalidation and be open to the public scrutiny of its standards may prove essential for its continued status in this respect, and it is likely that resistance of a profession to such measures would be be detrimental to the maintenance of its professional status in the current social and political climate. The commitment to high professional standards in tune with current public demands and expectations appears to be essential in a more consumerist market for services governed, in part, by professional bodies with a high lay membership. The high levels of education and training which afford the professionals both an holistic overview and

specialist insight into the patient's condition are likely to become more valuable commodities as distinguishing features between the professions and those who deliver the more technical services which they prescribe and coordinate. A balance needs to be struck between the control of day-to-day work and long-term strategy for a profession, acknowledging that changes are being constantly introduced and rescinded requiring flexibility to weather the short-term changes to bring about a more favourable long-term situation.

- **Retain a unified professional institution.**
  There can be little doubt that the professions benefit in many ways from existing as collective institutions, even though their individual members make their own choices in many circumstances. The identity of a profession must be firmly established in the minds of the clients or patients in order for the profession to be positioned as a social construct in contemporary society, and some work is needed to communicate effectively with client groups as well as with groups within the profession to ensure that identity standards are effectively developed and conveyed. It could be argued that weak leadership in the dental profession allowed for more individual decisions to be taken by independent professionals in the circumstances relating to the April 2006 contract. However, the diversity of the profession and the range of decisions taken on an individual basis appeared to strengthen its combined resolve and ability to adapt and continue its development as a contemporary profession. Perhaps then traditional leadership is not needed in a collegiate professional community, where good communication of information and a personal sense of commitment to the values of the community allow members the freedom to make their own choices as to how they contribute to the collective profession in the future.

While those who embrace a commercialised professionalism appear to have benefited more from recent policy and socio-economic change in dentistry, in accordance with Hanlon's proposition (Hanlon 1998), it could be argued that this success is due to their willingness to adapt to whatever the policy changes demand, and not commercialism *per se*. With further change already on the horizon for the dental profession and others in healthcare, flexibility and willingness to respond to both government and patient demands will be key to the survival of these professions, who must at the same time individually and collectively uphold their high standards of service and levels of expertise to satisfy the contemporary expectations of society.

8.6 Final Conclusions

The overall conclusion from this thesis is that the professions are continuing to change and develop as a social construct, with varying degrees of success. The change appears largely to be reactive rather than proactive in nature, and the continued success of the professions in terms of their historical survival depends on both their own internal professional strengths and characteristics, as well as contextual social, economic and political factors, particularly those which influence demand for their services. Recent government policy appears to be directed at undermining the power of the professions through increased regulation, and in attempting to redefine the role and social construct of 'a profession' to incorporate skilled workers with lower levels of educational attainment, who lack the theoretical breadth of knowledge required for an holistic overview of the field of professional practice.

However, the dental profession, which has been the focus of this thesis, has been shown to have successfully adapted to and adopted the changes it has faced in recent decades and has been able to renegotiate a new professional identity, consequent to the implementation of policy introducing radical change to their professional practice. Having been granted the freedom to remove itself from the tightly controlled state-funded systems, it has demonstrated the potential for a profession to adapt and survive when a social, economic and political context which is conducive to this process exists. It might be postulated that a more independent model, of a professional providing services through a commercially funded system, may now be required to ensure the continued survival of the healthcare professions in the UK in the future.

Appendices

Appendix A
A short history of the traditional professions

The Clergy

The ancient profession of the clergy precludes the idea that professions arose only in the 18th and 19th centuries, though the characteristics of the early clerical profession might not match later contemporary ideas of a true profession. The medieval clergy were devoted to God, and the early Catholic Church provided a solid framework of organisation, career structure, training and discipline[1]. However, the post-Reformation English clergy underwent structural change and 'professionalisation' in a time of growing capitalism but before the era of industrialisation, thus forming a 'profession' in the terms described by O'Day (1987) as "a hierarchically organised but occupational group which claimed status in society on the basis of the expert services which it offered the commonwealth" (p.28).

After the Reformation, numbers dropped sharply with the dissolution of the monasteries, and the clergy became less conspicuous in society, with less distinction between layman and cleric as an increasingly pastoral definition of the ministry in the Church of England was embraced, in which the clergy no longer acted as an intermediary between God and man but enacted the role of a teacher who could help their parishioners to prepare for salvation (O'Day 1987). Ethical and exemplary behaviour were key to this pastoral role.[2] This new institutionalised church led by ecclesiastical experts was still an instrument of the state rather than an autonomous self-governing body, and power was concentrated with the Convocation of bishops and the crown, rather than with the local conference and lower house of clergymen (O'Day 1987). At this early stage the altruistic ideals of a professional were already evident, together with an organisational structure, but the existence of autonomy was dubious with power resting solely with those at the top of the structure and with government.

A distinct uniform distinguished the clerics from the laymen, although at this time an intimate knowledge of the scriptures was all that was required to join the profession. No formal qualification was necessary until in the 1500s when examiners were introduced to ensure the quality of recruits, and younger candidates from an educated background were preferred who had not already undertaken work in other occupations (O'Day 1987). A basic Bachelor of Arts degree was supplemented by intimate knowledge of religious texts, and the clergy was intended to become a graduate profession with recruitment via the universities and adequate financial remuneration[3]. By the early 17th century the expansion of university numbers and the greater availability of training in the provinces led to an improvement in the quality of clerics appointed, and an MA became the most popular degree among the clergy (O'Day 1987). Thus this profession became intimately linked with a university education, and theology was indeed the basis of the universities of Oxford and Cambridge amongst others. A standard of education was set, though at this stage the curriculum was dictated by the universities and not the profession itself. It might however be supposed that that majority of the staff in universities at that time were of the clergy themselves. The potential to obtain an appropriate mix of academia with vocational training had already become an issue at this time, one which appears to be ongoing in the present day for a number of professions.

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[1] In the medieval church there were two distinct hierarchies, those of orders (subdeacon, deacon, priest, bishop) and those of occupation (religious orders, pastoral ministry, civil government, ecclesiastical law courts and others).

[2] Career structure at this time was indistinct and many did not progress beyond their first posting. Financial remuneration remained pitiful in many livings, often reliant upon tithes, fees and glebe income. Pluralism commonly persisted despite the authorities insisting that clerics should not indulge in secular 'unprofessional' occupations such as fishing, hunting and farming.

[3] The traditional system of patronage had led to the appointment of many clerics who were unsuited to pastoral duties and this was addressed by an overhaul of the recruitment system, engaging examining chaplains to improve the efficacy of the patronage selection process (O'Day 1987).

It is reported that a sense of corporate identity developed amongst the clergy in the 17th century as they arranged professional meetings, shared educational experiences and attained improved social status, all of which added to a sense of belonging. O'Day argued that a profession at this time was more than a status or occupational grouping, but depended on the organised expression of common interests, be they occupational, social or economic (O'Day 1987). This then contributed to the collegiality aspect of membership of a profession, and this sense of organised expression of common interests seemed important in the continued evolution of the profession[4]. There is a view of increasing division between the Church and the communities it sought to serve, and this isolation from the mainstream through membership of an exclusive group seems to have become more important as early as the 17th century in terms of changed, and perhaps deteriorating, relationships between professionals and their clients.

By the 17th century the clergy had become a recognisable profession in itself by our modern day standards, but it had no control over its recruitment, training and placements, these powers still resting with the universities, the crown and the wealthy landed classes. Standards and discipline were enforced internally through the diocesan, parochial and court structures, and the church lay outside of the bounds of civil and criminal law (to the annoyance of the lawyers). Thus self-regulation and the setting of standards and rules of conduct was an internal matter for the profession from its earliest development, and remained so over a long period of time.

The career structure of the clergy was inadequately developed with no single ladder of advancement, maintaining a clerical elite of university-based high fliers, and an increasingly well-educated but lower class of parish-based clergymen[5]. A later rise in income was matched by a rise in the social origins of the clergy and in their social status in society[6]. Thus income and social status both became symbols of professional status in society in 17th century England. However, altruistic motives of professionals could then be brought into question, when rewards in monetary form may have detracted from a true calling to serve, and the monopolistic way in which services were delivered brought an air of policing, rather than of serving or caring, to their professional practice (O'Day 1987).

The clergy is also reported to have struggled in terms of its 'sense of being' at this time. It could be argued that individuals might seek the services of medicine, the law and the military, for health, justice and security in the course of their lives, but the church may not be a service that is naturally sought by man. Pastoral care and the image of a shepherd tending his sheep were heavily promoted in the post-Reformation era to allay this tension between worldly and spiritual duties, and increasing concerns over tight state control enforced through the clergy as agents of public order (O'Day 1987). While there might have been definite similarities between the clergy, and the medical and legal professions, there were also clear distinctions arising from the intangible nature of the services provided by the ministry.

During the 18th century the clergy remained a considerable force in terms of numbers and authority into the industrial era, living within a culture of strong Christian tradition (Corfield 1995). The established clergy were present in vast numbers across the country, but at this time the Church's monopoly came under attack and competition

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[4] This professional grouping caused alienation from society, fuelling antagonistic relations with laypersons outside of the professional circle and perhaps increasing the 'togetherness' of the professional group.

[5] It is possible that a significant number of the latter moved away from the Church and into politics because of this (O'Day 1987). Parish clergy tended to hold their posts over long periods of time, which may have been of benefit or otherwise to the local parishioners, depending on the incumbent's pastoral skills. They were at least well-established and known in their position in the community, rather than transient.

[6] Their pay structure remained incoherent with large regional and local variations in livings. Payments improved markedly between 1700 and 1830, although still not high in relation to other professional groups at this time.

grew between the Church of England and other denominations, as well as between the clergy and secular professions, who increasingly impinged upon their areas of work throughout the 18th century. The clergy were under close scrutiny and required to commit to their occupation 24 hours a day with a true vocational calling. Clergy who conveyed doubts in their religious beliefs could not be tolerated in this 'sacred profession', with its reputation for learned study and close historical ties with education. Their unique moral status and calling meant that the clergy were particularly open to criticism of their failings[7], often related to their handling of money[8] and their pluralism of occupation[9] (Corfield 1995). There was a great discrepancy between various livings, the shortfall met in part by the setting up of Queen Anne's Bounty to augment the livings of the poorest.[10] Their singular status however gave them exemption from jury and military service and they were barred from parliamentary election (Corfield 1995).

The clerics' ceremonial role endorsed their rising social status, with respectful congregations receiving religious instruction through the pulpit and the written pamphlets of prayers and sermons which were widely circulated[11]. The 1689 Act of Toleration in England allowed freedom of worship to all who believed in the Trinity, i.e. Protestants, and the idea of 'one church, one people' in Britain was abandoned at this point[12]. The lay preachers, a number of them women, presented a challenge to the 18th century establishment, most notably in the form of the Methodists who engaged non-educated and non-ordained preachers to reach the rural areas (Corfield 1995). In Ireland the scene was still dominated by the Roman Catholic Church, and in Scotland the Presbyterian Kirk of Scotland was established, though each had their rivals who served to divide the clerics.

Lay patronage continued to influence appointments to as many as half of the livings up to the mid-19th century, with a further one third in the hands of the Oxbridge colleges (Corfield 1995)[13]. Thus the profession was already struggling with its traditionally established identity. It found itself on the receiving end of sharp criticism of its conduct, under attack from competitive forces, and with little autonomy or control over appointments or recruitment. Similar issues appear to be at the forefront of the situations and challenges which face the modern professionals today, and so it would appear these are certainly not new, nor unique, in our current social and political eras.

The Protestant state in Britain meant that religion was inextricably linked to public office and all who held high rank in public office had to be seen to be taking communion under Anglican rites. The divisions between denominations persisted and there was no single unified 'profession' for all clergymen. Clerical power became more divided as it resisted the monopoly of any particular regulating or organisational body, and there were many internal disputes and schisms, though the overall power of the clergy remained. In the second half of the 18th century, non-conformist congregations grew,

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[7] Criticisms of these professionals were not seen to equate to hostility towards the professions or organisations themselves, and the 18th century satire directed towards the clergy was not intended as a slur on the Church itself. The clergy were characterised as bigoted hypocrites who could be insincere and rather wanting in their sermonising. They were expected to set an example and extend their principled preaching to every aspect of their own lives, so that any insobriety or frivolity did not pass unnoticed. All forms of over-indulgence and gluttony were criticised, constantly reminding the clergymen of their social visibility

[8] Money was also linked to the clerics, in relation to the collection of tithes from all in the parish, providing a very visible tie between locally derived income from parishioners and the unsuitable ways in which it was spent.

[9] The great variation in the value of livings encouraged many clergymen to diversify into others fields or to take on multiple parishes, with absentee parsons delegating their parochial duties to their meagre and impoverished curates (Corfield 1995)

[10] The introduction of 'Queen Anne's Bounty' was in direct response to a 1736 report on clerical poverty, which it sought to address through grants to poor livings in England and Wales. (O'Day 1987) .

[11] Plagiarism was a readily accepted form of borrowing for those who had less talent in devising their own discourse.

[12] Similar acts followed in Scotland and Ireland, in contrast to Austria where in 1781 it became compulsory for all to conform to the Catholic Church with obligatory attendance. (Corfield 1995) .

[13] As appointments were not centrally controlled, 'futures' were discretely offered for sale, to be purchased by the families of those individuals seeking a living, giving power to money as well as to lay ownership. Posts were held on freehold tenure for life, and included many of somewhat eccentric demeanour and renown, including Jack Russell, the hunting parson with the best pack of hounds in Devonshire.

but the Church of England retained its power as the state-sponsored church. It also retained its powerful internal hierarchies of power from its bishops in the House of Lords, the deans and archdeacons of the cathedral communities, down to the regular parochial clergy of the rectors and vicars (Corfield 1995). Anthony Trollope's 'Barchester Chronicles' novels which were published as weekly parts in the 1850s and 1860s provide a rich insight into the power structures, social status and internal wrangles within the Church of England at this time, and highlight many of the threats and challenges which the clergy encountered in this period. We can assume that these clerical issues were of contemporary interest to the reading population at that time, being delivered in much the same way as episodes of modern soap operas.

The first directory of the clergy in the form of the Clerical Guide to the Church of England was published in 1817[14], followed by the definitive Crockford's Clerical Directory from 1858 onwards (Corfield 1995). Gregory King estimated that there were 10,000 clergymen in England and Wales in the 1690s, with perhaps a further 1,500 in Scotland and 2,500 in Ireland. By 1803 this estimate had increased to 13,500 for England and Wales, with 1,900 and 3,500 in Scotland and Ireland respectively. By 1851 these numbers had virtually doubled, with the census recording 26,235 clergymen in England and Wales, with 3,812 in Scotland and 6,241 in Ireland, giving a total of 1 clergyman to every 737 people in the British Isles (Corfield 1995)[15].

The internal power structures were so entrenched in the clergy that reform was slow. Convocation, the church's own parliamentary body, did not meet between 1717 and 1852, and the clergy had no other forum in which to debate issues. By the 1830s local societies had formed, and the 'second Reformation' was underway with reorganisation of structures and reduction in pluralism, strengthening the church's position against dissenters. The profession called for the revival of Convocation as a means of strengthening and regulating the church. However, by that time one in three of all clerics was not Anglican, as the 1851 census showed. Apathy, indifference and atheism were seen to add to the growing threats to the future of the established church, and the other professions were becoming well-established in society and powerful in their own rights, reducing the clergy's role in areas such as land management and education (Corfield 1995).

A number of the defining features that we would associate with a profession appear to have arisen from the Clergy in England in its early and later development, and it also appears to have suffered from similar challenges and threats that are perceived to exist towards the professions today. Prest (1987) would argue that the clergy never regained their prestigious and privileged position after the Reformation, in that there was no secure restriction on recruitment, allowing all-comers to undertake their pastoral and preaching duties. This might well have contributed to the longer-term demise of the clergy as one of the main professions in Britain. It could however be argued that a profession does not 'rise and fall', but like any other organisation, transforms in order to survive in the current and anticipated economic, political and social context. The notion of rising and falling, or emerging and receding, often alluded to in the literature, appears to relate primarily to the issue of power and status of the profession in society, and seems to be intimately linked to the characteristics and behaviours which are particularly associated with a profession, including the good it is contributing to society, its competence in selection and training, its ability to deliver an expert service, and the standards of its practice in terms of quality and ethics. Perhaps

[14] As each parish had its own resident clergyman, many of them incumbent for extended periods of time, there was little perceived need to publish a clerical directory

[15] Plural incumbencies led to absenteeism on a grand scale, regulated in part by the issue of licences for non-residence in 1803. Thus 43% of parishes in 1827 relied upon their curate or clerical assistant to take services, who lived on extremely poor wages with uncertain prospects.

the changes observed in the form and behaviour of the professions might more appropriately and usefully be regarded as an evolutionary type of positive adaptive response, in which each profession becomes better suited to survive in its current environment, or fails to adapt sufficiently or in a suitable manner, and thereby enters decline.

As the apparent origin of and template for the professions in the UK, the clergy has exhibited monopoly power, status, learning, registration, and the formation of professional groups. It has also demonstrated that a slow response to a changing social and political context, with entrenched structural and cultural elements, combined with declining demand for its services and challenge from other professional groups, has led to its loss of power and professional jurisdiction, and ultimately its demise in terms of its power and status in society.

The Law

Prest (1987b) reported that prior to the 19th century elevation of the medics and men of science, and after the dethronement of the clergy through the Reformation, "lawyers plainly constituted the pre-eminent English profession" (p. 64). In the early modern days of the legal profession, a wide range of occupations were associated with the law, and after the abolition of the Royal Prerogative Courts in the 17th century, the common lawyers benefited greatly from a large increase in business.

The common lawyers at this time trained through an apprenticeship rather than book learning[16], but successfully challenged the power of the university-trained civil lawyers who dealt almost exclusively with matters of the Church and Admiralty (Prest 1987b). Living, working and training around the Inns of Court and Chancery in Holborn in London, they appeared to be a hardy collective who were immune to public disdain, and in the 18th and 19th centuries they strengthened both in numbers and power. The wide ranging scope of the law, and the high reputation attached to it, gave the lawyers a confident, dignified and respected standing in society, and made it an occupation worthy of a gentleman. A detailed knowledge of the law required extended and applied study in order to grasp its intricacies, which added to its air of mystery to the layman[17].

Over a period of time from the 1600s onwards, the segregation and differentiation of the roles of barristers and attorneys became apparent (Prest 1987b). The 'upper branch' of the profession comprised the barristers who increasingly specialised in litigation and advocacy, together with the civil lawyers who specialised in clerical and admiralty matters. Both these groups had originated from the aristocracy and were gentlemen by birth (Prest 1987b). However, the largest number of lawyers, the attorneys and solicitors, formed the 'lower branch' of the profession, dealing not only with matters leading to litigation but to other legal documentation and advice, much of it associated with families, finance and property. The unwritten conventions of the distribution of work between the attorneys and the 'learned elite' barristers were originally based on status rather than function, only after 1650 becoming more aligned with their respective roles in the practice of law (Prest 1987b). Thus the origins of law professionals at this time were from both the elite and lower social classes.

This situation was perpetuated by barristers attracting grossly inflated fees for work in their restricted field of practice, while most attorneys and solicitors accepted the lower status and role they acquired with its nonetheless substantial material benefits (Corfield 1995)[18]. The early legal profession could be regarded as a solid core of affiliated

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[16] Training commonly comprised either an articled clerkship to a local lawyer (derived from mediaeval tradition), or service in the household of the landed gentry to become a legal man of business.

[17] Summaries of the law only began to be published in classic and standard texts during the 1700s by eminent practitioners, with relevant tomes produced for English and Scots law. (Corfield 1995).

[18] In the early 17th century, prior to the publication of official lists, the identification of a legal professional rested largely on his appearance and attire, and his well versed use of jargon. Lawyers at this time wore black or dark colours, often

lawyers with a wide range of marginal practitioners, divided by a flexible and permeable boundary. It was in the core interests of both upper and lower branches of the legal profession to squeeze out the lay practitioners and amateurs, and tighten up on the 'non-professional' admissions to the inns of court (Prest 1987b; Corfield 1995). The process of self-regulation began in the 1740s, and by 1750 the legal world was becoming much less complex in organisation and language. The barristers enjoyed large measures of social prestige and vocational autonomy, while the lower branch was subject to more direct scrutiny and rigorous regulation.[19]

Since 1402 those practising in England and Wales had to be enrolled in an appropriate law court, with defaulters 'struck from the rolls'. This system however was not rigorously implemented, with consequent problems which became of open concern in the early 1700s. In 1729 an Act was passed for 'the better Regulation of Attorneys and Solicitors' so that after 1730 all attorneys would be examined by a judge. Once allowed to practice, the attorney could be disqualified if found guilty of professional wrongdoings. At the same time, the articled clerkship became the first stage of a recognised and standardised professional training pathway (Corfield 1995). Whereas the clergy had little defence against new entrants to their profession and competition once the 1689 Act of Toleration had been passed, the lawyers made it their business to ensure that those who did not meet the high standards of the profession were excluded [20].

Thus by the 18th century the lawyers had a recognised internal structure, standardised training pathways, a system of registration and self-regulation with a clear code of professional conduct, and a monopoly of practice. The profession took it upon itself to set and maintain high standards for its members' conduct, almost certainly fuelled by the suspicion and contempt which many expressed with regard to the profession and the poor public profile it often presented. Knowledge of obscure case law and a cunning disposition were synonymous with success in law, in which knowledge generally remained uncodified and thus shrouded in mystery[21].

Lawyers proliferated in the period from 1560 to 1660, as the demand for their services was rising with an overall rise in litigation (perhaps consequent upon price inflation and increasing land sales) and the number of attorneys continued to rise after this date (Prest 1987b). The political arithmetician Gregory King estimated that there were 10,000 'persons of the law' (not including barristers) providing a broad range of legal services in 1688, this rising to 12,000 by 1759 (Prest 1987b). In 1730 it was estimated that there were perhaps 6,000 attorneys and solicitors practising in England and Wales, of which a third had addresses in London (Corfield 1995)[22]. Despite problems associated with data collection and the motives of those employed for this purpose, a

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sporting a closely trimmed beard, perhaps carrying a pen case but never a sword (Prest 1987). They were characterised as being dry and dull, delivering long-winded speeches and droning on relentlessly in incomprehensible language which incorporated law-French and Latin (Corfield 1995). Law-Latin was impenetrable to anyone outside of the profession and raised public resentment and accusations that lawyers were deliberately concealing their dealings in an alien language. From 1733 legislation precluded the use of law-Latin in court and all proceedings were subsequently conducted and recorded in full in English, although technical terms in Latin, for example *habeas corpus*, could continue to be used.

[19] Those who did not attain or maintain a high regard were known as 'pettifoggers' from the 18th century onwards - the lowly tricksters and rascals of the law - and lawyers who by the very nature of their work come close to the criminal fraternity were often regarded as villains themselves (Corfield 1995).

[20] There were of course many who bypassed the hurdles placed ahead of them in order to practise 'under the radar' of regulation. These 'understrappers' were not embraced by the legitimate members of the profession, though they often provided legal services to elements of the public, often illiterate, who would not otherwise have been able to afford professional legal services.

[21] The devil often appeared in imagery together with lawyers, who were seen to be dangerous in that they went everywhere and knew everyone's business. Barristers were especially suspicious, as they would plead any case, for a fee, regardless of right or wrong.

[22] Each lawyer was designated as a 'Gentlemen' in the enrolment lists, which led to some confusion in that a 'Gentleman' did not need to divulge his occupation, especially when standing for parliamentary election! Barristers however were accorded the courtesy title 'Esquire' and were equally difficult to account for, as the Inns in the early 18th century listed 'of grace' members who had neither studied to the required standards nor practised in law (Prest 1987b).

huge proliferation in the numbers of lawyers in the 18th century became evident, and this undoubtedly increased pressure on the efficiency of the regulatory processes, such as they were. However, numbers were curtailed once registration was introduced and substantial fees became required for articled clerkship training.

Many wished to demonstrate their learning publicly and establish respectability through the establishment of professional societies. Internal regulation of good practice prompted the formation in 1740 of the 'Society of Gentleman Practisers in the Courts of Law and Equity', run as a club with approximately 200 members who met at inns and coffee houses. By 1792 it called itself 'The Law Society', and was responsible for vetting entrants to the profession and lobbying parliament on matters relevant to the legal profession. The demarcations of practice between the barristers and attorneys (solicitors) were debated, contested and finally agreed, creating two adjacent monopolies within one profession (Corfield 1995). At this stage the main difference between the clergy and the law appeared to be the independence of the lawyers from state control, and the lack of inherited and ancient power structures. This left it free to develop in a more organic manner, taking the more desirable elements of professional status that the church had already established, and incorporating them into a new model of a profession that was much more independent and free thinking. Though still based on the premises of interpretation, judgement and serving the greater good, the lawyers enjoyed much more liberty to shape their own destiny and adapt for survival in the world in which they found themselves practising at this time.

As with the clergy, a collective sense of identity in the legal profession was enhanced through the publication in the 18th century of lists of practising lawyers, organised geographically, with the vast majority of practices at that time being single-handed, especially outside of London. An annual license fee of £3 (£5 in London) was introduced in 1785 by William Pitt the Younger (who had himself undertaken some legal training), followed in 1794 by a hefty stamp duty on first registration of £50 (£100 in London). While many in the profession protested, others thought it worthwhile to promote respectability and exclude the rogue element from the profession (Corfield 1995).

Provincial societies of lawyers came into being across the UK, promoting the principles of association and self-regulation, and the overarching Law Society set out a framework for national supervision within the profession. In 1833 a series of lectures for articled clerks began, and in 1836 a Common Law Examination Board was constituted which brought legal education to a common national standard, while the Law Society (until then a voluntary association) became the sole registering body for attorneys and solicitors by Parliamentary consent in 1845[23]. The legal profession thus introduced the precedent of exclusive professional membership, limited to those who had attained the required standards of training and practice, further restricted by the payment of a sizable sum of money in the form of a membership fee, all of which added to their status and commanded the respect of society.[24]

The lawyers' altruistic professional commitment to their clients and to society was endorsed through the adoption by barristers of the 'cab-rank rule', of not choosing between the briefs that arrived before them, ensuring that all defendants were equally entitled to their advocacy. The courts became increasingly 'lawyerised' in adopting conventions and customs around the work of the barristers, who were by this time required to be a graduate of one of the four Inns of Court situated between Gray's Inn

[23] This had much in common with the medieval guilds, and some similarities with the developing trade unions, though its members were self-employed rather than employees.

[24] Dress and behavioural codes continued to develop to play a significant role in professional life. The barristers and attorneys developed a code of mutual politeness and a rhetoric of unity, the value of reciprocal ties being recognised by both. Barristers were distinguished by their own form of dress of wigs and robes, harping back to the late 17th century

and the Inner Temple in the area of 'legal London'. The new Law Society Hall was constructed at its centre in Chancery Lane in 1831, amid the main law courts and high courts which demarcated the barristers' home territory.

The codes of dress and conduct, the geographical areas where business was conducted, and the material symbols of status and success thus became synonymous with the successful profession of the law. The regional court circuits attracted touring judges and barristers, who were highly visible socially and greeted with a great deal of pomp and ceremony. "Theirs was a sociable, clubbable, self-important world" (Corfield 1995, p.88). The touring barristers arranged their own messes for dinners and social activities, which became the informal equivalent of the attorney's Law Society, until a national Bar Committee was established in 1883 with representatives from the Inns of Court and the circuit messes.

Barristers were a scarcity with only 300-350 practising in England and Wales in the 18th century, adding to their prestige and social worth (Corfield 1995) but also perhaps encouraging a decline in their own services by their retreat from wider society into courtroom advocacy (Prest 1987b). By 1805 there were estimated to be 730 barristers in all, growing fourfold to 2,816 by the census of 1851.[25] As with solicitors, training for barristers became more formalised.[26] The barristers defended their exclusive territories in the Inns of Chancery and managed to effectively keep the attorneys and 'lower branch' at bay. Educational reforms were slow to establish a foothold but in 1851 a Council for Legal Education was founded by the Inns of Court, and subsequent trainees were required to attend lectures or undertake an examination, made compulsory in 1872[27]. Examinations based on learning by rote were replaced in due course by more acceptable forms of measuring required standards for practice (Corfield 1995). The judges were technically elevated above the legal profession, though arising from it, being remunerated through state salaries and appointments with lifetime tenure.[28]

The legal profession thus grew in power and wealth from the 17th century onwards and has continued to be disproportionately associated with dominance in public life (Prest 1987b). It appears to have originated both from the university-educated aristocracy and the educated gentlemen of the middle classes, and has evolved from distinct upper and lower branches which perform and relate in terms of mutual respect. It established a professional body in the form of The Law Society, which still performs a regulatory role, and membership and educational standards for the profession are set by this professional association, which operates not as a closed shop but by restricted membership and with the legal authority of the state. Professional practice has thus been established as being self-regulating and autonomous. One clear distinction from the clergy is the independence of lawyers, as self-employed practitioners, from direct state control, and their ability to self-organise without the historical ties and structures of an overarching establishment such as "the Church". Their practice has always been intimately linked to money, and their reward has in the main afforded greater opportunity for financial gain than in the clergy. While they profess to be engaged in providing a service for the good of their clients and for society as a whole, the altruistic

[25] This led to cut-throat competitive strategies, especially in terms of undercutting fees in a system which was and remains almost entirely in the hands of the private sector.
[26] Students were allowed to read at the Bar at one of the four Inns of Court, with a specialisation in either Equity Drafting for Conveyancing, or Special Pleading. Programmes of study held no set form, but included attendance at a number of Inn Dinners, and extended to 7 or 8 years, especially for those who were not already graduates.
[27] Educational developments in Ireland and Scotland followed along similar lines, with Edinburgh having a disproportionately high number of lawyers in its midst.
[28] The judges developed their own codes of dress and conduct, and having been appointed from the senior barristers, they were addressed by them as 'Brother'. Their appointments carried the weight of social credulity and authority. Their small numbers and well documented achievements boosted their public and professional esteem, which reflected well on the legal profession as a whole. (Corfield 1995).

element of the legal profession is perhaps the weakest and least evident of its characteristics, in comparison to a number of other professions.

Medicine

Having considered the eras traditionally associated with the dominance of first the clergy, and then the legal profession, further examination of developments in the era of industrialisation from the late 18th century onwards reveal the rapid development of the medical profession particularly, as an establishment of Victorian society. The rise of the medical profession has been widely associated with industrialisation and urbanisation, and there is debate as to whether it is infact linked with one or the other, or both. It evidently underwent a substantial transition from a fairly humble occupation to an elite profession in the 19th century (Pelling 1987). The tardiness of this transformation in relation to developments within the clergy and legal professions may rest with the increased effectiveness of and advances in scientific methods in medicine at this time. Differences are evident in the process of professionalisation between the two older learned professions already considered, and in medicine yet another route appears to have been pursued.

There was a close bond between medicine and the Church through the English monasteries before the Norman Conquest, when universities were under ecclesiastical influence, and those wishing to become a practitioner of 'Physic' studied an arts degree and subsequently graduated in medicine, gaining a licence to practice from the university. Many practitioners were also ordained, and as their professional status grew they were rewarded with higher clerical positions such as canonries and rectories from bishops and kings (Carr-Saunders and Wilson 1933). So while the law at this stage was also intimately linked to the church (though it later grew very much in isolation and sometimes in opposition to the church), the medical men also were often one and the same as the clerics.

In the 15th century there were a handful of elite Physicians and far fewer Surgeons in Britain, heading a widely diversified flock of health practitioners. As with the internal division in law, Medicine was also divided, but into a tripartite of physicians, surgeons and apothecaries (following the Continental model) representing specialisation and the division of labour, both commonly recognised elements of the professionalisation process (Pelling 1987). In England the College of Physicians (founded in 1518, and later granted Royal status by Henry VIII) and other regional institutions became influential in providing training, control and membership which granted some form of demarcation between a layman and a medical man.[29] As in law, the medical profession attempted to develop its own controls and codes of conduct away from the direct control of the universities and their clerical powerbrokers.

In reality the College of Physicians had many characteristics of a guild at that time. It ensured that no person except a graduate of Oxford or Cambridge could practice physic unless examined and approved by the College[30], though in a parallel system the church also continued to licence physicians for the next 150 years (Carr-Saunders and Wilson 1933). However, while structures were being put in place to improve medical education and training standards, there were not nearly enough qualified practitioners to meet the health care demands of society at this time (Carr-Sunders and Wilson 1933)[31].

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[29] Conversely, in Europe the medical profession became structured around the medical colleges and faculties of the universities.

[30] Many eminent physicians became men of great distinction, and John Calus founded the Oxford College which later bore his name, though it started out with a poor reputation for a medical school in the 1500s.

[31] Apprenticeship also has had an interesting relationship to the medical profession, given the later tendency to devalue this practical form of training. While initially a form of inexpensive education that did not involve the university system, the medical colleges at Oxbridge from the 16th century included elements of apprenticeship training in their curricula.

Registration appears to be a common thread binding the early professions. The establishment of a College of Physicians enabled a register of practitioners to be kept from early in the 1500s. The original Munk's Roll of the College of Physicians in 1518 accorded every member with the title 'gentleman'. They existed as an elite, well-read and highly educated group, who associated closely with the aristocracy in a patronage relationship and rarely saw a patient in the flesh. They were few and far between, and the majority of the population were treated by an assortment of more lowly types of practitioners (Pelling 1987).

The relationship of the professions with the guilds raises many issues, not least of which is the reasons why the professions have survived to the modern age while the guilds have not. The College of Physicians was founded at a time when Guilds were the norm, and so in order to clearly distinguish the profession from the commercial nature of the crafts and trade guilds its altruistic role as a 'beneficent and civilising force' was stressed, together with the requirement of its community to renounce personal gain in the public interest. There are however records of physicians belonging to early medical guilds in Bristol, Norwich, York and Canterbury, confusing still further the distinctions between these organisational forms and occupational communities (Pelling 1987).

Holmes (1982) argued that the subsequent rise of the medical profession was not as closely linked with industrialisation as some would have us believe, as a large alternative body of practitioners serving the population was already in existence at that time outside of this professional elite. Their growth was perhaps more aligned with developments in science and not with urbanisation and social restructuring. Holmes' traditional approach to the professions was to demarcate between learned bookish professions and the more lowly practical handiwork of the crafts, posing an interesting dilemma in explaining the rise of the surgical specialties in particular (Holmes 1982). Pelling reported that the early medical profession had been described as looking like:

> *"...a series of battlegrounds, largely lacking in standards or centralised control, and yet at the same time over-rigidly stratified into the three parts of practice represented by apothecaries, surgeons and physicians."* (Pelling 1987:90)

though this point may have been stressed purely to prove a starker contrast with the order and uniformity of the middle-class profession established at a later date.

As the physicians rose in status from the 15th century onwards, the surgeons' status declined, being members of a small guild numbering only 17 members in 1435 (Carr-Saunders and Wilson 1933)[32]. In 1540 the Surgeons came to an understanding with the Barbers that amalgamated them into the Barber-Surgeons Guild. However, there remained a clear distinction between the two, and no barber was to practice surgery, except in respect of tooth drawing, and no surgeon was to shave a client (Carr-Saunders and Wilson 1933).

The founding of the College of Physicians in 1518, the merging of the Barbers company with the small elite of Surgeons in 1540, and the separation of the Apothecaries from the Grocer's Company in 1617, created the professional bodies and institutions that served to substantiate the tripartite divisions which still exist to some extent in modern medicine, though possibly with differing hierarchical status. The physicians looked down on the chirugions (surgeons) as manual operators and, while an Act of 1540 had allowed the physicians to practice surgery, the surgeons had no right to prescribe for their patients, and required a senior physician's consent to carry out major surgery. The surgeons were still infact closely tied to the ecclesiastical

[32] Though in earlier times they had ranked in status with the physicians as court and army surgeons, they did not come into contact with Greek learning.

systems, and all those considered fit to practice by the Company of Surgeons had to be approved and licensed by the Bishop of the Diocese (Carr-Saunders and Wilson 1933). Apothecaries (the future general practitioners) were generally further up the social ladder than the barber-surgeons, possibly because of the precedence of their non-manual work being more highly regarded than manual labour (Pelling 1987). There appeared to be little unity at this time, and a single 'medical profession' was not evident.

The Guilds at this time shared many features in common with the developing professions, including specialisation, self-regulation, public and legal recognition, and examining bodies for qualifications.[33] The guilds also upheld a public duty to maintain standards of production and the signs by which members declared their qualifications, through for example their attire and premises. It would appear then that many of the rules and codes associated with the professions had been derived from the Guilds before them.

So while the College of Physicians was seen to be a frontrunner in the maintenance of standards within its membership, the guilds had been responsible for this practice for some time in their own trades and crafts. The elimination of competition by staking out a monopoly of practice was also meticulously exercised by the guilds, together with the swearing of an oath by members on admission to the guild. Many of the guilds were intimately related to interests of public health, with appropriate controls and regulation, often through the municipal authorities. It is thus difficult to argue that only professional peer groups could maintain and control standards effectively, when the guilds and municipal authorities had previously been engaged in such practices for some time, though their efficacy in this regard is perhaps difficult to gauge.

The College of Physicians exercised a great deal of autonomy on behalf of its members and, although strongly allied to the Crown, its relations with universities were limited, possibly proving detrimental in terms of its public recognition and control over its members' practice. Indeed the London Barber-Surgeons as a guild were more integrated into civic life than the College of Physicians (Pelling 1987). As with the clergy at this time, many physicians were part-time practitioners, challenging the contemporary view regards a professional as dedicated solely to their chosen field. Thus Pelling would argue that it might be more appropriate to consider a profession more in terms of a trade or craft guild, and less as a full-time autonomous position (Pelling 1987)[34].

Given the shortage of qualified practitioners, the Apothecaries continued to flourish as the mainstay of medical treatment for the masses. [35] In 1617 they separated from the Grocers' Guild to form their own Society of Apothecaries, and underwent a period of huge growth in the 17th century. This forced the Royal College of Physicians to make provision for free treatment for the poor by their members and set up a free dispensary in 1688 (Carr-Saunders and Wilson 1933). In 1748 the Society of Apothecaries was allowed to set up a board of examiners to licence those who dispensed drugs within 7 miles of London, and became established as a lower tier of the medical profession in 'general practice'. They were thus due much of the credit for the improvement in health and decreasing death rate in Britain in the late eighteenth century.

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[33] In the 16th century they also became more appreciative of the requirement to keep trade secrets within their guilds, and to regulate disputes between members internally, who were not allowed to resort to law until the case had been heard before seniors of their own company, thus enforcing control over their own members' behaviour.

[34] In terms of pluralism, there seemed to be a strong association of the barber-surgeons with music. Links with other businesses were concerned with dress and appearance, as well as distilling (related to the production of new drugs by the apothecaries) and, ironically, the selling of tobacco. Physicians were also associated with academia and the clergy, as well as with international trading.

[35] An Act of 1542 had denounced the Company of Surgeons as being self-interested and not concerned with the well-being of their patients, and gave the Apothecaries the opportunity to prescribe drugs themselves.

In the late 16th century it is estimated that there were 500 medical practitioners in London[36], giving a ratio of one to every 400 people and indicating that medicine was a significant occupation at this time (Pelling 1987). However, use of the generic label of 'medical practitioner' in quantitative studies concerned with this period might potentially confuse interpretation of the tripartite distinctions between the practitioners.

The 17th century patient appeared to have been extremely active, being critical and well-informed, and consuming large amounts of medical care. Poverty often caused more demand, as well as boosting the prospects of unlicensed practitioners, who practiced medicine part-time. Holmes (1982) postulated a rise in demand for medical services in the 18th century due to an increase in middle-class prosperity and the development of towns as service centres. This argument has been adopted by others to account for further growth in the profession in the 19th century. However, the poor clearly contributed significantly to the demand for medical services in earlier centuries.

The medical profession's development from this broad base of practitioners adds weight to Pelling's consideration that a linear view of a profession's development is too restrictive and narrow in its approach (1987). An evolutionary 'Darwinian' approach of a rare and highly evolved professional, specialised to survive in a particular environment, may be closer to reality but still does not comfortably accommodate the part-time practitioners who provided a range of other trades and services in accordance with social and economic pressures.[37] Consultations were commonly carried out by proxy, through a friend or relative, and privacy and confidentiality were not a concern (Pelling, 1987).[38] The modern trend towards healthcare provision at the supermarket and internet diagnostic services may not too far removed from what has gone before.

The fees paid for medical services in the 1700s varied greatly from nothing (in the case of services given to the poor) to a range of conditional contracts with part payment upfront, followed by settlement in full when the cure was completed.[39] A cure was often purchased as an item, rather than as a full service package including diagnostic services, so in this respect commodity market relations existed at an early period in medicine. Many today would hold that healthcare should be free at the point of delivery and have difficulty in conceiving that an alternative fee-paying private system to 'free' NHS care once existed and was the norm for many centuries

Competition in the 17th century existed in the form of practitioners who might provide an alternative service or better contracting terms. A retainer system of annual payment to attend a family, similar to modern capitation schemes, was also in existence from early times, giving practitioners an assured income and an opportunity to undercut competition, though not without calculated risk (BDA 2007b). Competitive tendering for services was also the norm for the purchasing agreements of local authorities and Boards of Guardians. Much of this commercial aspect of medicine persisted into the National Health Insurance era in the early 20th century (Pelling 1987) and is re-emerging today.

In the 17th and 18th centuries, as many as 50% of graduates from Cambridge and even more licentiates and unlicensed practitioners went into practice in the provinces and

[36] 50 of the College of Physicians, 100 Barber-Surgeons, 100 apothecaries and 250 other practitioners.
[37] The provision of medical services at this time was primarily through shop premises, with public rather than private consultations, and providing a range of other distractions including food, drink, music and displays to entertain and divert their customers' attentions.
[38] In some circumstances the relationship between a physician and his patient was very remote, with London hospital physicians attending only once a week as a 'Consultant', their patients brought before them by lesser officers in a public hall, and with no provision for the examination of patients who could not walk or get out of bed.
[39] Patients often engaged in self-diagnosis and hired a practitioner to effect a particular cure. If things went wrong, patients would seek to reclaim their fees before taking legal action.

small rural centres.[40] However, in rural areas, unlicensed practitioners were the more common, and there were many unofficial women practitioners as well as a more significant role for shared traditional knowledge to be included in the professional scope of practice. Competition appears to have been less fierce than in the cities, and apparent rural specialisms may have been due to limitation of knowledge rather than advanced knowledge in one area (Pelling 1987).[41]

Despite the College of Physicians, the medical profession remained somewhat disorganised and unable to offer a united front. The learned professions were regarded as being too commercially minded, with "the profit motives of tradesmen" (Pelling 1987:115) A campaign for reform of the learned professions in the 17th century in response to society's reaction to their monopolies of practice, resulted in a degree of consolidation of the medics' position in society and led to more commitment in the form of increasingly full-time practice. However, the perceived distance between the practitioners and their clients often led to poor public perception of their roles.[42]

The well-established Surgeons in London attracted similar criticism in terms of high fees and a tendency to distance themselves from patients. However, the surgeons were very much more 'hand's on' and down to earth than the physicians by the very nature of their work, and embraced more readily the less-learned practitioners who were nonetheless recognised as skilled in their craft. The Surgeons also began publishing texts in the vernacular making them more accessible to all. As the population rose between the 1500s and 1700s, there was great social mobility and expansion of educational opportunities. Trades and professions both rose in status, especially those with access to education, creating a 'pseudo-gentry' in the towns. The Surgeons of the Barber-Surgeons Guild in the 16th and 17th centuries showed signs of progress when other guilds were in decline, and surgical knowledge at this time was advancing rapidly, together with the standards of recruits. In 1745 an Act dissolved the Union of Barbers and Surgeons and the distinct Company of Surgeons was formed (Carr-Saunders and Wilson 1933).

Meanwhile, the ancient universities with their medical schools at Oxford and Cambridge were reported as having "slumped into 18th century torpor" (Carr-Saunders and Wilson 1933). Corfield (1995) stressed that public confidence in the medical profession was essential to ensure its survival through the 18th and 19th centuries. Uniformity was not a feature of the medical profession even in the 19th century, the practitioners being closely tied to local social and economic factors (Pelling 1987)[43]. Despite satirical challenge, their social status continued to rise, with an increased corpus of medical knowledge with a scientific basis, together with their ever strengthening professional institutions. By the mid-18th century the term 'physic' was losing favour and 'medicine' became the preferred term. Thus "medicine united therapeutic practice with precise knowledge" (Corfield 1995. p.138), essentially incorporating both art and science into their professional practice. Public demand led to a rise in interventionist practice, with raised patient expectations and ventures into preventative programmes such as inoculation for Smallpox. Medics were expected to

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[40] 80% of the population lived outside of the towns and cities, where the majority of professional practitioners were located in small rural towns.

[41] Early specialists were bonesetters, ophthalmologists, lithotomists and women's' and children's specialists, linking Medicine to other occupational groups at this time.(Pelling 1987)

[42] Well-read physicians were though regarded with the clergy as Latin-speaking timewasters who provided little useful or practical service to society, and specialisms which generated esoteric and monopolised knowledge were publicly deplored. The clergy remained heavily involved in providing and licensing medical services, though the College of Physicians were resistant to this. Physicians were thus urged to use English in place of Latin, so that patients could understand their prescriptions.

[43] At this time, doctors were satirically depicted as being more interested in the spread of disease to earn them a living, rather than in its cure. The surgeons were the most repellent, being intimately associated with butchery and cadavers. All in the medical profession were regarded as greedy and callous, including the brutal dentists wrenching out teeth, and the gross drink-sodden midwives (Corfield 1995).

arm themselves with the latest scientific knowledge which was made available through regularly published journals from 1750 onwards.[44]

Thus by the end of the 18th century, the medical profession was publishing in journals and being seen to further the boundaries of scientific knowledge for the greater good, while also having established strong professional institutions with independence from the state and university systems. Close observation of patients was encouraged, in contrast to the distancing seen by earlier practitioners, and great stress was placed on communication in an increasingly international sphere of practice. By 1850 medicine was based on better scientific understanding, a range of effective drugs, refined surgical techniques and an accepted classification of disease. Cures were still limited, but diagnosis was improving rapidly and treatment was appreciated not only in terms of individual well-being but also in the interests of public heath. Cases were reported and discussed between colleagues to further understanding and improve practice across the profession (Corfield 1995).

The scholarly title of 'Doctor' (originally denoting one with a higher degree) became increasingly used to denote a medical practitioner in the 1800s. A show of pride within the profession was evident[45]. Biographies and memoirs of famous medical men were published, and their portraits painted[46]. The Royal College was consequently viewed as elitist and driven by social qualification. John Wesley expressed his concern in 1747 that medical men appeared to consider themselves rather more than human, and there were more generalised fears at the degree of the doctors' control over the secrets of health care, exerting increased expert power over patients. Patients however continued to hold or withhold trust in their medical practitioners by choosing which of their instructions to follow, and self-medication was a continuing tradition (Corfield 1995). The issue of trust in the commercial context of business transactions was problematic for the professionals at this time, and some thought it necessary to show trappings of wealth in order to convince patients that a successful practice was being maintained, and to distance themselves from the range of quacks practising in the locality[47]. The systems of regulation up to the 1850s were not tight enough to preclude the practice of unofficial practitioners, whose ranks included a number of women healers. Women traditionally had a role in nursing within the household and local community, but the 18th century saw the advent of the 'man-midwife' who was trained in anatomy and delivered babies with the use of new surgical instruments such as forceps. The numbers of traditional female midwives declined, and by the 1820s delivering babies was one of the mainstays of general medical practice. In the 1851 census there were no females practising medicine, but over 28,000 nurses and 3,500 midwives (Corfield 1995)[48].

In 1876 the campaign for equal access was successful and both women and men were allowed to qualify and register as medical practitioners in the UK. Registration became the new benchmark of professionalism. The General Medical Council (GMC) of Great Britain was formed in 1858 with the remit of listing all who were registered to practice medicine, endorsing the monopoly of expertise and explicitly clarifying its boundaries. For the first time control was enforced by striking off those who failed to maintain standards of practice, something the profession itself had long called for, and mirroring the practices of the Law Society. However, the Medical Act of 1858 did not embrace all the reforms that many considered necessary and did not go as far as the French and

[44] A new magazine entitled "The Scalpel" was issued in 1822, but failed to attract a sustainable readership, while a rival publication "The Lancet," first issued in 1824, continues weekly publications to this day.
[45] Physicians expressed their status by dressing in black coat, knee breeches, tie-wig and gold topped cane, later replaced by a stethoscope.
[46] John Radcliffe became a famous physician of the 18th century, making a large fortune from his practice, and others pursued lives of elegance and wit in the upper ranks of the art and literary worlds.
[47] Named because of their fast 'quacking 'patter with patients.
[48] By 1859 there was one woman listed on the medical register, but she had qualified in the US.

other continental systems in terms of nationalisation and standardisation of training. In Britain, regulation was devolved by parliament to the profession itself rather than being a state responsibility, and the GMC was overwhelmingly composed of medical practitioners appointed by the colleges and universities. Registration was based upon qualification not practice, and new training pathways were developed to merge the old tripartite areas of practice into one, increasingly referred to as 'General Practice' (Corfield 1995).

The old distinctions between branches of the profession continued to survive in the institutions and corporate bodies, such as the long-established and exclusive Royal Colleges of Physicians in London, Dublin and Edinburgh. The manual craft of the surgeons became transformed into a professional skill, their original title of 'chirurgeon' became 'surgeon', and a doctor's consulting room became known as a surgery[49,50]. In 1800 the Surgeons' Company gained a royal charter to become the Royal College of Surgeons of England in London, building an imposing headquarters in Lincoln's Inn Fields, close to their professional colleagues in the law (Carr-Saunders and Wilson 1933; Corfield 1995)[51]. The main functions of the Royal Colleges at this time were to examine candidates and grant licences to practice, but they did not provide training. However, their membership remained small, around only 200 members in the Royal College of Surgeons in 1834. These members were responsible for overseeing the examinations process to grant licences to the 8000 or so licentiates, many of whom were apothecaries that also held a surgical qualification (Carr-Saunders and Wilson 1933).

The standards of the medical Royal Colleges in the 1830s were still regarded as deplorably low, stimulating a reform movement calling for a single licensing authority, a standard uniform medical qualification and an end to the functional divisions within the medical profession. However, the Royal Colleges of Physicians and Surgeons survived intact after the 1858 Medical Act, perpetuating the division between medicine and surgery (Corfield 1995). This situation still exists today, with exclusive professional bodies for physicians and surgeons, their membership recruited by advanced examination.

Since the Apothecaries had organised themselves into the Apothecaries Society in 1815, they had been empowered by law to examine and license apothecaries in England and Wales who had completed a 5 year apprenticeship, though licensing was not obligatory for all practitioners. The Society did though have the power to prosecute all who practised without a licence (Carr-Saunders and Wilson 1933). The 'Surgeon Apothecaries' were the forerunners of General Practitioners, whose status and reputation rose, though in competition in some respects with the rising numbers of druggists and pharmacists, one of who was John Boot from Nottingham (Corfield 1995)[52]. However, the rise in education and status of the general practitioners made the differences between themselves and the physicians and surgeons more keenly felt (Carr-Saunders and Wilson 1933). The Society of Apothecaries was recognised as pioneering in the development of the previously unheard of written form of examination in the 1820s and 30s. In 1841 the Pharmaceutical Society of Great Britain was established to provide training for pharmacists, and in 1852 it was given the power to

[49] Surgeons at this time suffered both from public distaste at their interventions, and also from their close professional ties to the unsavoury and often illicit trade in corpses, required to further their anatomical skills. Celebrated pioneers in Surgery such as John Hunter did much to further their cause, as did Sir Caesar Hawkins, the first medical man to receive an honour for professional services in 1778.

[50] The Royal Colleges of Surgeons were formed in Dublin and Edinburgh to mirror those of the physicians. .In Glasgow the Physicians and Surgeons had already formed a joint college in 1599.

[51] Its membership was initially restricted to those in London, but in 1843 was widened to include the whole of England.

[52] They held some advantage over the Physicians and Surgeons in that they could prescribe and dispense drugs for their patients, which the former could not. They could also practice more freely across Britain, without the geographical restrictions imposed by the territorial licensing systems of the Royal Colleges.

register all pharmaceutical chemists in the country (Corfield 1995), setting a clear distinction between the General Practitioners (Apothecaries) and the Pharmacists.

Expansion in the medical profession was rapid from the late 18th century onwards, and by 1851 the profession was thought to be overstocked, with one practitioner providing medical services for every 302 people (though many of these practitioners were not qualified). Doctors were increasingly employed in salaried roles to provide services to the institutionalised and poor. Group identity was encouraged by the doctors' tendency to gather in societies, which were both socially and educationally supportive. Edinburgh had become a medical school of international repute, together with London, Paris and Dublin. The Medical Societies flourished in London, Liverpool and Edinburgh, and doctors elsewhere began to meet regularly in local societies to promote their own professional interests. The Provincial Medical and Surgical Association met for the first time in Worcester in 1842, later to become the British Medical Association in 1855 with a national membership (Corfield 1995)

A system of medical education became developed and formalised during the 19th century, as by this time the university courses had become very theoretical and were at a low ebb. From 1835, candidates for the Bachelor of Medicine at Oxford no longer had to take an Arts degree, though they did still have to study Galen and Hippocrates, along with new practical elements of their training (Carr-Saunders and Wilson 1933). As medical training became formalised, new medical schools opened in a rather *ad hoc* manner across the country, and apprenticeship was supplemented by 'walking the hospitals'. [53] Apprenticeships eventually became superseded by more formal training in the basic sciences, followed by instruction in medicine and practical experience in a hospital (Carr-Saunders and Wilson 1933; Corfield 1995).

In the 19th century many more hospitals became established, increasing the capacity for the public to attend for medical consultation, as the doctor did not have to travel from home to home. The hospital consultants were now elevated in status to become the medical elite. The hospital as an institution in which medicine was practised became increasingly important after 1800, and it could be argued that the professional medical community grew up in strong association with the hospital structures which provided a place for professionals to meet and share their learning and experience. However, much relevant professional activity (including services to the poor) took place outside of these institutions, and the hospitals may have been elevated in their importance purely because records existed for subsequent historical analysis. Most clients at this time were seen as outpatients and thus the doctors had little control over them. The establishment of lunatic asylums stimulated further demand for medical services, as part of the 'medicalisation' process which pervaded society in the 19th century. Amateur doctoring, especially by the clergy, became less common, and doctors became increasingly confident in their abilities and of their place in the higher echelons of the middle classes (Corfield 1995).

The Medical profession thus gained strength through a range of strategies and behaviours in which they successfully combined expert knowledge with a legalised monopoly of practice, elevating themselves to a status in society which commanded respect and trust. By the 20th century they had a well-established internal organisational structure with systems of registration and regulation through the General Medical Council, and a publicly visible professional organisation in the BMA (the two being distinct, unlike the Law Society which performs a dual role for the lawyers). As distinct from the clergy and Law, the success of the medical profession was closely allied to the development and acceptance of scientific thinking in such matters as

[53] Senior doctors supplemented their incomes by lecturing to students. The famous teaching hospitals such as St Barts, Guys and St Thomas's earned their reputations through the professional status of their staff, though tuition was offered only on a private basis.

Darwin's theories of evolution and the physics of Kelvin and Rutherford. Although it had a long established structural system developed from the Royal Colleges from the 1500s, it had successfully struggled to gain and retain independence from the powers of the church and the universities. Ultimately however it returned to a system of university learning supplemented by practical training, with ever-stricter standards of practice determined by the profession itself, and an organisational structure in the hospital service which would later readily lend itself to state control and bureaucratisation in the public services of the 20th century.

Appendix B The new model professions

Those professions that had grown up within the church became secularised by the end of the 16th century as the Church receded from its dominant position in society. Students no longer had to enter an ordained life to succeed in the professions, and as wealth passed into private hands there were more opportunities to earn a respectable income other than through an ecclesiastical benefice. The common law lawyers became dominant in their profession, while also taking on much in the way of administrative and political positions, providing a realistic opening for those who were not gentleman to better themselves. It seemed that the lawyers took over from the church as the dominant profession in the sixteenth and seventeenth centuries. Only architecture, in its earliest form, escaped the lawyers' grasp, together with teaching, which remained with the clergy in many cases until the 19th century. The trade guilds also faltered as the markets expanded and capital was more widely distributed, leaving those who provided services rather than goods, such as the surgeons and notaries, to flourish.

Ackroyd (1996) and others discuss the 'new model professions', including the *Architects, Engineers* and Veterinary Surgeons, while Etzioni (1969) regarded nurses, teachers and engineers in a group he *termed the 'semi-professions'*.

The **Veterinary Surgeons** formed in 1783 from an unofficial group of practitioners who were enthusiasts for 'the Encouraging of Agriculture and Industry', and essentially developed an interest in farriery. In 1791 they set up a Veterinary College in London and in 1823 a similar college was formed in Edinburgh. In 1844 the two merged to form the Royal College of Veterinary Surgeons, which from 1881 was given the power by parliament to examine and keep a register of practitioners. Thus in this profession, an informal society became a formal organisation, which became nationally incorporated and was eventually given state backing to carry out formal professional regulation. In this case all the veterinary surgeons became registered by one body, irrespective of their own specialty areas.

Civil engineers applied their learning of the art and science of the day to bring about what later became known as the Industrial Revolution. Civil engineers gained a specialist name (as distinct from the military engineers) only in the late 18th century, and by the mid-19th century there were mechanical, electrical and mining engineers with public heroes embodied in Isambard Kingdom Brunel and the like. The Society for Civil Engineers was formed in 1771, which in 1793 became the Smeatonian Society, its present day name. In 1818 a group formed the Institute of Civil Engineers which received a royal charter in 1825 and set up headquarters in Whitehall. The profession aimed to promote a sense of robust practicality and to be an intermediary between brains and brawn. The newly emerging specialists set up amongst others the Institution of Mechanical Engineers in 1847 and fragmentation ensued, with division into respective specialty areas. Thus in engineering, there was a division into specialist areas for registration and professional membership, driven by the demands for certain types of skill sets at the time in which the profession was developing.

Architects sought to apply their specialist knowledge in the 'Elegant and Necessary Art of building', setting up a society of gentleman practitioners to this end in 1774 to promote the improvement of architecture. The profession however proved hard to organise given the diversity of roles within the building and construction industry, and its close ties to the patronage systems. In 1791 the Architects' Club was founded as a dining club and it wasn't until 1834 that the separate Institute of British Architects came into being, which was chartered in 1837 to become the R.I.B.A.. A rival faction separated in the form of the Society of Architects in 1884, but reunited with RIBA in1925. The statutory registration of architects however did not become compulsory until 1938. In this case the profession found difficulties in divorcing itself from the

control of its clients, and despite covering a diverse range of skills and applications, it has found it best to remain united as a profession, rather than to fragment into smaller constituent parts.

These examples of the formation of the newer professions shows that their development and evolution has been far from uniform, but the importance of an organisation as a sign of status and self-discipline became an important trend with two-fold benefits. It gave those within the profession an identity, a peer group with which to relate, and the means to set and maintain standards of practice and training. It also gave potential clients the reassurance that a professional had reached a recognised standard of proficiency and continued to conduct themselves and practice in an appropriate professional manner. Numerous professional groups were founded in the 19th and 20th centuries, and specialist validation became an expectation of customers outside of the landed elite. The patron had turned into the client, and the scale of professional work changed as increasing numbers of professionals required a more structured and less *ad hoc* system of qualification.

In other walks of life the formation of occupational societies was rife during this same period of time. **Writers and authors** formed their own Literary Club in 1764, but the Society of Authors (1843) and the Guild of Literature and Art (1850) remained weak with limited support. Actors, artists and musicians suffered the same lack of formal recognition as many other 'new professions' despite much dedication on their individual parts, and therefore individual patronage continued to play an important part in these occupations. The training was informal, remuneration uncertain and a collective identity was hard to establish. However, members were increasingly regarded in professional terms despite the lack of professional organisation.

Teachers also suffered from the lack of a clearly demarcated area of expertise, and the lower levels of the profession continued to enjoy a miserable status. The wide range of 'teachers' from Oxford dons to governesses again made it difficult to establish a collective identity, and many who were employees enjoyed little autonomy and much scrutiny in their work. Many male teachers were also clergymen and their loyalties lay with the church. Training was minimal so skill levels were sometimes poor and entry levels into teaching were sometimes very low. There was a high degree of internal fragmentation and the teachers themselves did not envisage themselves as a single profession.

The **army and navy** continued to recruit from the men of good families, though a few notable exceptions such as Horatio Nelson and Captain Cook did rock the boat by coming from more lowly beginnings. Formal examination was introduced
for Naval Officers from 1677 onwards, and formalised training established at the Naval Academy at Portsmouth in 1729. However, nothing could replace the value of practical experience gained whist on active service and the majority of training was carried out at sea. The senior naval commanders formed what was known as the 'profession of arms' and held high social status as well as the power of the state.

The **army** was less professionalized and did not form a professional association, their rank (like the clergy) being taken from their hierarchical position in their employing organisation. Patronage was also a continuing element in the army, and the sale of commissions did not cease until 1871, though senior posts were no longer for sale after 1760. The army was reluctant to relinquish its purchasing systems of recruitment, but finally acknowledged that purchase of rank was not compatible with professionalism and the sales were abolished, restoring military promotion to a meritocracy. Moves to promote a professional identity in the army were introduced through the 1751 army dress regulations, when personal insignia on uniforms was banned, and a Royal Military Academy at Woolwich began training cadets from 1741, with passing out parades from 1764. The Royal Military College at High Wycombe was

founded in 1799, and later moved to Sandhurst in 1812, and *military texts and manuals* were published on military strategy (Corfield 1995).

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