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Newly Professionalised Physiotherapists:

Symbolic or Substantive Change?

ABSTRACT

Purpose

There is renewed interest in the professions as a range of occupations pursue professionalisation projects. This paper turns analysis to an important omission in current research – the skills deployed in the work of these professions. Such research is necessary because skills determine the formal classification of occupations as a profession.

Design

Drawing on qualitative research, this article explores the deployment of skills in work of one newly professionalised occupation in the UK's National Health Service – physiotherapists.

Findings

The findings point to a disconnect between how this occupation has become a profession (the skills to get the job, and related political manoeuvring by representative bodies) and the mixed outcomes for their skills deployment (the skills to do the job) in work as a profession.

Originality/Value

The article provides missing empirical understanding of change for this new profession, and new conceptualisation of that change as both symbolic and substantive, with a 'double hybridity' around occupational control and skill deployment for physiotherapists as a profession.

Key words: double hybridity, NHS, physiotherapists, professionalisation, skills, Standard Occupational Classification

INTRODUCTION

With a raft of occupations currently pursuing professionalisation projects, there is renewed research interest in the professions. This research tends to focus on the process by which these occupations become reclassified as professions, and on the political manoeuvring of occupational representative bodies that underpin these professional projects (e.g., Muzio *et al*., 2013; Saks, 2010). This focus is important but myopic and detracts attention from changes to the skills deployed – that is, used – in the work of these occupations. This omission is both curious and significant given that it is changes to these skills that ultimately determines the formal reclassification of an occupation as a profession (Elias and Birch, 2010). Lacking this focus, Noordegraaf (2007) argues there is often no substantive change in skill deployment but rather a rhetoric that offers 'being' professional as merely 'symbolic'. A refocus on skill deployment is therefore required to enable an assessment of the substance of professional re-classification to determine whether it is merely a symbolic veneer.

Drawing on qualitative research, this article redresses this omission by examining the skills deployed – that is used – in the work of a newly professionalised occupation – physiotherapists in the UK's National Health Service (NHS) – and evaluating what, if anything, is now different about this occupation's skill use and thus whether its upgrading to a 'profession' in the UK's Standard Occupational Classification System (SOC) is merely symbolic or reflects substantive change. This occupation was selected because it is an exemplar of a number of occupations recently reclassified and upgraded as professions (ONS, 2010, p. 6). It is also mainly located in the public sector, upon which much of the new debate about professionalisation has centred (e.g., Evetts, 2011). The physiotherapist case therefore has wider resonance in understanding the current wave of professionalisation.

The next section of the article outlines debates about professions and professionalisation. The second section provides an overview of the UK's SOC, including the reclassification of physiotherapists and other health-related occupations as "professionals". The third section describes the research methods employed in the study and the selection of physiotherapists as the occupational case. The fourth section presents the findings. The fifth section then locates the case of physiotherapists within developments to similarly reclassified occupations in the NHS.

The concluding section suggests that current conceptualisations of professionalisation require an analytical rebalance that envelops skill deployment outcomes.

PROFESSIONS AND PROFESSIONALISATION

Renewed interest in the professions reflects a number of occupations pursuing professionalisation projects (Evetts, 2006, 2011; Muzio and Kirkpatrick, 2011; Muzio *et al*., 2013; Noordegraaf, 2007). The aim of these projects is to achieve regulation over both a field of practice and access to that practice. Occupational representative organisations' route to achieving this aim is enhanced training and education; typically in the UK, the adoption of higher education as the required occupational entry route and the acquisition of a bachelor's degree. Many of the successful occupations, such as teaching, nursing, midwifery and physiotherapy, are female-dominated and attainment of professional status represents a long struggle for recognition of the value of their work in the face of gender discrimination (e.g., Witz, 1990). In the case of physiotherapists, as well as nurses and midwives, pre-entry education and training provision has been transformed with a shift in locus from the workplace to the higher education sector and graduatisation (NMC, 2010).

With so many occupations now labelled as professions, questions have been raised about what it now means to be a profession. Such category questions are not new. In the 1950s and 1960s, drawing on functionalism (in particular Parsons, 1939), it was argued that what is now termed the 'traditional' professions such as law and medicine was a category based on particular occupational traits. These traits being working in others' interest, usually the public, and drawing on specialized, high-level, abstract knowledge acquired through lengthy training and education. (e.g., Greenwood, 1957; Merton *et al*., 1957; Rueschemeyer, 1964). As Larson (1977) explained: 'professions are occupations with special power and prestige. Society grants these rewards because professions have special competence in esoteric bodies of knowledge linked to central needs and values of the social systems, and because professions are devoted to the service of the public' (p. x). In the 1970s and 1980s, this position was challenged as little more than ideological dressing masking self-interest. What distinguished the professions from other occupations, it was now claimed, was the right to occupational closure and self-regulation but

which served occupational not public interest (e.g., Abbott, 1988; Freidson, 1974; Johnson, 1972; Larson, 1977). As the structure of employment changed in the later part of the twentieth century with the growth of the public sector and large-scale organisations generally, a variant of this second position emerged centred on the location or "situation" of these occupations. It was argued that independent professions (aligned with the traditional professions and their independent practices) needed to be contrasted with professionals employed in large bureaucratic organisations. This latter type experiences more control and domination, and is more exposed to organisational demands for efficiency and cost-savings (e.g., Brannon, 1994). These occupations represent "new model professions" (Ackroyd, 1996, p. 606), which, though within organisations, still seek to mould their work and organise the division of labour to suit their own interests.

Attempting to bridge these arguments, and following Brint (1994), Muzio and Kirkpatrick (2011) argue that professions must now be analysed in relation to both occupational and organisational interests. As they point out, most professions, even the traditional ones of law and medicine, are now employed within such large organisations. These professions too encounter the new demands and, as a consequence, find themselves in an ambiguous, if not weakened, position caught between bureaucratic and professional controls. For Noordegraaf (2007) the consequence of this "hybridity" is that these workers' experience and circumstances are not constituted by occupational control but rather a rhetoric that offers "being" professional as merely "symbolic", just a performative act but which inculcates normative control amongst these workers (pp. 778–779).

Given that in the Anglo-Saxon countries professions' development historically centred on creating occupational independence from the state (Muzio and Kirkpatrick, 2011), Evetts (2006) asks why the state within these countries is now pushing to create professions. She answers her own question by arguing that professional projects are often now imposed "top down" by the state (Evetts, 2003, p. 411). Evetts, Muzio and Kirkpatrick, and Noordegraaf argue that this form of top-down professionalisation is most marked in the public sector, particularly with newly professionalised health, education and social work occupations. Indeed, Evetts (2009) states that it is a situation particularly pertinent to the UK's NHS whereby it is used as an ideological tool to

appease and appeal to occupations in the context of organisational rationalisation. However Muzio and Kirkpatrick as well as Noordegraaf acknowledge that more empirical evidence is needed about these new professions. Without it, there is a tendency, Muzio and Kirkpatrick (2011) state, to regard the affected professions as "passive victims" (pp. 395, 397).

Whilst the new wave of research focused on the political manoeuvring underpinning professionalisation has raised important issues and developments, one unintended consequence is that a key element of what formally constitutes these occupations as professions – the skills deployed in their work – has dropped off the analytical radar. That there is a need to return to analysis of these skills is underlined by the fact that these skills feature in the occupational classification schema against which professionalisation projects are formally realised; in the case of the UK, the official SOC. Paradoxically, whilst ignoring such classifications, the new wave of research continues to reference SOC-classified traditional professions as the benchmark for the new professions (e.g., Ackroyd and Muzio, 2007; Evetts, 2011; Noordegraaf, 2007).

RE-CLASSIFICATION AS "PROFESSIONALS"

Revised every decade, the UK's SOC is a classification scheme that differentiates, groups and hierarchicalizes occupations by "skill level and skill content" (ONS, 2010, p. ix). The SOC has nine major occupational groups, 1 (the highest level) to 9 (the lowest level). Each major group is then subdivided into sub-major groups, then minor groups and then occupational unit groups at the four-digit level (ONS, 2010). The skill level required for competent performance in professional occupations is higher than the level required for associate professional and technical occupations (ONS, 2000, 2010). Qualifications/training/experience also differ. Associate professional and technical occupations typically require a "high-level vocational qualification, often involving a substantial period of full-time training or further study" and "additional task-related training is usually provided through a formal period of induction" (ONS, 2010, p. 4). Professional occupations typically require a "degree or equivalent qualification, with some occupations requiring postgraduate qualifications and/or a formal period of experience-related training" (ONS, 2010, p. 4). The SOC classification thus ascribes the label "professional" to an occupation based on a definition that envelops both the labour market and labour process demands of these

occupations – in other words what skills are needed to both get and do the job – the latter meaning those skills deployed in work. Re-classification within the SOC is the mark of success for those occupations realising their professionalisation projects (e.g. McCann *et al*. 2013).

In the last SOC revision in 2010 a number of these occupations were reclassified and upgraded from Major Group 3 to 2 to be professional occupations on the basis of higher-level skill acquisition (becoming degree-requiring occupations). Many of the reclassified occupations are in the public sector and, within that sector, the NHS. Of particular note are the many occupations previously within the sub-major group "health & social welfare associate professionals" now reclassified as "health professionals" sub-major group – a professional group that includes a range of "established" or "traditional" professionals such as general practitioners (GPs). Table I maps this shift. These occupations comprise nurses, midwives and a grouping of occupations referred to as the "allied health professions" (AHPs) (highlighted in grey in Table I) that were formerly supplementary to medicine i.e., physiotherapists, chiropodists/podiatrists, speech and language therapists, medical radiographers and occupational therapists (SEHD, 2006, p. 48). Thus, with the SOC 2010 revisions, physiotherapists were, for the first time, classified as "professionals" rather than "associate professionals".

INSERT TABLE I ABOUT HERE

These occupations' reclassification as professions primarily rests on higher-skill level acquisition pre-employment (that is, as proxied by qualifications, a bachelor's degree). In this respect, the Royal College of Nursing (RCN), the nursing representative body/union, had campaigned for an all-graduate occupation in the early 2000s, reasoning that nurses needed to "be inside a world where graduate education is the currency of professional development" (RCN, 2004, p. 1). An increase in nurse graduates followed and approved degrees became the exclusive entry route for UK nurses in 2013 – a process following that of midwives five years earlier (NMC, 2010). The ongoing graduatisation process and lobbying by the representative body undoubtedly swayed the SOC upgrading decision: "In liaison with the professional body for nursing (Royal College of

Nursing) the decision was made to reallocate nursing occupations from Major Group 3 in SOC2000 to Major Group 2 in SOC2010", Elias and Birch (2010, p. 11) explain.

The rationale for upgrading other AHPs followed similar lines to that of nurses and midwives. Under the banner "modernising regulation" (DoH, 2001), the UK's Health Professions Council (HPC) extended statutory protection of the occupational titles of AHPs. Established in 2002, the HPC replaced the Council for Professions Supplementary to Medicine (CPSM). Compared with its predecessor, the HPC has enhanced powers. The exclusive, not just partial, route into the AHPs is now through an HPC-approved undergraduate or even postgraduate degree and the state now concurs with the view of these occupations' representative bodies that these occupations should be considered autonomous professionals in their own right – reflected now in the formal reclassification of these occupations as "professionals" in SOC 2010. Paramedics, notably, were not upgraded to 'professionals' and remain 'associate professionals', despite the fact that these occupations are also primarily located within the UK's NHS and now regulated by the HPC. McCann *et al*., (2013) argue that the problem for paramedics is that their professional body (The College of Paramedics) were less able than other representative bodies to lobby effectively and push for upgrading.

RESEARCH DESIGN

The exploration of professionalisation reported in this article revisits and updates data from a project completed in 2009 examining skill and training developments within UK intermediate occupations. These occupations include the associate professions and skilled trades (Major Groups 3 and 5 of SOC 2010). In terms of occupational selection, most AHPs work in the largest bureaucracy in the UK – the NHS. Physiotherapists and a number of other AHPs emerged in the UK from the mid-1800s following growing state concern for the wellbeing of the "slum-dwelling population", anxiety about the possible spread of disease to affluent areas and its potential impact on the public purse (Nicholls and Cheek, 2006, p. 2339). Physiotherapy became fully established in 1894 after a group of nurses formed The Society of Trained Masseuses (STM). This Society was the forerunner of the Chartered Society of Physiotherapy (CSP), still the representative body and trade union for the occupation. The scope of practice of

physiotherapists links three core skill domains applied to the body's physiological "systems": massage and manipulation; electrotherapy; exercise and movement (CSP, 2005).

Physiotherapists were selected as an "exemplifying" (Seawright and Gerring, 2008, p. 299) occupational case, being an AHP at the time of data collection on the cusp of being reclassified as "professionals" in the UK's SOC and the largest group of occupations within UK AHPs. As a health-related occupation in the public sector, physiotherapists are also indicative of the type of occupations being signalled as characteristic of the "new model professions" (Ackroyd, 1996, p. 606). The selection of the physiotherapy case therefore provides an opportunity to examine the changes in the skills deployed in the work of a significant, newly professionalised occupation in the UK public sector's NHS in the context of its professionalisation project. This examination then provides opportunity to evaluate what, if anything, is now different about this occupation and thus whether any reclassification is merely symbolic or reflects substantive change.

Whilst there are a number of skill surveys in the UK, these surveys either do not drill down to the four-digit level – the level of specific occupational groups in the SOC – or, if they do, they have cell sizes too small at this level to enable analysis of their skill use (e.g., Felstead *et al*., 2014). Even if survey data was available, it would still be important to dig beneath the numbers, as Fleming *et al*. (2004) point out in a critique of the classifying of a number of occupations as "knowledge workers". Hence the research adopted qualitative methods. Primary empirical data was drawn from some 27 research participants. A purposive sampling strategy (Patton, 1990, p. 169) was used to identify potential participants from a range of relevant stakeholders i.e., physiotherapists, employers, regulatory and professional body representatives, policymakers, physiotherapy students. Together, these stakeholder perspectives offer crucial insight into changes in the skill deployment of physiotherapists. Semi-structured interviews were undertaken with: physiotherapists (n=5); employers (n=4); the professional body and labour union for physiotherapists, the Chartered Society for Physiotherapy (CSP) (n=3); the new regulatory body, the Health Professions Council (HPC) (n=1); the Scottish Executive Health Department (SEHD) (n=2), which was responsible for health policy and the administration of the NHS in Scotland; and university physiotherapy lecturers (n=4). Semi-structured interviews were also undertaken with three physiotherapy students, one of whom was a CSP student representative, (n=3) in addition

to a focus group with physiotherapy students (n=5). All students were in the latter stages of their degree studies and had undertaken a broad range of practice-based placements across the NHS in Scotland. The majority of research participants (n=22) were women, reflecting the fact that physiotherapy is a female-dominated occupation.

Interview and focus group guides were prepared for all stakeholder groups, and all interviews and the focus group were digitally recorded and fully transcribed. The majority of interviews and the focus group were conducted face-to-face, and three interviews were conducted via telephone. Evidence suggests that there is little substantive difference in data gathered by face-to-face and telephone interviewing (Sturges and Hanrahan, 2004). Interviews lasted approximately 45-60 minutes. A thematic analytical approach was adopted, guided by Braun and Clarke's (2006, p. 47) 'phases of thematic analysis'. Our initial coding included deductive (*a priori*) codes and inductive (empirical) codes (e.g., Miles *et al*., 2014, p. 81). The deductive codes were derived from themes, concepts, ideas from the literature, and topic areas in the focus group and interview guides. The inductive codes started to surface during the research process, and were finalised after reviewing the final transcripts. We then began to re-focus our analysis to identify broader themes. The findings from this analytical approach are reported below.

SKILLS NEEDED TO DO THE JOB

Before presenting the findings of the changes in the skills to do the job, this section starts with background information on recent developments in physiotherapy education and training and an outline of recent changes within the NHS.

Changes in the skill development of physiotherapists

Historically, skills for the traditional professions such as medicine and law were developed initially in universities (Hughes, 1963) – and still are. Physiotherapy education and training in the UK was previously based in NHS-funded and administered hospital schools, with negligible links to higher education (Brook and Parry, 1985). Students undertook the three-year CSP Diploma (Harris and Naylor, 1992) and the CSP set the course content, assessments and examinations. In the 1980s physiotherapy education began to move into polytechnics. Polytechnics were more

amenable to developing physiotherapy courses because they were less academic than universities (Brook and Parry, 1985). In 1992 physiotherapy became an all-graduate occupation and all courses became university-affiliated when polytechnics converted to universities.

Developments in physiotherapy education and training are better understood in the broader context of changes across the NHS. The relocation of training to the higher education sector was partly driven by the *National Health Service and Community Care Act 1990* which required hospital trusts to "balance their budgets" (Pollock *et al*., 1999, p. 180). Future demand for physiotherapists in Scotland is inextricably linked to the changing demands on the NHS in the UK more generally. Public healthcare sustainability is heavily dependent on the redesign of services so that changing needs, such an ageing population, are met within projected budgetary constraints. The traditional scope of practice of AHPs was to expand and change in order to meet the new service demands. Professional boundaries were to be dismantled in a clear shift away from "traditional professional 'silos'", replaced instead by "new workforce roles" (SEHD, 2006, p. 3).

Under a major change to collective pay agreements, all NHS staff, other than doctors and senior managers, were assimilated onto new pay bands and terms and conditions as part of the Agenda for Change (AfC) agreement.[1] With AfC, jobs were evaluated and mapped onto a nine-point pay banding system; Band 1 is the lowest band and Band 9 is the highest. Newly qualified physiotherapists – as with other newly promoted AHPs – typically enter the NHS at Band 5 (new practitioner level) and, after gaining two-years' work experience, move into Band 6 roles (experienced practitioner level). All NHS clinical jobs below Band 5 are sub-practitioner posts not requiring degree qualifications for entry and incumbents work under the supervision of registered practitioners. For physiotherapists at Band 5 and above, however, skills are now also developed initially in universities.

Changes in the skill deployment of physiotherapists

Entry-level Band 5 posts are essentially internships for newly-qualified graduates to gain experience before moving into Band 6 posts: "We only need grade 5 anticipating a grade, a level

6 vacancy, so these are feedstock" said one employer. Most physiotherapists working within the NHS are located at Band 6.

Beyond these posts, there was some evidence of upskilling. To help reduce orthopaedic consultants' waiting lists, Extended Scope Practitioner (ESP) physiotherapy roles have been introduced. ESPs are highly-specialist physiotherapists working at advanced practitioner level (Band 7) beyond the customary scope of physiotherapy practice. ESP physiotherapists now undertake tasks once exclusively undertaken by doctors and point to higher-level skill use in work:

> I was one of the first in the UK to become a specialised, what they call an Extended Scope Practitioner … we have the skills to inject patients, we have the skills to order X-rays, scans, do bloods … we are basically doing the job of the surgeon pre-operation. (Physiotherapist)

> These practitioners … can take decisions on patient management and screening that previously would have been done by a registrar to a consultant. And, they're really acting at a very, very high level. (Employer)

An important outcome is that physiotherapists can now circumvent GPs and refer patients directly to ESPs. As a physiotherapist stated, "ESP physios are affiliated to the surgeons … So if we had anyone we wanted referred through direct to orthopaedics then before we'd go through their GP, now we've got the ESP physio to do it". Other aspects of NHS service redesign are also serving to remove GPs from the referral process. Direct access to physiotherapy services via patient self-referral was once uncommon within the NHS (Holdsworth and Webster, 2004) but there is now a clear shift towards direct patient access. Another physiotherapist explained:

> At one time to see a physio you needed to be referred by a GP. Now we have what you call direct access or phone-ins, so you can basically come to the physiotherapy department and say "Can I see a physio?".

Opportunities for utilising higher-level clinical skills and circumventing doctors stand in stark contrast to the past when, it was suggested, physiotherapy practice was restricted and physiotherapists were closely monitored by doctors:

> About 20 years ago, 30 years ago, I remember when I first started the treatment card would be no bigger than twice the size of a business card and you had to follow exactly what the surgeon had said on the card or you were called to task. (Employer)

However, the number of ESP physiotherapy posts at Band 7 and above is small, one employer explained. To offset the costs associated with the, albeit modest, increase in the number of specialised ESPs there is a reduction in practitioner-level posts and a corresponding increase in sub-practitioner-level posts at Bands 2-4:

> There will be less Band 6, much less Band 5 … and a whole lot of 4s and enough 3s and 2s … Obviously if you're replacing a Band 5 with a Band 4 you can pocket some money … you know there's no new money. (Employer)

Indeed, whilst the NHS proposes that a "skills escalator" exists to expand roles and encourage upward progression possibilities, it also states that "efficiencies and skill-mix benefits are generated by delegating roles, work and responsibilities down the escalator where appropriate" (NHS Employers, 2006, p. 72). Many sub-practitioner assistants, for instance, are now undertaking tasks previously undertaken by practitioners:

> Physiotherapists, they use assistant practitioners that are functioning at level 4 … Now they're not a regulated workforce but they're often carrying out tasks that were once the remit of the regulated [Band 5+ AHP] workforce. (SEHD respondent)

Data drawn from a broad range of stakeholders also indicates a push towards genericism at Bands 5 and 6, practitioner-level roles.

> People need to be a bit more flexible in how they work and in the roles that they are willing to fulfil … it doesn't bloody matter if you're a physio, an OT [occupational therapist], a speech therapist or a nurse … because the skills you need to deliver that can come from any of these professions at that level. (SEHD respondent)

> They're trying to make generic therapists … they've got ESPs going on and they've got people within physiotherapy becoming really specialised and that, and then on the other side of it … there's not going to be so much focus on being an OT [occupational therapist] or being a physio or being a speech and language therapist because they're going to be generic therapists in the future. (Physiotherapy student)

Physiotherapy work and responsibilities therefore appear not only to be moving up (Band 7+) and down (Bands 2-4) the skills escalator but, increasingly, across the 'professional' boundaries of physiotherapists and their proximate, traditionally segregated, occupations. The idea of generic therapists was met with cynicism from those respondents concerned with maintaining traditional occupation demarcations, not least because it was suggested that generic therapists' new tasks were not just doing 'a lot of things the same' but a route to deskilling:

> We've always maintained a generic therapist is a deskilled person. They maybe have multi-skills but they're not highly skilled. So if your mother had a stroke and she needed a speech therapist and she needed an occupational therapist and she needed a physiotherapist and she needed a podiatrist, would you want one person to do all of that? (University lecturer)

In fact, one employer suggested that some training courses in the UK were already offering generic therapist bachelor degrees whereby students were "graduating as a generic person rather than a discipline-specific person". Genericisation fundamentally undermines the professional aspirations of physiotherapists. After a long and hard struggle for professional recognition based on possession of specialised vocational skills and knowledge attested through the possession of a degree, the victory may be illusory, with the possibility of one of the key markers of being a professional – the acquisition of special competence in an esoteric body of

knowledge – disappearing (e.g. Larson, 1977). The possibility was not lost on an employer who stated:

> The professions fought long and hard to get our titles recognised, and that took a long, long while, and it does seem rather strange that they've just won that fight and we are talking about having more genericity within the Allied Health Professions …

This apparent setback with the skills deployed by some physiotherapists is matched by another for the occupation as a whole: greater recognition of occupational titles has come at a price – the loss of occupational regulation by the CSP to the HPC.[2] The primary function of the HPC is "the protection of the public rather than protection of the particular profession" explained an HPC respondent. This function was a key recommendation of a review of the regulation of the professions supplementary to medicine and the resultant establishment of the HPC; as was the recommendation that the CPSM boards should have their powers curtailed because they were "powerful, autonomous and dominated by the profession being regulated" (JM Consulting, 1996, p. 5). The establishment of the HPC has served to undermine the power of the CSP across a number of key occupational areas. Previously, the CSP and the Physiotherapy Board of the CPSM undertook joint validation of physiotherapy courses in the UK (Dimond, 1999). Physiotherapists held a majority on the Physiotherapy Board and physiotherapists essentially controlled training, qualifications, other professional standards and discipline (Øvretveit, 1985). An HPC representative acknowledged that the loss of control across these key areas may have left some professional bodies feeling "like they were kind of redundant".

Loss of control in key occupational areas presents challenges for the CSP. The professional body is no longer the sole 'defender' of the profession:

> The defence of the profession, the integrity of the profession was solely really the remit of the professional bodies. Now the integrity of the title physiotherapist belongs to a … a public body, a statutory body for public protection. Now, as with any body of course, any professional body, there's still lots of other stuff that it's concerned with … But some of the baseline issues around

> competencies can now be handled by the HPC. The real danger is to what extent … the HPC is going to continue to rely on the professional bodies.

With this change, the role of the CSP has re-focused more on lobbying activities: “influenc[ing] workforce planning” and “profiling the value of physiotherapy”, explained a CSP representative. What is more, all HPC competencies/standards are now essentially generic, with minimum competencies relating to specific occupations:

> The standards we are setting are very much at a generic level … if a new profession came on [they] would basically just kind of slot in. So our pool of professions and programmes would widen, you wouldn’t need to restructure in terms of our processes. (HPC respondent)

Increased genericism offers employers greater potential for role/task flexibility whereby, after meeting the minimum standards, employers are relatively unrestrained in further developing role remits and their use of staff. As one employer stated:

> When you look at the guidance as to what a physio can and can’t do, 80 percent of it is the same as OT [laughs] … I think it was very profession specific and that is now a problem but we’ll work through it. I think it’s good that the HPC ... brings together all the Allied Health Professions, so at least there’s the possibility of becoming less demarcated … As long as we’re not using a Joe Bloggs on an admin grade [to do the job] … then we don’t have a problem.

Moreover, NHS physiotherapists’ terms and conditions were previously determined by arrangements set by the UK’s General Whitley Council. Role boundaries, NHS physiotherapists’ titles, pay grades and related tasks were relatively fixed under these arrangements; however, the abolishment of these arrangements and adoption of AfC has further afforded the NHS employers more scope to redesign job roles. As another employer explained: ‘Agenda for Change is giving us the opportunity to revise titles … [with] the old Whitley grading … You were either a physio or you weren’t, and if you were a physio these were your conditions’.

PROFESSIONALISATION, PHYSIOTHERAPISTS AND BEYOND IN THE NHS

Overall, in terms of the development of physiotherapy skills, training and education has moved into universities and new physiotherapists must now be graduates. However, the deployment of those skills within the workplace for physiotherapists is more varied. The new NHS service delivery model has provided unprecedented opportunities for some physiotherapists. There is evidence of high-level skill development and deployment and in areas which, until recently, were the preserve of doctors. Physiotherapy is also establishing direct referral mechanisms that sever the umbilical cord to doctors – though such developments do not in themselves herald the decline of doctors' dominant role in determining healthcare. For this small number of physiotherapists at Band 7 and above, upskilling has occurred that aligns with the occupational upgrading within the SOC. At the same time, to offset the pay costs associated with this change, employer demand for entry-level NHS physiotherapy posts will shrink whilst the number of sub-practitioner level posts expand with more routine work pushed down the job hierarchy to expanded Bands 2, 3 and 4. Physiotherapy work is thus subject to "snakes and ladders" within the NHS; some work has moved up to be more complex, some slid down to workers with lesser (sub-degree) qualifications. This type of skill polarisation has been observed recently in the traditional professions, namely law with an emerging "elite" of equity partners and "expanding cohorts" of salaried professionals (Ackroyd and Muzio, 2007, p. 741). The difference in the case of law is that these salaried professionals have the same qualifications and are on the same ladder as the partners and have opportunity to climb the ladder (Forstenlechner and Lettice, 2008). In the case of physiotherapists there is a fundamental role redesign with distinct qualifications for two different bands of workers plus structural budgetary constraints. In addition to this polarisation, the introduction of the HPC and AfC and the declining power of the CSP have afforded employers the opportunity to further redesign roles and push for greater genericism amongst physiotherapists at middle Bands 5 and 6. Such skill genericism results in less opportunity for specialisation and greater likelihood of deskilling, and is a change that potentially envelops the vast majority of physiotherapists in non-advanced practitioner roles. For physiotherapists, taken together, the two processes of, first, polarisation and, second, genericism suggest not a unilateral move to higher-level skill use in work for the occupation as a whole but,

rather, that the occupation is undergoing a process of skill fragmentation, with upskilling for some, potential deskilling for others and with some additional role degradation. Significantly, these two processes – polarisation and genericisation – have occurred whilst the occupation has been reclassified and upgraded to be professions in SOC 2010.

As its largest AHP occupation within the NHS, physiotherapists are a significant case, a useful exemplifier in analysing professionalisation in the UK public sector. Moreover, they are also typical: the skill and task changes to physiotherapy are occurring to other AHP occupations in the NHS. Chiropodists/podiatrists, speech and language therapists, medical radiographers and occupational therapists are all experiencing: a small growth in specialist roles at Band 7 and above; a clear drive towards genericism or "cross-cutting" roles at Bands 5 and 6 (practitioner-level); and some tasks and responsibilities being pushed downwards to Band 4 and below (sub-practitioner-level) (e.g., Pollard *et al*., 2005; Skills for Health, 2010). Elsewhere in the NHS, healthcare assistants and assistant practitioners will balance a reduction in the nursing and midwifery workforce (NHS Employers, 2009). It is clear therefore that the skill polarisation and genericisation that have occurred within physiotherapy are being extended to other AHPs, nurses and midwives, and are likely to become entrenched. The extension of these developments to the nursing workforce is particularly significant. As with physiotherapists, nurses and midwives have also now been reclassified as professions in the SOC. What is more, whilst nurses and midwives have traditionally been classified within the NHS as an occupational group distinct from AHPs, there is a clear push towards the homogenisation of the nursing, midwifery and allied health professions (NMAHP) workforce – and, with it, further polarisation and genericisation (e.g., Scottish Government, 2017).

What is significant about these changes is that they are occurring whilst these occupations have been reclassified and upgraded to be professions within the SOC. A disconnect has therefore emerged between the successful political manoeuvring of these occupations to *become professions* and the mixed outcomes occurring to their skills and tasks *as professions*. This disconnect offers new empirical and conceptual insights into the new professions, whilst also raises issues about occupational classification, as the concluding section outlines.

CONCLUDING REMARKS

With the current wave of professionalisation projects, new model professions have emerged (Ackroyd, 1996). In contrast to the traditional professions (e.g., Larson, 1977), these new professions experience bureaucratic control, lack occupational control and professionalisation is often imposed "top down" by the state (Evetts, 2003, p. 411). As more occupations professionalise in this way, the very point of defining the category has been argued to be a diversion: any "professionalism" is merely symbolic, an ideological tool intended to appease and appeal to occupations in the context of organisational rationalisation, tighter budgets and more demanding customers/clients and service standards (Evetts, 2003, 2006, 2009). The outcome is hybridity, with the new professions lacking the occupational control of the traditional professions but having a veneer of "being professional" (Noordegraaf, 2007).

Unfortunately, empirical evidence to support these claims is lacking, with most analytical focus instead on the political manoeuvring by occupational representative bodies to become a profession (e.g., Muzio *et al*., 2013). Providing the missing empirics, the research reported in this article provides an answer as to whether this professionalisation is symbolic, as Noordegraaf (2007) contends, or substantive. The answer is complex. Extending Noordegraaf's claim, the findings suggest a *double hybridity* (see Table II) arising from dual exposure to bureaucratic and normative controls.

INSERT TABLE II ABOUT HERE

The first form of hybridity centres on occupational control. Our empirical evidence suggests that control has been lost but also gained. With respect to the former, Noordegraaf is right to suggest that these new professions within the NHS, exemplified by physiotherapists, lack occupational control; this control has been lost to a state-created regulatory body, the HPC, whose remit is the protection of the public not the new professions. These professions therefore lack regulation over a field of practice, even if their titles are protected. In this sense there is then some truth in Noordegraaf's (2007) claim that from the perspective of the traditional professions, the professionalisation of physiotherapists would be "nonsensical" (p. 778). However, regulated

access to that practice has also been secured through the switch in skill development to higher education, a key requirement of occupations classified as “professional”. This achievement is driven not simply “from above” by managers, employers and the state but also “from within” by the occupational representative body (e.g., Evetts, 2006, 2011; McCann *et al*., 2013). Both drivers act together, simultaneously rather than in concert perhaps, to realise the graduatisation of physiotherapy and other former associate professionals in the NHS. These occupations are therefore not passive victims (e.g., Muzio and Kirkpatrick, 2011) but active agents in change that results in regulated access to these occupations.

The second form of hybridity centres on skill deployment. Here too the empirical evidence reveals varied outcomes with professionalisation. Although reclassified and upgraded to be professionals through their reconfigured skill development, analysis of the skills deployed by physiotherapists’ in their work reveals a more nuanced outcome. Our findings suggest that a veneer of “being professionals” (e.g., Noordegraaf, 2007) does exist for many physiotherapists but, importantly, not all. Some in the occupation have experienced genuine upskilling, using specialised knowledge to exercise task autonomy and discretion, and their tasks have become more complex – outcomes associated with the traditional professions. Nevertheless, other physiotherapists have experienced genericisation, leading to assertions of deskilling. In addition, some tasks have been displaced onto less qualified workers within the occupation. The limitations on upskilling are driven from above as the NHS has sought organisational rationalisation within the context of tighter budgets.

Overall, with this double hybridity, change for physiotherapists is both symbolic *and* substantive. With graduatisation and reclassification, this occupation has the status of a profession. Moreover, some in this new profession (at Band 7+) have similar skills and work to that of traditional professionals – though occupational closure has not been accompanied by the occupational self-regulation enjoyed by the traditional professions. Coupled with the potential for the loss of existing skills amongst most physiotherapists (at Bands 5 & 6) through genericisation, professionalisation may seem like a hollow victory for this female-dominated occupation (e.g., Witz, 1990). Our empirical findings show the need to conceptualise the current wave of professionalisation projects drawing on analysis of skill deployment and not just the

political manoeuvring by representative bodies to reconfigure skill development that results in occupational reclassification. An analytical rebalancing to include skill use in work is not just useful, it is required and needs to become mainstreamed again in research of the professions (e.g., Abbott, 1988).

However, in this endeavour, our findings also suggest that the methodology underpinning the SOC needs to be revisited. It too requires to be based on empirical examination of the deployment of skills in work rather than assumptions about these skills' use being read off qualifications. It might even be that a disconnect exists between the skills required to get the job and the skills required to do the job for more occupations beyond physiotherapy. For example, unlike the SOC, following past criticism about the use of indirect measures of occupational skill, the US Dictionary of Occupational Titles now uses expert job analysts and workplace observations to assess a job's skill level (Dickerson *et al*., 2012).

Future research should also turn to other similarly reconfigured and reclassified occupations in the NHS. We speculated about some of these other new professions but detailed empirical examination is required. It would also be useful if our double hybridity concept was empirically tested more broadly, beyond the NHS to envelop those occupations within other large bureaucratic organizations labelled "new model professions" (Ackroyd, 1996). Future research should also examine how the sub-degree workforce in physiotherapy develops. There is evidence from the education sector, in schools for example, that when classroom/teaching assistant occupations are formalised there can be an upwards 'skills creep' in which these workers informally take on the role of teachers but without recognition or commensurate pay (Warhurst *et al*., 2014). Similar developments may occur in the NHS given that similar public budget constraints exist in both health and education sectors. Finally, it would be insightful if matched internationally comparative studies of these occupations could be generated, most obviously comparing the Anglo-Saxon with other countries (e.g., Muzio and Kirkpatrick, 2011). This new set of research would extend the inchoate evidence-base that we have provided in this article and further develop understanding of professionalisation in the twenty-first century.

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Table I Titles of health & social welfare associate professionals' unit groups reclassified as professional occupations in the SOC2010 (Allied Health Professions highlighted in grey)

SOC 2000 MAJOR GROUP 3:				SOC 2010 MAJOR GROUP 2:			
ASSOCIATE PROFESSIONAL & TECHNICAL OCCUPATIONS				**PROFESSIONAL OCCUPATIONS**			
Sub-Major Group	**Minor Group**	**Unit Group**		**Sub-Major Group**	**Minor Group**	**Unit Group**	
32			**HEALTH & SOCIAL WELFARE ASSOCIATE PROFESSIONALS**	**22**			**HEALTH PROFESSIONALS**
	321		**Health Associate Professionals**		**223**		**Nursing and Midwifery Professionals**
		3211	Nurses			**2231**	Nurses
		3212	Midwives			**2232**	Midwives
					221		**Health Professionals**
		3215	Chiropodists			**2218**	Podiatrists
		3214	Medical radiographers			**2217**	Medical radiographers
	322		**Therapists**		**222**		**Therapy Professionals**
		3221	Physiotherapists			**2221**	Physiotherapists

		3222	Occupational therapists			**2222**	Occupational therapists
		3223	Speech and language therapists			**2223**	Speech and language therapists
		3229	Therapists n.e.c.			**2229**	Therapy professionals n.e.c.

Source: ONS (2000, pp. 25–27) and ONS (2010, pp. 12–18)

Note – Therapists n.e.c. (not elsewhere classified) include dieticians, orthoptists etc.

Table II Double Hybridity

	Losses	Gains
Occupational Control (Hybridity 1)	Professions lose regulation over field of practice to state-created regulatory body, whose primary focus is protection of the public, not protection of professions.	Greater protection of professional titles. Graduatisation and re-classification – confer 'status' of profession.
Organisational Control (Hybridity 2)	Limits to upskilling for most. Genericisation, leading to deskilling, and some work displaced onto less qualified workers within the occupation.	Genuine upskilling for some, able to exercise task autonomy and discretion, and tasks more complex – outcomes associated with the traditional professions.

Notes

[1] It should be noted that whilst the research was conducted in Scotland and the funding of health and the NHS is devolved to Scotland, governance of health professionals through the HPC is UK-wide

[2] Prior to the new pay bandings and terms and conditions, NHS physiotherapists' pay was determined by arrangements set by the General Whitley Council.