The Construction of Intra-Professional Status in Medicine and its Role within Processes of Organisational Change

By

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A thesis submitted in fulfilment of requirements for the degree of
Doctor of Philosophy

To

Warwick Business School
University of Warwick

September 2018

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Acknowledgments

I would like to offer my heartfelt gratitude to my supervisors Professors Jacky Swan and Gerry McGivern for their invaluable support over the last seven years.

I would like to thank the Innovation, Knowledge and Organisational Networks (IKON) research group at Warwick Business School for their financial support.

The completion of this thesis wouldn't have been possible without the bucket loads of patience and unwavering support from my kindred spirit, Jen. I love you so much – thank you!

I dedicate this thesis to our daughter, Asta, whose arrival during the final phases of writing up, provided added challenge for good measure, but whose smiles have made the late nights all worth it.

Declaration

I hereby declare that there is not any material contained in this thesis which I have used before or which I have published. The thesis is my own work. This thesis has not been submitted for a degree at another university.

Chapter One

Introduction

1. Chapter One: Introduction

The medical profession continues to sub-divide and sub-specialise into increasingly smaller units (Rosen, 1944). From cardiologists to cardiac surgeons, gynaecologists to geriatricians, orthopaedic surgeons to otologists, renal physicians to respiratory physicians, virologists to vascular surgeons, and diabetologists to dermatologists, to name but a few. It has been said that the profession is becoming increasingly composed of groups of doctors that have separate identities, boundary awareness, ideology, and governing principles. As such there is no longer a core within the profession that shares a sense of unity (Roth & Ruzek, 1986: 166).

But how does this differentiation affect the identity of doctors and how does it affect the way they perceive those working in the other sub-groups of the profession? Does a cardiologist consider themselves to be higher status than a dermatologist, or are they just different in kind? Does a general practitioner or psychiatrist feel subordinate to a hospital specialist? How do doctors construct their professional status, and do doctors working within different specialties, or who work in different organisational contexts, do it in different ways? How do these constructions of status manifest themselves, and to what extent can they provide insights into the behaviour of doctors within processes of organisational change?

1.1. Purpose of the Study

The focus of this thesis is the concept of 'status', and more specifically, 'professional status' – the status that is derived from an actor's professional role. In order to enhance our understanding of professional status within professional groups, this thesis will consider the status of doctors. As members of the model or prototypical professional group (Burnham, 1998: 2), doctors enjoy a high status compared to members of other occupational groups. However, an understanding of how doctors construct their status is sorely lacking in the literature.

Importantly, this study conceives of status as being socially constructed and having a subjective quality rather than being an objective and structural reality. The approach to this research and the interpretation of its findings are informed by the

philosophy of constructivism (Denzin & Lincoln, 2018). In studying the construction of status, and the micro-level processes of interpretation and sense-making that underpin this approach, this study is a departure from the mainstay of the literature concerning professional groups which have emphasised their objective characteristics such as their wealth, power and influence (Freidson, 1970; Larson, 1977; Starr, 1982).

This thesis will provide a better account of the way that doctors construct their intra-professional status – in other words how they perceive themselves and other segments or groups within the profession. Enhancing our understanding of intra-professional dynamics matters, in part, because the increasingly diverse segments of the medical profession have different interests, motivations and involvement in processes of organisational change, leading to different settlements and outcomes (Halpern, 1992). There is a gap in the literature related to the role of intra-professional differences within processes of change. Most studies have conceived of professions as fixed and homogenous entities within which members share common identities, ideals and intentions. The erroneous implication being that differences in intra-professional identities and their impact on processes of organisational change are insignificant and can be discounted (Ozturk, Amis & Greenwood, 2016).

This thesis will demonstrate that our understanding of the way that professional status shapes, or is shaped by, processes of organisational change is not well understood and is under-explored within the literature. In particular, this study will consider how opportunities and threats to professional status play an important part in professionals' acceptance or resistance to change.

It should be emphasised that the focus of this study is on the role of status *within* change, rather than change *per se*. The literature concerning change is vast and complex. This thesis delineates its focus to status as a phenomenon within processes of organisational change, rather than as a cause of, or determining factor of the outcome of change processes. Similarly, the status literature is also vast and pan-disciplinary. Given the focus in this thesis on subjective interpretation of status, in surveying the relevant literature and informing the development of theoretical

models this thesis will take inspiration from some of the cognitive models offered by social psychology which are under-utilised within the management and organisation studies literature (Pearce, 2011).

1.2. Research Questions

This research study will address the following two research questions:

- How does the medical profession construct professional status?

- What is the role of professional status within processes of organisational change?

The thesis will be structured according to these two research questions. For instance, the literature review will be split into two sections concerning the definition and conceptualisation of status, and studies that have considered its role within processes of organisational change. Similarly, the findings sections will also be split into two sections addressing each research question respectively. It should be noted, however, that there is an obvious relationship between these two questions and the nature of the phenomenon being studied.

1.3. Context & Empirical Study

The research methods used in this study are informed by the philosophy of constructivism. This research study utilises qualitative methods including semi-structured interviews and a case study approach. Semi-structured interviews are used to address the first research question related to the construction of professional status, and a case study approach is used to address the second research question, considering the role of status within processes of change.

In total, forty interviews were undertaken with a range of informants including hospital consultants, general practitioners and other actors. The data analysis involved a process of inductive theorisation, based on the Gioia et al (2012)

methodology, to develop a theoretical model to account for how doctors construct professional status.

In order to consider the role of professional status within processes of organisational change, the research study focuses on three case studies relating to organisational change within the English National Health Services (NHS). The subjects of the three case studies include (i) Vascular: the centralisation of vascular (emergency) services; (ii) Cardiology: the extension of primary angioplasty (heart attack) services; and, (iii) Respiratory: the integration of a hospital-based and community-based team. These case studies will be used to explore change that has occurred across different organisational boundaries.

1.4.   Importance of the Research

In recent years, there have been some profound changes that have challenged the traditional model of medical professionalism. For instance, there have been changes in working conditions, the character of the workforce (Christmas & Millward, 2011), the level of public confidence in the profession, particularly following well publicised professional failures (e.g. the Alder Hey organ retention and Bristol Royal Infirmary heart scandals etc.), growing public expectations and demand for services, new ways of working including a greater emphasis on multi-disciplinary working, growing managerialism and bureaucratisation of service delivery (Alder & Kwon, 2013), the emergence of evidence-based medicine (Timmermans & Berg, 2003), the information technology revolution, and an acceleration of the pace of change in medical knowledge and practice (Leicht & Fennell, 2008; Castellani & Hafferty, 2006).

However, despite these challenges to the traditional model of medical professionalism, doctors retain a significant and powerful position (Currie *et al*, 2012). They are at the apex of the healthcare professional hierarchy, with their power deriving from both the social legitimacy of their mission and their exclusive ability to apply expert knowledge to particular cases. The medical profession continues to be the key decision maker related to change (Battilana, 2011: 819; Ackroyd, 1996). It is therefore essential to be able to account for doctors' responses to processes of

organisational change, and to derive lessons for how change could be approached in a way that is sensitive to the cognitive processes that underpin them.

Furthermore, although most accounts of status recognise it as a basis for social differentiation and its role in the formation of social hierarchy (Magee and Galinsky 2008), these accounts can sit incongruously with the internal structure (or lack thereof) governing the relationship between the subunits of the medical profession, which do not lend themselves to being conceived of within an orderly hierarchy (e.g. Merton, Bloom & Rogoff, 1956; Schwartzbaum, McGrath & Rothman, 1973). Indeed, Bucher & Strauss (1961) refer to the 'minimal structure' of the medical profession.

Unlike the rigid hierarchy that governs the relationship between junior and senior ranks of doctors, the relations between members of the different medical specialties, and indeed between medical specialties across different organisations, has no formal hierarchical structure (Halpern, 1992). Beyond their areas of functional differentiation, there is little encroachment of one specialty into the affairs of another specialty, or into the affairs of a specialty working in a different organisation. The only exception being when the boundaries between respective jurisdictions become blurred or modified as a result of organisational change (Abbott, 1981). It is therefore important to be able to provide an account of professional status within processes of organisational change that can account for the peculiar structure, diversity and complexity of the medical profession.

1.5.   Contribution to Theory

This thesis will make several contributions to the literature, including providing an account of the subjective quality of status which has been lacking in the study of the professions and to provide a better account of how status is constructed, contested and dynamic. It has been remarked that there is a need for more studies concerning status in the management and organisation studies literature, which until relatively recently have been relatively few and far between (Chen *et al*, 2012).

Furthermore, this thesis will make a contribution by addressing an under-appreciation in the organisational change literature regarding the role of

opportunities and threats to professional status as explaining acceptance or resistance to change, and to provide a more developed understanding of how doctors construct and reconstruct their professional status in response to organisational change, with reference to their role identity and in relation to others. In so doing, this thesis will take inspiration from some of the cognitive models developed in the field of social psychology to explain the cognitive underpinning associated with responses to organisational change.

1.6.   Structure of Thesis

This thesis will be structured as follows: In Chapter Two, I will define the concept of 'status' and distinguish it from related terms. I will consider the status literature and highlight key theoretical perspectives relating to how status shapes social relations. I will consider research that conceives of status having a structural and objective quality by examining the ranking of specialties in terms of their relative prestige, and outline some of the limitations of this approach. Finally, I will consider the literature related to organisational change, with specific reference to studies that have considered change in a healthcare context.

In Chapter Three, I will set out my research methods. I will explain why I have chosen to use a qualitative methodology including the use of interviews and a case study approach. I will outline my overall approach to the research study. I will outline the steps I have taken for data collection, including primary and secondary sources. Then I will describe the steps I have taken for data analysis and theorisation.

In Chapter Four, I will provide a detailed exploration of the key themes that have emerged from the data relating to the construction of intra-professional status. I will describe eleven key themes. I will then explain how I translated these themes into a data structure, and how this forms the basis for the theoretical model to explain how doctors construct professional status. The theoretical model will then be discussed, and I will introduce the concepts of contributory and mitigating themes.

Chapters Five, Six and Seven will consider three case studies of organisational change. These case studies include the centralisation of vascular surgery services (Vascular), the extension of services for patients suffering from heart attack (Cardiology), and the integration of a hospital-based and community-based respiratory team (Respiratory). I will analyse these case studies with reference to the eleven key themes of how doctors construct professional status that I have identified. I will also provide additional observations related to these themes that are identified in the case study data.

In Chapter Eight I will present a cross-case analysis of the three case studies, to

identify common patterns and differences, and using this analysis, I will offer a theoretical model to explain the role of professional status within processes of organisational change.

Finally, in Chapter Nine, I discuss my findings and theoretical models in comparison to pre-existing literature and draw associated conclusions. The thesis will be concluded by summarising the principal implications of this research for practice, the significance of these findings, potential limitations or weaknesses of the study, and subject areas for future research.

Chapter Two

Literature Review

2. Chapter Two: Literature Review

The literature on status is vast and straddles a number of disciplines such as social psychology, economics, sociology and anthropology. These divergent disciplinary perspectives have coloured the way that status has been conceptualised. However, despite the body of research that has been developed in these fields, the study of status has only 'occupied a rather minor place in the management and organisation literature' (Pearce, 2011: 1), and it is only in the last few years that scholars have turned their attention to the powerful role of social status in explaining organisational behaviour and dynamics. According to Chen *et al* (2012), an explicit empirical or theoretical examination of the concept of status is scant in leading management journals, with the greater theoretical presence being in leading social psychology and sociology journals.

There is considerable overlap between the study of status and other areas of research including power, legitimacy and reputation (Stringfellow & Thompson, 2014). Deephouse & Suchman (2008: 60) attribute the similarities between these literatures to shared 'antecedents, consequences, measures and processes.' As a result, 'different authors use different mixes of the three terms for essentially the same empirical referents.' Given the diversity of theoretical perspectives, and overlapping areas of research, it is unsurprising the terminology deployed in this field of research is also characteristically inconsistent.

This chapter will start by defining the concept of 'status', and how it can be distinguished from related terms such as 'reputation', 'power' and 'legitimacy'. I will then consider how status manifests itself in status structures by considering a number of key theoretical accounts including Functionalist, Symbolic Interactionism, Conflict-Dominance, Social Exchange Theory, and Expectation States Theory. I will then define the concept of 'intra-professional status' and give an account of the paucity of studies related to this field. The differentiation between groups according to their relative intra-professional status will then be considered by exploring the literature on prestige ranking of specialties and diseases. Finally, I will explore literature related to the role of professional status within processes of organisational change within healthcare. I will argue that the subject of threats and opportunities to

professional status is a key and under-explored element within organisational change literature, explaining acceptance or resistance to change.

2.1. Defining Status

As a sociological concept, **'status'** reflects differences in social rank that generate privilege or discrimination, rather than merit or achievement-based rewards. One of the earliest articulations of the concept is attributed to Weber (1978), whose classic definition of social inequality, referred to three fundamental types of inequality: the first based in the marketplace (class), the second based in estimations of honour (status group or *Stand*), the third being party. The concept of 'class' and 'status group' are fundamentally different, 'status group' being rooted in abstract emotion and 'class' in rational calculation. Weber defined 'status' (*ständische Lage*) as 'an effective claim to social esteem in terms of positive or negative privileges' that can be based on lifestyle, education, and hereditary or occupational prestige (*ibid.*, 305).

Similar definitions, emphasising the characteristics of precedence and privileges, have been offered by many contemporary theorists within the field of sociology. For instance, Abbott (1981: 820) defines 'status' as 'a quality entailing deference and precedence in interaction, a quality of professional or public honour.' He also claims that 'status systems are generated by bases or dimensions of honour – power, wealth or knowledge'. Echoing the theme of precedence, Wejnert (2002: 304) defines 'status' as the 'prominence of an actor's relative position within a population of actors.'

Within the field of management and organisation theory, Washington and Zajac (2005: 284), define 'status' as 'a socially constructed, inter-subjectively agreed-upon and accepted ordering or ranking of individuals, groups, organizations, or activities in a social system.' Huberman, Lock & Önçüler (2004: 103) refer to 'status' as a 'rank-ordered relationship among people associated with prestige and deference behaviour.' Finally, Jensen & Roy (2008: 496) define 'status' as 'prestige accorded [actors] because of the hierarchical positions they occupy in a social structure.'

In order to more clearly define the concept of 'status', it is necessary to differentiate it from the concepts such as 'reputation', 'power' and 'legitimacy'. There is a substantial body of literature that discusses the differences and relationships between these concepts (see Bitektine, 2011; Washington & Zajac, 2005; Jensen &

Roy, 2008). According to Washington & Zajac (2005: 283) the notion of **'reputation'** refers more closely to the economic concept of perceived quality that generate *earned*, performance-based rewards. For theorists such as Wilson (1985) and Weigelt & Camerer (1988), reputation was a signal that allowed audiences to predict future behaviour, performance or quality, based on what had been observed in the past. The concept of 'status' is qualitatively distinct from 'reputation' because it refers to the *unearned* ascription of social rank.

Although the sociologist Joel M. Podolny's (1993) seminal article, 'A Status-Based Model of Market Competition', used the term 'status', it actually more closely referred to the concept of 'reputation'. Indeed, Podolny (1993: 830) defined 'a producer's status in the market as the perceived quality of that producer's products in relation to the perceived quality of that producer's competitors' products.' He did consider using the term 'prestige', but considered it incongruous, or 'perceived quality', but this failed to convey the sense of an implicit hierarchy or ranking (*ibid.*). This is a good example, and by no means an isolated definitional overlap in status literature.

Magee and Galinsky (2008) claim that **'power'** and 'status' are related but distinct constructs. They are both relational variables that form the bases of hierarchical differentiation. However, they are definitionally distinct because 'power' is based in resources, which belong to an actor, whereas 'status' exists entirely in the eyes of others. 'Power' and 'status' can also be mutually reinforcing: power leads to status, and status leads to power. According to Pearce (2011), it is necessary to distinguish deference to those with the 'power' to help or hurt you, from deference to the 'status' of those you honour and respect. Again, there are further definitional overlaps as theorists such as Ibarra (1993) equate power with status.

'Legitimacy', on the other hand, is acknowledged to be derived from Weberian notions of the legitimacy of different authority types (Weber, 1978). This theory was further developed by Parsons (1960) who viewed legitimacy as the congruence of an organisation with social laws, norms and values. This conception is echoed by Suchman (1995: 574) who defines legitimate behaviour as 'desirable, proper or appropriate within some socially constructed system of norms, values, beliefs and

definitions.' Similar definitions are offered by a number of theorists including, Zimmerman & Zeitz (2002: 416), who state that 'legitimacy' is 'a social judgement of appropriateness, acceptance, and/or desirability.'

According to Washington & Zajac (2005), 'legitimacy' refers to the level of social acceptability bestowed upon a set of activities or actors, which may correlate positively, be uncorrelated, or even negatively correlated with the concept of 'status'. According to Piazza & Castellucci (2014), 'legitimacy' emphasises the similarity of some actors' dimensions, to what is socially expected of the actor regarding these dimensions, whereas 'status' focuses on how these dimensions provide a basis to determine a rank ordering of actors.

Deephouse & Suchman (2008: 61) have also considered the difference between the concepts of 'legitimacy' and 'status'. They state that 'legitimacy' is fundamentally 'non-rival': it is rarely a zero-sum game within a given population, whereas 'status' is fundamentally 'group-rival'. Groups compete for status and individuals move between groups primarily through sponsorship rather than by performance. Furthermore, 'legitimacy' is 'homogenising', producing herd-like conformity, whereas 'status' is 'segregating.' Owing to these characteristics, 'legitimacy' tends to be associated with all entities that share a given form. On the other hand, 'status' tends to attach to 'status groups' rather than individual social actors or entire populations. Finally, because of its association with authority, 'legitimacy' is fundamentally 'political', producing a right to act in a certain way within a given sphere of activity, whereas 'status' is 'honorific' eliciting deference and tribute, and having the capacity to valorise or contaminate by association.

The concepts of 'legitimacy' and 'status' are closely related for a number of reasons. The act of conferring 'legitimacy' by social actors promotes structures that they perceive as beneficial to themselves or their social (status) group (Bitektine, 2011). Furthermore, 'legitimacy' empowers the organisation or social group to enunciate claims on the basis of status. A legitimate organisation or social group has the freedom to pursue its activities, to access resources and achieves greater stability (Brown, 1998: 35; Deephouse & Suchman, 2008). In other words, it informs and enables social differentiation and the pursuit of status rewards.

2.2. Status Literature

'Status' has been conceptualised in a variety of different ways. The particular focus of these theoretical approaches, and their account of the dynamics at play, is reflective of the particular discipline of the authors. These theoretical approaches can be distinguished according to the level of analysis (i.e. the individual, the group or organisation) and their relative emphasis on status having a subjective or an objective quality. The following section will consider these two dimensions.

Firstly, there is an acknowledgement in the literature that status can manifest itself at different levels of analysis. For instance, Piazza & Castellucci (2014) distinguish between approaches that conceive of status as either being a phenomenon ordering the relations between social groups, or, the hierarchical relationship among individuals taking the form of differences in deference or influence. Similarly, Magee & Galinsky (2008) state that status can be an intra-group or inter-group phenomenon, with individuals within a social group being arrayed according to the amount of respect that they receive from other groups members, or, social groups being arrayed according to the respect that other social groups have for them.

Status can also simultaneously be related to the individual, group and organisational contexts, and can act across these different levels of analysis. For instance, Chen *et al* (2012) conceive of status working at several levels: as a 'meso' concept it integrates microlevel psychological processes and group dynamics with macro-level organisational arrangements. In this conceptualisation, status hierarchies can manifest themselves at an interpersonal level, an intra-group level, inter-group and a 'market' or inter-organisational level.

Secondly, studies can be distinguished based on their relative emphasis on status having a subjective or an objective quality. For instance, Pearce (2011) draws a distinction between status being conceptualised as a subjective evaluation, and status being conceptualised as an objective and structural reality. In other words, status can be conceptualised as being shaped by the subjective perception of individuals, which may result in the existence of divergent, and potentially

contradictory views about the status of the same thing. On the other hand, status can be conceptualised as something about which there is a degree of social consensus. This approach conceives of status as having a quality irrespective of whether it is acknowledged or approved of by the individual.

The theoretical approaches that have been derived from some sociological and economics perspectives tend to emphasise the importance of structural factors in establishing social status (e.g. Podolny, 1993). For instance, Parsons (1937) conceived of status as resulting from a person's structural position along several dimensions – kinship unit, personal qualities, achievements, possessions, authority and power – but not a subjective individual evaluation. At the other end of the spectrum, theoretical approaches from the stable of social psychology (e.g. Secord and Backman, 1974) emphasise the paramount importance of individual's perspective in the construction of status.

Although there are some differences in theoretical approaches, it should be noted that the majority of scholars within the field of management and organisation studies recognise that status is socially constructed; it is grounded in social consensus, but must be perceived by individuals, and can be assessed, although not reduced to, structural characteristics (Pearce, 2011: 6). In other words, status hierarchies are primarily subjective, but there tends to be a high degree of consensus about individuals' and groups' positions within these status hierarchies (Magee & Galinsky, 2008).

2.2.1.   Theoretical Perspectives

The status literature can also be distinguished according to the particular theoretical perspective used to explain the role played by status in shaping social relations. According to Ridgeway (2001: 354), there are four general theoretical perspectives that have been used to explain the emergence and nature of status structures in groups: Functionalism (Parsons, 1937; Bales, 1950; Parsons & Bales, 1955), Symbolic Interactionism (Sauder, 2005), Conflict-Dominance (Mazur, 1985; Mueller & Mazur, 1996; Freidson, 1970), and Social Exchange Theory (Blau, 1964; 1994).

Ridgeway introduces a fifth perspective, Expectation States Theory and Status Characteristics Theory (Ridgeway, 1991; Berger, Ridgeway and Zelditch, 2002).

The **Functionalist** account of social stratification can be divided into two main theoretical perspectives: Kingsley Davis and Wilbert Moore's 'Davis-Moore Thesis' and the theory of Talcott Parsons. Firstly, Davis and Moore (1945) conceived of social inequality as being a 'universal necessity' in any social order. They held the view that social stratification was necessary to meet the needs of a complex social system so that the most important positions are occupied by the most qualified and competent people. The formation of status hierarchies, therefore, serves to organise individual efforts for effective decision making and collective action to work towards group goals. When more competent members are afforded higher status, this helps the group to adapt and survive (Ridgeway, 2001).

This account was heavily criticised by Tumin (1953: 393) who pointed to the fact that social stratification and high inequality can be dysfunctional for the society: 'social stratification systems function to limit the possibility of discovery of the full range of talent available in a society [and] function to encourage hostility, suspicion, and distrust among the various segments of a society and thus to limit the possibilities of extensive social integration.'

The functionalist perspective of Parsons shares many of the characteristics of the Davis and Moore Theory. However, Parsons (1964:70) stated that 'central for the purposes of this discussion is the differential evaluation in the moral sense of individuals as units.' In other words, individuals are stratified by status or honour according to how well they live up to the dominant values of a given society. This value system ensures that the most important positions are filled with the most qualified and competent people through their striving for status.

Although Parsons (1964) recognised wealth and power differences, these were considered of secondary importance; the individuals who best live up to the values shaped by social institutions will receive more status, as well as secondary rewards that are associated with high status e.g. wealth or power. According to Kerbo (2002)

this account has been criticised for its assumption that society has needs of its own i.e. people working in the most important positions are doing so for the needs of society, and the needs or interests of individuals or groups are subordinate. Furthermore, even assuming that people primarily strive for status, shaped by the common value system, Parsons ignores the fact that those values may have been shaped by those with wealth and power in society.

The functional account of social status has been largely discredited since the 1970s and rejected in favour of accounts that better captured the importance of micro-interactions that inform the structure of social relations. **Symbolic Interactionism** conceives of status as being the product of actors co-constructing shared meaning, including the value of the self and others in a social context (Alexander & Wiley, 1981). According to Blumer (1986: 74-75), symbolic interactionism 'sees human society not as an established structure but as people meeting their conditions of life; […] it sees group life not as a release or expression of established structure but as a process of building up joint actions [...] it sees society not as a system, […] but as a vast number of occurring joint actions, […] all being pursued to serve the purposes of the participants and not the requirements of a system.'

Another key theorist that contributed to symbolic interactionism is Goffman. According to Rogers (1980) he conceived of every social order as being based on the principle that any individual with certain social characteristics can morally expect to be valued and treated in an appropriate manner. These social characteristics are unevenly distributed which results in an unequal distribution of the right to expect deference in a given situation.

The degrees and modes of deference exhibited towards individuals sharing similar social characteristics point to their location in the social hierarchy. This hierarchy shapes interaction by determining the allocation of privileges and duties among actors. An actor's status is never fully established, it is created and re-created through the interplay of acts of deference and demeanour and their symbolic and ritual elements. In this conception, social hierarchies are implicitly negotiated as

actors present a valued social 'face' but depend on the interactional support of others to enact that face within the group (Ridgeway, 2001).

In contrast to symbolic interactionism, the **Conflict-Dominance** approach (see Dahrendorf, 1959; Collins, 1975) conceives of status as emerging from the negative interdependence created by the scarcity of resources. These resources can be conceived of as material goods, rewards or power. According to Chen *et al* (2012), there are two routes to social status – dominance and prestige. The former is achieved through behaviours such as aggression, coercion or intimidation, and the latter is based on perceived competence, pro-social behaviours and association with high-status actors (see Henrich & Gil-White, 2001). These dominant behaviours establish hierarchical rank and determine relative access to scare resources. In the case of actors with unequal rank, they produce deference behaviours, but in the event that actors are more evenly matched, there may be visible contest for status rank (Ridgeway, 2001).

A considerable amount of research into status implies that people should pursue status rationally as a symbol of ability or based on competence and as a means to obtain power or resources (Huberman, Lock & Önçüler, 2004), and that this engenders a positive interdependence between actors. According to **Social Exchange Theory** (Blau, 1964; Homans, 1961), status hierarchies emerge from group members rational interests in maximising collective rewards by cooperatively offering deference for valuable contributions.

According to Blau (1964: 14) 'forces of social attraction stimulate exchange transactions. Social exchange, in turn, tends to give rise to differentiation of status and power. Further processes emerge in a differentiated status structure that lead to legitimation and organisation, on the one hand, and to opposition and change, on the other.' The value of an actor's contributions to the group are affected by attributes, such as gender, that carry status value in the wider social context.

Finally, **Expectation States Theory** (Berger, Conner and Fisek, 1983) and its major sub-theory, **Status Characteristics Theory**, consider how status differences affect

actors expectations of one another. This theory assumes a situation where actors are orientated toward the accomplishment of a collective goal, and that status structures emerge as a consequence of the process by which actors in a group compare and define themselves in relation to one another, in order to act toward the collective task (Ridgeway, 1991; 2001). In other words, status hierarchies are a product of the expectations actors develop regarding the usefulness of each actor's contributions towards the shared goal, compared to the relative contributions of others.

The performance or behavioural expectations that actors hold for each other are shaped by the salience of 'status characteristics', the impact of social rewards, and the patterns of behavioural interchange between actors, which activate cultural beliefs (Ridgeway, 2001). Status characteristics are attributes that differentiate actors into social categories, which are invested with differential status value, and carry different 'status value beliefs' about the relative worthiness and competence of actors in those categories (Berger, Ridgeway and Zelditch, 2002). Status characteristics can be diffuse (i.e. have general expectations) or specific (i.e. relevant to a defined task). A status characteristic becomes salient when the actors differ on the characteristic or when the actors perceive the characteristic to be relevant to the group task.

Status value beliefs do not just differentiate between groups but indicate people that in all categories of the distinguishing attribute agree, or at least concede, that one category is better than the other (Ridgeway *et al*, 1998: 332). This is an interesting conceptualisation as a number of other theoretical approaches, such as **Social Identity Theory** (Tajfel, 1978; Turner, 1987), have suggested that differentiation between groups is sufficient to create an in-group bias which privileges their own category as better, and leads actors to favour their own group over another (Ridgeway, 1998; Brewer & Kramer, 1985; Messick & Mackie, 1989; Mullen, Brown, & Smith, 1992). Expectation States Theory, on the other hand, dictates that even those in the devalued category accept, as a social fact, that the other group is better than their own (Ridgeway, 2001).

This process of status value belief acquisition mediates between the micro-level face-to-face interaction between actors, and macro-level structural conditions and widely shared cultural beliefs (Ridgeway & Balkwell, 1997). This theory also recognises that widely shared cultural beliefs are culturally specific, and so allows for different conceptualisations of status characteristics in different societal contexts.

There have been a number of critiques of Expectation States Theory including Knottnerus (1988) who claimed that its conceptualisations of cognition, generalisation and status stereotypes were coloured by mechanistic and rationalistic assumptions concerning the way actors process information. The result is an overly narrow depiction of what cognition encompasses – it does not account for what poor information processors people can be, using shortcuts to make decisions, and acting in a less than rational way.

*   *   *

What can we conclude about the conceptualisation of status from these theoretical perspectives? There are substantive differences between these approaches including the level of analysis and the focus on status having an objective or subjective quality. Functional and Conflict-Dominance accounts tend to emphasise the objective quality of social structure, whereas Symbolic Interactionism and Expectation States Theory focus on the subjective quality of social interaction. As we will see in the following section, the study of the professions has tended to focus on Conflict-Dominance structural perspectives (e.g. Freidson, 1970; Abbott, 1981), meaning that the subjective quality of status, and its basis in micro-level interactions between actors, has been relatively neglected in this field.

2.3. Intra-Professional Status

There are parallels between the concept of intra-group status mentioned in the previous section and intra-professional status. The obvious distinguishing feature being that the actors being studied are not only part of a group, but also a member of a profession. There is a myriad of definitions for a 'profession' (see Muzio, Brock & Suddaby, 2013: 714; Huising, 2015: 264). Given that medicine is typically considered the prototype of the professions, and the one that conceptions of professions tend to be based (Butcher & Strauss, 1961), for the purposes of this research study, 'professions' are simply defined as 'occupations based on advanced, or complex, or esoteric, or arcane knowledge' (Macdonald, 1995: 1).

There are surprisingly few studies that have considered intra-professional status (Abbott, 1981: 820). Professions have often been treated in the literature as homogenous groups. There is actually considerable heterogeneity within professions that needs to be considered. For instance, Drazin (1990: 251) stated that professions are internally differentiated and consist of multiple communities or segments that participate in a wide variety of tasks and activities and that adhere to correspondingly diverse communal systems of norms and values. These internal professional communities have divergent and often conflicting political interests, associations and memberships, work in different settings and have different characteristics.

The early Functionalist school accounts of the professions (Parsons, 1951; Carr-Saunders & Wilson, 1964), the later 'professional dominance' accounts that considered, more critically, the power and privilege of the medical profession (Freidson; 1970; Larson, 1977; Starr, 1982), and the proponents of 'deprofessionalisation' (Haug, 1988), proletarianisation (McKinlay & Arches, 1985) and corporatisation (McKinlay & Stoeckle, 1988), generally focussed on the medical profession at a macro level, and its interactions with the state and other actors. These accounts tend to emphasise the homogeneity and stability of the professions, rather than micro-level analyses that emphasise the heterogeneity and/or instability within professions (Sanders & Harrison, 2008).

There are, however, some notable exceptions within the field of sociology that considered the diversity within professions. For instance, Butcher & Strauss (1961: 326-328) stated that the medical profession contained 'many identities, many values, and many interests.' They observed groupings emerging within the profession that they called 'segments'. These segments do not simply equate to medical specialties, because they claim that a close look at a specialty will betray its claim to unity, revealing that they also contain segments. Professions are, therefore, 'loose amalgamations of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular period in history' (1961: 326). The character of these segments differs on the basis of their sense of mission, work activities, methodology (approach) and technique, clients (patients), colleagueship, interests and associations, and public relations. Halpern (1992) characterised these segments as 'professions within a profession.'

This conception of the medical profession as multiple segments with differing characters permits the existence of divergent conceptions of what constitute the core of their professional identity. For instance, the most characteristic professional act for some radiologists may be attacking tumours with radiation, for others it is interpreting x-ray pictures. For some pathologists, it is looking down the barrel of a microscope, for others it is experimental research (Bucher & Strauss, 1961: 328). Furthermore, Bucher & Stelling (1969) state that this internal differentiation within the profession is continuously evolving. This leads to new affiliations and divisions between segments. According to Halpern (1992) these intra-professional dynamics matter, in part, because these segments have different interests and levels of involvement in boundary disputes with other occupations, leading to different settlements.

More latterly, the approaches from the field of sociology have conceived of professions as ecologies or systems rather than fixed entities, which have better accounted for the diversity within the profession. These approaches have considered how, as part of a system, jurisdictions between occupational groups are created, maintained and changed. According to Abbott in his *The System of Professions* (1988), different occupations within a division of labour jostle for their status and position, and in so doing extend, maintain and lose their jurisdictional boundaries.

External forces create a state of continuous flux in which tasks are created and abolished and jurisdictions are reshaped. The internal structure of a profession is important; the more strongly organised a profession, the more effectively it can fight for jurisdiction. The most important principle of professional life is, therefore, the control of tasks, and, the jurisdictional battles may be resolved in a variety of settlements, which create temporary stability in the competitive process.

Furthermore, because jurisdictions are exclusive, they constitute an inter-dependent system; a change in jurisdiction for one will affect others. When external or internal forces cause a chain of effects in the system of professions, these disturbances will propagate until the balance is restored in a variety of ways, ranging from full jurisdiction to a division of labour, subordination, intellectual and advisory jurisdiction or the destruction or creation of a professional group. This does not mean that professions can stretch their jurisdictions indefinitely - the more diverse the set of jurisdictions, the more abstract the cognitive structure binding them together, and, therefore, the more vulnerable to an increase in specialisation within and diffusion into a common culture without.

*   *   *

What does this account of intra-professional status suggest we are missing about our understanding of status? There is evidence that the subject of intra-professional status is an under-researched field (Abbott, 1981). Even though some theories, such as systems theories, demonstrate a better appreciation of the diversity of professional groups, the conception of status is expressed in terms of control of tasks and jurisdictions. There is a lack of a thoroughgoing understanding of how doctors in the diverse segments of the profession construct their professional status, which may, or may not, be related to their jurisdiction.

Despite the paucity of research related to intra-professional status, the relationship between the internal segments of professional groups within medicine has been extensively explored in terms of the ranking of their relative prestige, which will be

explored in the following section. The ranking of prestige presupposes some objective qualities that can be arrayed according to a status hierarchy.

2.4. Ranking of Prestige

The distinction between the related concepts of 'status' and 'prestige' represents another case of definitional ambiguity. In many cases, indeed in many of the publications cited in this chapter, the terms have been used interchangeably. On the other hand, Weber (1978), and many sociologists, distinguish between the two terms by referring to 'prestige' as an aspect of relative status.

Similarly, Wegener (1992) distinguishes between the two terms as operating at different levels of analysis. The subjective evaluation of the relative standing of different social groups is referred to as 'prestige', but the structural, objective categorisation is called 'status'. This definition is problematic given that many studies of relative prestige have concerned themselves with structural categorisations (i.e. occupations). It can, therefore, be assumed that the use of the term 'prestige' is either synonymous with status, or at the very least an aspect of status derived from the subjective interpretation of the relative standing of different groups.

A ranking of prestige is a form of status structure; an ordered pattern of influence and deference among a set of actors, representative of their shared beliefs or social representations about status value (Ridgeway, 2001: 352). Given the functional diversity of the medical profession, it is unsurprising that a number of studies have considered the relative prestige of different medical specialties. As the following sections will demonstrate, these studies have focussed on ranking medical specialties, or the diseases associated with medical specialties, according to their perceived prestige.

2.4.1. Ranking of Specialties

In one of the earliest studies, Merton, Bloom & Rogoff (1956: 564) asked medical students to rank the relative standing of medical specialties. They concluded that surgeons, physicians, and professors working in medical schools were the highest, and general practitioners and psychiatrists were the lowest. Schwartzbaum, McGrath & Rothman (1973: 365-370), asked practicing physicians to rank the relative prestige of twenty-two medical specialties. They concluded that the highest

ranked specialties include neurosurgery, internal medicine, general surgery and thoracic surgery, and the lowest include preventative medicine (public health), occupational medicine and administration.

Shortell (1974: 1-3) asked physicians, patients and business school students to evaluate the prestige of forty-one medical and allied health specialties. They concluded that the highest status specialties were thoracic surgery, neurosurgery and cardiology, and the lowest were general practice, allergy, dermatology and preventative medicine. Similar studies have been undertaken, producing comparable findings, by Matteson & Smith (1977), Rosoff & Leone (1991), Creed, Searle & Rogers (2010) and Album & Westin (2008).

Hinze (1999) was able to demonstrate that doctors tend to rank their own specialty higher than others ranked it. For specialties that contained several subspecialties, the focus became the order of the internal hierarchy – there is something about the familiarity of doctors with the subject matter. There was general acknowledgement that cardiothoracic surgery and neurosurgery were at the top of the hierarchy; most other specialties were placed in the 'middle morass'.

There are a range of explanations for prestige differences within the medical profession. For instance, the earliest explanations emphasised the role of authority, power and control of resources as determining the relative prestige of a medical specialty. For instance, Shortell (1974: 1-3) concluded that a specialty's prestige is associated with the degree of control that it exerts over a patient's fate. A specialty is afforded higher prestige if patients are highly dependent upon its practitioners. Becker *et al* (1961: 240) stated that the medical hierarchy is organised according to the amount of experience and responsibility of those occupying the various ranks. The medical student being the very lowest rung as they have little experience, cannot exercise any medical responsibility, except insofar as it is delegated to them and carried out under the supervision of a licenced physician.

A number of studies have considered the act of referral between doctors to understand how this serves to order the relations between medical specialties. For instance, some theorists have used Social Exchange Theory to explain the pattern

of referral behaviour in terms of rewards and costs (Shortell & Anderson, 1971; Shortell, 1973; Shortell, 1974b). These studies concluded that high-status doctors have more cohesive patterns of referral compared to low-status doctors; there is a different perception of rewards and costs depending on a doctor's position in the status hierarchy; greater emphasis is placed on patient treatment factors by high-status doctors, whereas lower status doctors have a greater focus on building their network of practice; higher status doctors referred primarily to other higher status doctors, however, lower status doctors also tended to refer more often to higher status doctors.

The general trend towards referral to high-status doctors is explained by Shortell (1973: 346-347) as having a validating effect for high-status doctors. However, for lower status doctors, they perceive greater value in protecting themselves against loss of jurisdiction and a desire to associate themselves with doctors of a higher status. Shortell also points to evidence of an association between higher status and greater professional competence in clinical practice.

Compared to the early Functionalist accounts, later accounts from different disciplines have placed more emphasis on the role of shared values, symbolism and meaning in the informal organisation of medical practice. For instance, Abbott (1981: 819-830) rejects what he describes as conventional accounts of professional status hierarchies that are often based on the proxies of income, power, client status and substantive difficulty. Abbott posits 'professional purity' as the determining feature of professional status. The sub-units of a profession are able to exclude non-professional issues from practice; they deal with issues pre-digested and pre-defined by colleagues. The act of referral is, therefore, a form of successive, iterative purification. The lowest status specialties deal with problems that are tainted with human complexities.

Unlike the conventional conception of a hierarchy of prestige, Abbott (1981) does not conceive of an exact ranking of specialties, but rather, a 'loose order' that structures social relations. He also notes that as professionals seek the admiration of their peers, they withdraw from front-line practice. As a consequence, the whole profession gradually regresses towards a purer form of practice – and by extension

conquers new ground and claims jurisdiction over new knowledge and fields of practice. The jurisdictional gap that is left in the profession's wake becomes the subject of conflict and competition between other emergent professions and groups. He claims that professional regression is a fundamental feature of professional life. Light (1984: 182-183) critiques Abbott's conception of professional purity as lumping all professions together as a group, when in fact the basis for intra-professional status differs for each group and presenting a concept of regression that is value-loaded because progress is conceived of as a linear movement.

2.4.2. Ranking of Diseases

There is a concordance between the ranking of diseases or disorders and the medical specialties that treat them. According to Pettersen, Olstad & Rosenvinge (2009), diagnoses are far more than pure medical tools to guide treatment choices and to aid communication between fellow professionals. They are also social entities, conveying meanings and attitudes about the standing of disorders and the patients suffering from them. These meanings adhere to a universal common sense and may reflect a particular professional culture. As a consequence, it is unsurprising that the ranking of medical specialties and diseases paints a similar picture.

For instance, Album & Westin (2008) asked physicians and medical students to rank specialties and diseases. They concluded that neurosurgery, thoracic surgery, cardiology, anaesthesia and paediatrics were the highest, and geriatrics, dermatovenereology (dermatology and sexually transmitted infections), physical medicine (treatment of disease using physical therapies), psychiatry and general practice were the lowest. The corresponding ranking for diseases includes myocardial infarction (heart attack), leukaemia, spleen rupture, brain tumour and testicular cancer among the highest, and fibromyalgia (rheumatic condition causing muscular or musculoskeletal pain), anxiety neurosis, hepatic cirrhosis (liver failure), depressive neurosis, schizophrenia and anorexia among the lowest.

Pettersen, Olstad & Rosenvinge (2009: 23-27) considered the ranking of disorders according to their perceived importance. They concluded that acute, somatic (relating to the body) disorders with a known etiology (causation) were given the

highest rank. Therefore, disorders such as breast cancer, AIDs, cardiac infarction (heart attack), brain tumours and stoke are related the highest. Conversely, the lowest ranked disorders included sciatica (pain in legs), ulcers, alcoholism, appendicitis and ankle fractures.

According to Album & Westin (2008: 182-186) diseases and specialties associated with technologically sophisticated, immediate and invasive procedures in vital organs located in the upper parts of the body (especially the brain and heart; organs invested with symbolic value) are given high prestige scores. This is particularly true when the typical patient is young or middle aged. A potentially lethal disease with a dramatic and short course ranks highly, whether the end result is death or recovery. Diseases that are treatable have prestige over those that cannot. On the other hand, low prestige scores are given to diseases and specialties associated with chronic conditions located in the lower parts of the body, or having no specific bodily location, with less visible treatment procedures, and with elderly patients. In addition, diseases associated with an intemperate lifestyle are considered less prestigious.

Norredam & Album (2007: 658-659) state that prestige is determined by the characteristics of the disease, such as organ localisation, aetiology (cause of disease), chronicity and treatment possibilities. For instance, the heart and brain were perceived as nobler organs due to their symbolic value, in comparison with the lungs, intestines or extremities. The lowest prestige is conferred on diseases that are not localised on a specific organ, do not have a known aetiology (causation), and have chronic symptoms e.g. fibromyalgia, chronic fatigue syndrome. Conversely, diseases that have acute symptoms that can be treated with radical surgery or technologically advanced measures have the highest prestige. Norredam & Album (2007: 658) conclude that high prestige is associated with active, specialised, biomedical and highly technological types of medical practices on organs in the upper part of bodies of young and middle-aged people.

Mizrahi (1986), in *Getting Rid of Patients*, attributed the status of certain diseases and patient groups to the impact of professional socialisation on doctors, which produced a negative and distorted doctor-patient relationship. For instance, medicine has traditionally given priority to the acquisition of diagnostic skills.

Therefore, patients that have illness for which there is no cure, and from which they will not get better, are socially undesirable, uninteresting or frustrating to them. Hence, there were few intrinsic and extrinsic rewards for taking care of these patients. The implication is that doctors weigh not only the medical status of patients, but also their social status and value.

Johannessen (2014) considered how doctors acquired the knowledge to rate diseases in a prestige hierarchy. The study demonstrated that notions of disease prestige were reproduced through doctors telling 'disease narratives' in medical education. Disease narratives involve causally ordered patterns of disease-related events, with doctors acting against the disease and patients being acted upon by the disease, as perceived by the storytelling doctors. For instance, the author cites the use of narratives by neurosurgeons to describe subarachnoid haemorrhage (a rare form of stroke) which is an acute and potentially lethal but curable disease. Neurosurgeons were cast as heroic, masculine, extraordinary lifesavers, able to act where others fall short. Similar research has been conducted by Sinclair (2000) and Hunter (1993) who emphasised the fact that medicine is more of an art than a science, which underscored the profession's reliance on interpretation and telling a story.

The ordering of these prestige rankings of disease can be partly accounted for by reference to the concept of legitimacy. The early Functionalist theorists viewed illness as a deviance, because good health is necessary for functional society, and illness renders the sufferer not a productive member of society. According to Parsons (1951), the ill adopt the 'sick role', which has the following prerogatives: the ill person is not responsible for assuming the sick role. Whilst they are ill they are exempted from carrying out some of their normal duties. However, they must try and get well, and being ill is only a temporary phase. In order to get well, the ill person must submit themselves to the appropriate medical care. For Parsons, the concept of legitimacy is important in distinguishing the criminal from the ill.

This conception of the traditional 'sick role' is challenged by Freidson (1970: 237-239) for being over-simplistic. He states that the conditional nature of the 'sick role'

delegitimates chronic, incurable or stigmatised diseases. Instead, he offers three kinds of legitimacy:

i. Conditional legitimacy – exempted from normal obligations on condition that illness is temporary

ii. Unconditional legitimacy – exempted permanently from normal obligations and obtaining additional privileges in view of the hopelessness of the illness

iii. Illegitimacy (stigmatised) – exempted from some normal obligations, but gaining few, if any, privileges and taking on additional obligations.

The imputed legitimacy and seriousness of disease denotes its social meaning (Freidson, 1970). So, minor deviations may include a cough or cold as being conditionally legitimate (i.e. it is a temporary manifestation), pockmarks as unconditionally legitimate (i.e. you can't get rid of them, but they carry no particular stigma), and a stammer as illegitimate (i.e. you can't get rid of it and it carries a stigma). Serious deviations may include pneumonia as conditionally legitimate, cancer as unconditionally legitimate and epilepsy as illegitimate. The theory helps to define analytically distinct varieties of deviance.

Freidson's (1970) conception of the imputed legitimacy of disease continues to be influential. For instance, Haldar, Engebretsen and Album (2016: 561) considered the role of legitimacy in prestige rankings. They considered how informal disease prestige rankings are produced, maintained and circulated among doctors, when they collide with the values of the profession and the formal value of equality of treatment.

Moreover, they asked how can doctors recognise the existence of a disease prestige hierarchy, and handle the illegitimate nature of this hierarchy, without acknowledging that these views are their own. In other words, how can they discuss a topic loaded with unsanctioned values and express illegitimate (i.e. informal and cannot be discussed in all contexts) views? This study demonstrated that there is a duality between the perceptions of the medical profession, regarding the relative prestige of diseases, and what can be formally acknowledged, because of the conflict with the values of the profession.

* * *

What can we conclude from this series of studies? Firstly, there should be some caution in drawing general conclusions. The studies are not directly comparable because they have different subjects of enquiry – esteem, status and prestige – different methodologies, different respondents – physicians, medical students, patients, the public – and consider a different number and range of medical specialties and diseases/disorders.

There are several other limitations to these studies. For instance, in defining a ranking of specialties or diseases by prestige, these studies have tended to be descriptive rather than explanatory. They conceive of prestige or status as being arrayed in a hierarchical structure, and therefore, as having an objective quality. These accounts fail to represent the extent to which status is constructed, contested and dynamic. Even accounts such as Abbott (1981) that purportedly reject conventional accounts of professional status hierarchies, posits the notion of professional purity, which is based on the idea of there being gradations of professional practice. The diversity of the profession is expressed in terms of being more or less professionally pure, rather than acknowledging that there are different perspectives, identities and constructions of what constitutes professional practice (Light, 1984).

2.5. Status Within Organisational Change

The preceding sections have been concerned with defining status, how status manifests itself in status structures and the relative prestige of different specialties. The following section will focus on the role of intra-professional status within processes of organisational change. It will provide an overview of the relevant literature concerning organisational change in healthcare, to provide insights into the way that professional status shapes, or is shaped by, these processes. The subject of threats and opportunities to professional status will also be considered, as a key and under explored element within the literature, explaining acceptance or resistance to change.

The studies explored in this section are divided into three main themes. Firstly, the threats and opportunities to individual professional status and role identity posed by processes of organisational change (Reay *et al*, 2017; Kellogg, 2011). Secondly, the differential response from actors based on their social position to processes of organisational change (Battilana, 2011; Compagni, Mele & Ravasi, 2015; Lockett *et al*, 2014). Thirdly, the opportunities and threats to professional groups associated with the change of jurisdictional boundaries between them (Currie *et al*, 2012; Zetka, 2001).

2.5.1. Status Threats & Opportunities

There is a vast literature related to motivation for and resistance to change (see Dent & Goldberg, 1999). Many of these studies take some inspiration from Lewin's (1951) notion of field analysis, with the idea that the *status quo* represented an equilibrium between the barriers to change and the forces favouring change. Resistance to change has been explained as a response to a threat to an individual's social identity (Van Dijk & Van Dick, 2009; Scheepers & Ellmers, 2004), the anticipated consequences of change such as a loss of status (Dent & Goldberg, 1999), loss of control (Klein, 1984), or consequential threats such as a loss of job security, status and income (Kotter & Schlesinger, 1979).

These opposing forces that resist or encourage change can be framed as 'threats or opportunities' and 'motivations to achieve gains or avoid losses' (Kennedy & Fiss, 2009: 900). There are a considerable number of studies, from a range of different disciplines, that have articulated the myriad of benefits related to social status (Pearce, 2011; Pettit, Yong & Spataro, 2009), and the rational desire to pursue higher status (Goffman, 1969; Lin, 1999; Thye, 2000). Some evolutionary psychologists have even described it as a primary biological need, proving adaptive advantages (Waldron, 1998).

According to Ozturk, Amis & Greenwood (2016) because status is associated with privileges and benefits, status maintenance concerns are central to those of a higher status. Pettit, Yong and Spataro (2009) conducted research to explore individuals' reactions to the prospect of gaining or losing status. They concluded that the value placed on an individual's existing status was greater than the value placed on higher status which had not yet been attained. In other words, the desire to maintain status, or to avoid status loss, is greater than the desire to achieve a gain in status.

The reluctance to lose the benefits associated with social status can explain the fierce resistance to any changes that may disrupt the existing status hierarchy. For instance, Kellogg (2012: 1549-1566) states that if a high-status actor's status is threatened, they will defend their position by denigrating, disassociating from, or discriminating against, lower-status groups. They may also emphasise the status characteristics that distinguish themselves from lower-status groups. Indeed, intra-professional identities can emerge, or strengthen, in response to threats to status, with groups defining themselves in opposition to competing groups (Ramirez *et al*, 2015). According to Troyer & Younts (1997), one of the main motivations for individuals' participation in groups is defence against the loss of status.

2.5.2.   Role Identity

The following section will consider two cases of organisational change within healthcare. Firstly, Reay *et al* (2017) considered the professional role identity change of family physicians (GPs) as a product of primary health care reform in Canada. The authors note that healthcare is a highly institutionalised context, which has taken

for granted norms, values and beliefs about how things are done, by whom, and under what circumstances. This means that role identities within healthcare can be highly resilient. In particular, physician role identities were regarded as 'incredibly resilient because they are highly socialised and institutionalised' (*Ibid*. 1044). The study considered the meaning of logics and how the relationships among them are critical to understanding the behaviour of social actors. More specifically, they highlighted the importance of micro-level workplace interactions where new meanings are developed and shared to shape organisational life.

The study demonstrated that although change is exceptionally difficult in the organisational context of healthcare, professional role identity can be altered through collective efforts to reinterpret multiple guiding logics and their relationships. In this particular case, this reinterpretation happened through different types of social interactions that shifted the collective professional role identity, of what it means to be a family physician, from 'autonomous expert' to 'head of the team'.

The second study was undertaken by Kellogg (2011) who considered institutional change related to medical resident working hours in the United States. She conducted a comparative ethnographic study concerning the introduction of new regulations to limit the working hours of doctors. The rationale for this change was to protect patient safety by reducing the fatigue of doctors and to enhance their wellbeing. Quite remarkably, even though this change would have no bearing on their levels of pay, the change was resisted by some doctors. The doctors who resisted the change in working hours were the residents with the highest status in the surgical world. Kellogg (2011) christened these exaggeratedly macho doctors as 'iron men.' With no sniff of humility, these doctors are described varyingly as 'dogs of war', 'commanders', 'the biggest, baddest SOBs around.'

The resistance to the reduction in working hours was attributed to the doctors attempting to protect their high status and long-standing authority relations that afforded them privilege over other doctors. According to Kellogg (2011), their 'status has been built and maintained in part by long working hours, a macho demeanour, deference to seniority and avoidance of handoffs between residents.' Furthermore, they have been regarded both within and outside of the profession as 'action-

orientated male heroes who singlehandedly perform death defying feats, courageously acting with certainty in all situations.' The reduction in working hours was seen as an affront to their commitment to their work. It represented a challenge to the very core of their profession, its values and what it meant to be a surgeon.

The 'iron men' represented one constituent of the medical workforce. According to Kellogg, the residents appeared to be choosing sides in a fight – in the opposing corner were the 'reformers', who were supportive of the change to working hours. These reformers were interested in changing the *status quo* because their diverse social identifies led them to be disadvantaged in the surgical social system. They heralded from four groups: incoming doctors that did not yet understand the rules of the surgical world; residents for whom surgery was not their ultimate career path; female doctors; and male doctors that wanted to take on more responsibilities outside of the hospital, but who were uncomfortable with the macho 'iron man' persona, or who were particularly patient-centred.

The actions of the reformers challenged long-standing work practices, which those defending the *status quo* were skilled in, and their deeply held beliefs used to justify their privileged position atop the medical hierarchy. In response to the reformers attempts to initiate change, the defenders protected their interests with aggressive retaliation. The research study sought to understand the collective combat processes, between these two groups, at a micro-level, in their day-to-day work place encounters. Kellogg observed that change in working practices occurred only following both pressure being placed on the internal defenders of the *status quo*, and assistance being afforded to internal reformers.

What can we conclude about role identity and status, within processes of organisational change? The two studies provide a useful comparison. In the first study, although the organisational change presented a threat to the status and role identity of family physicians, and they were initially unsupportive of the change, it was ultimately successful. On the other hand, the second study, which focussed on reforming the working hours of doctors, was ferociously resisted by the 'iron men'. In both studies, the impetus for change was external to the organisation, they both

presented a threat to the professional status of doctors, and in both cases, micro-level everyday interactions were where actors made sense of these changes.

The distinguishing feature between these studies is the extent to which actors were able to reconstruct and maintain their professional status. In the case of the family physicians, the change was successful because the doctors maintained their professional status, albeit in a modified form. This meant that the content of their construction had changed, and they drew upon different characteristics of their role, and their relationship with others. The family physicians' status that had hitherto been based on their knowledge claims as an 'autonomous expert', was reconstructed and came to be based on their formal position as 'head of team'.

However, the change in working hours presented the 'iron men' with a serious threat to their core identity and construction of professional status. This is because their construction was based on their long working hours, macho demeanour, and heroic efforts. This construction is denuded by the implementation of a cap on working hours. As previously stated, the desire to maintain status or avoid losing status, is of paramount interest to actors (Ozturk, Amis & Greenwood, 2016; Pettit, Yong and Spataro, 2009). In comparison to the family physicians, these doctors did not have the ability, or willingness, to reconstruct their professional status on different terms.

2.5.3.   Social Position

The following section will consider three studies that relate to the social position of actors and their professional status during processes of organisational change. Firstly, Battilana (2011) considered the social position of actors and the likelihood of initiating organisational change. This study considered multiple change projects within the NHS. It was demonstrated that the social position in the organisational hierarchy moderated the difference between the status of the professional group to which actors belonged and the likelihood that they would initiate changes that diverged to a greater extent from the institutionalised model of role division among professionals.

The higher up actors were in the hierarchy of their organisation, the more likely they were to initiate changes that diverged from the role division among professionals, but the less likely they were to initiate changes that diverged from the role division among organisations (Battilana, 2011: 829). This may be because the former can be manged within the boundaries of the organisation (i.e. within the ambit of control of the doctors) without involving outside actors.

Secondly, Compagni, Mele and Ravasi (2015) studied the adoption of robotic surgery. They considered the relationship between the social position of actors and the timing of their adoption of the technology. Building upon a study that concerned the relative likelihood of central or peripheral actors embracing change (Greenwood & Suddaby, 2006), they concluded that both groups may adopt new practices very early in the process, but for different reasons. For central actors, the embrace of change is driven by an internal imperative to protect their leading position, and mastery of current practices, in the presence of a new practice that could potentially disrupt the social order to their detriment. For peripheral actors, it holds the promise of improving their social position by becoming exemplary users of the new practice.

Thirdly, Lockett *et al* (2014: 1102-1122) considered the influence of individual actors' contexts (unique backgrounds) on sensemaking about organisational change. The study concerned organisational change related to cancer genetics services, which was interpreted by actors located at different social positions. Drawing upon Bourdieu's *Theory of Practice* (1977), they concluded that the different social positions of individual actors will be characterised by unique capital endowments which will shape their disposition towards profession-centrism and allocentrism, and this in turn affects their sensemaking about opportunity construction and opportunity problematising.

An actors' inter- and intra-professional group status is important because it shapes the nature of their profession-centric dispositions. This study emphasises the intra-professional heterogeneity of the medical profession; two doctors may draw on different forms of cultural capital in their sensemaking about organisational change. For instance, if they occupy a high-status social position, they are more likely to sense make about organisational change in a way that reproduces existing

organisational schemata, because it serves to privilege their cultural capital, and they are more likely to align with their profession-centric disposition (Lockett *et al*, 2014).

This means that the actors who are likely to develop new organisational schemata will be doctors located in social positions not at the apex of the medical hierarchy. A doctor with high-status, positioned at the apex of the medical hierarchy, will have a low level of allocentrism, and will perceive that they have a greater agency for change. On the other hand, a lower-status, more practice-orientated doctor, would be more allocentric in terms of their understanding of needing the support of others to enact change.

These studies provide some interesting insights related to the construction of professional status and processes of organisational change. For instance, Battilana (2011) suggests that change to professional role division is more likely to be initiated by high-status actors (such as doctors) if it is within the ambit of their control and organisational boundaries. On the other hand, change in the role division between organisations is unlikely to be supported. In other words, the actors are willing to initiate the change if the threat that it poses to their status can be managed or controlled. Compagni, Mele & Ravasi (2015) also express the resistance to change in terms of threats to status. For high-status actors, the embrace of change can be a defence against a potential loss of their status, but for low-status actors, it represents an opportunity to improve their social position. The threats and opportunities to status are different sides of the same coin and are often a zero-sum equation (Stringfellow & Thompson, 2014).

Finally, Lockett *et al* (2014), provide an interesting reflection on the disposition toward change of higher and lower status actors. Their findings would suggest that a GP, as a lower status actor, would have a more allocentric disposition, and would recognise the need to work with others to effect change. On the other hand, higher status actors like hospital consultants, are likely to profess a more profession-centric disposition and would have a vested interest in maintaining the *status quo*. This conception is important because it recognises that doctors can draw upon different forms of cultural capital, determined by their social position, in their construction of their professional status. The perception of whether a change represents a threat or

an opportunity to status, or indeed the extent to which it does, is determined by the social position of the actors. This is because the social position determines the characteristics of an actor's role such as access to resources.

2.5.4. Jurisdictional Boundaries

The following section will consider two studies that relate to jurisdictional boundaries, and their relationship to professional status, during processes of organisational change. Firstly, Currie *et al* (2012) considered the emergence of new nursing or medical roles that, through the potential substitution of their labour, threatened the power and status of specialist doctors. This study focussed on the emergence of new roles in cancer genetics. In response to the external threat to their position, the medical profession responded through important, yet often invisible, 'institutional work' to supplant the threat of substitution with an opportunity for them to delegate routine tasks to other subordinate actors (Lawrence & Suddaby, 2006). This allowed them to not only maintain their professional dominance, to maintain control over the delivery of services, but to do so in a way that enhanced their professional status.

The study pointed to the importance of the institutional work of 'theorising' by professional elites, which invoked the concept of 'risk' that was used to maintain the prevailing model of medical professionalism. It demonstrated that elite professionals, in this case clinical geneticists, presented themselves as 'arbiters of risk' to make the case for the delivery of the genetics services to be delegated rather than substituted. Importantly, this does not just represent the resistance of elite actors to change, nor the reproduction of maintenance of existing institutional arrangements. Rather, this is a case of elite actors interpreting and responding to an external threat as a creative act, which is both purposive and active (Currie *et al*, 2012).

Secondly, Zetka (2001) considered how medicine's intra-professional division of labour responded to technological change – the development of gastrointestinal endoscopy. The research acknowledged that the functionally complex division of labour within medicine, creates 'interest divisions' that were structural in nature, and consequently held the potential to generate serious conflict among occupational groups. It is remarked that 'in major medical areas, such as cardiovascular,

neurological and gastrointestinal medicine, at least two specialties – one from medicine, one from surgery, share the same anatomical turf' (Zetka, 2001: 1498-1499). In the case of gastrointestinal medicine, two very different specialties occupied the same jurisdiction – one cognitively orientated (gastroenterology – i.e. medical) and one craft-based (gastrointestinal surgery).

In this particular case, the gastroenterologists were quick to exploit the opportunity of extending their clinical practice. They had an advantageous position within the referral system, which meant that they saw patients with gastrointestinal disorders before the surgeons and had the power to influence patients' treatment options. The arguments put forward by the surgeons, who worked downstream from the physicians, that they could offer more efficacious treatment were rendered moot. The authors juxtaposed the case of gastrointestinal endoscopy with laparoscopy which saw the gastrointestinal surgeons move quality to neutralise their disadvantaged position in the workflow.

Again, these two studies provide a useful comparison. Both studies concerned a threats and opportunities to professional status. In the case of the introduction of new nursing roles, this threat to their jurisdiction was neutralised, and their introduction was used by the doctors as a further opportunity to extend their professional status. The introduction of gastrointestinal endoscopy also presented an opportunity to develop the status of both the gastroenterologists and gastrointestinal surgeons. However, the intra-professional jurisdictional boundary between these groups, as opposed as the inter-professional relationship between medicine and nursing, was demonstrated to be more problematic.

The gastroenterologists, who would ordinarily be regarded as having a lower professional status than gastrointestinal surgeons, stole a march on them by exploiting their position in the referral chain to gain jurisdiction over this technology. This is contrary to the conventional conception that a referral chain confers status on the actor sitting at the end of the chain (Abbott, 1981; Shortell, 1973). In response to this lost opportunity, the gastrointestinal surgeons were shown to quickly gain control of the emergent field of laparoscopy, by voicing closure arguments, and

making the case for claiming jurisdiction over this technology because of their superior skills. This study highlights the dynamic nature of status construction (Abbott, 1981) and how doctors will seek to exploit an opportunity to develop their status that is consistent with their role identity.

*   *   *

What does the literature regarding organisational change tell us about the role of professional status within these processes? There is an established literature concerning motivations and resistance towards organisational change (see Dent & Goldberg, 1999). However, opportunities and threats to professional status are a key and under-explained element within organisational change literature, explaining acceptance or resistance to change. This section has considered studies concerning organisational change within healthcare with reference to role identity, social position and jurisdictional boundaries. It has been demonstrated that opportunities and threats to professional status are present throughout these studies, and would, therefore, be a useful theoretical frame to develop further.

There has been little concerted effort within the organisational change literature to construct a theoretical model that can account for the role of opportunities and threats, to intra-professional status, within processes of organisational change. There have been some notable exceptions within the literature (e.g. Kellogg, 2011). However, the focus of these studies tends to be on status conflict, the relationship between micro-level interaction and macro level processes etc. There is an insufficiently developed understanding of how doctors construct and re-construct their professional status in response to organisational change.

In order to explore these themes and to contribute to the literature in this field of research, this thesis will address the following two research questions: How does the medical profession construct professional status? And, what is the role of professional status within processes of organisational change? The following chapters will explain the approach to the research study, its findings and the conclusions that can be drawn.

Chapter Three

Methods

3. Chapter Three: Methods

This research study utilises qualitative methods. These methods have been chosen to provide a deep, rich interpretation of the social phenomena that is being studied. According to Creswell (2012: 44), 'qualitative research begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to a social or human problem. To study this problem, qualitative researchers use an emerging qualitative approach to inquiry, the collection of data in a natural setting sensitive to the people and places under study, and data analysis that is both inductive and deductive and establishes patterns or themes.'

According to Miles & Huberman (1994) qualitative research methods provide 'a source of well-grounded, rich descriptions and explanations of human processes', that are more likely to 'derive fruitful explanations [and] are more likely to lead to serendipitous findings.' These methods help the researcher 'get beyond initial conceptions and generate or revise conceptual frameworks', and the findings from well-analysed and well-presented qualitative studies have 'a concrete, vivid, and meaningful flavour that often proves more convincing […] than pages of summarised numbers.'

The use of qualitative methods is informed by the philosophy of constructivism. According to Denzin & Lincoln (2018: 98; 110-131), constructivism adopts a relativist ontology, a transactional or subjectivist epistemology and a hermeneutic, dialectical methodology. These three characteristics can be more fully described as follows:

- Constructivism's relativism means that users of this paradigm are orientated towards the production of reconstructed understandings of the social world. Realities are understood to exist in the form of multiple mental constructions, socially and experimentally based, local and specific, dependent on their form and content on the persons who hold them (Guba, 1990: 27). This is opposed to the philosophy of positivism that considers there to be a single, identifiable reality that can be apprehended, measured and studied, and by extension, can be predicted and controlled.

- Constructivism's subjectivist epistemology holds that the investigator cannot separate themselves from what they know. The findings of a research study are the creation of the process of interaction between the inquirer and inquired (Guba, 1990: 27). The investigator and the object of investigation are linked such that who we are and how we understand the world is a central part of how we understand ourselves, others, and the world. The position of the inquirer in constructivism is a co-constructor of knowledge, of understanding and interpretation of the meaning of lived experiences (Guba and Lincoln, 1994). This approach is opposed to positivism which is underpinned by a belief in total objectivity.

- Finally, constructivism elicits individual constructions that are refined hermeneutically, and compared and contrasted dialectically, with the aim of generating one or a few constructions on which there is substantial consensus (Guba, 1990: 27). This approach relies heavily on naturalistic methods, including interviews, to ensure that there is an adequate dialogue between the researchers and those with whom they interact in order to collaboratively construct a meaningful reality (Angen, 2000). This approach is opposed to positivism that holds a firm belief in the scientific method.

The approach to this research study echoes Denzin & Lincoln's (2018: 113) assertion that 'a goodly proportion of social phenomena consists of meaning-making activities of groups and individuals around those phenomena. The meaning-making activities themselves are of central interest to […] constructivists simply because it is the meaning-making, sense-making, attributional activities that shape action (or inaction).' Therefore, in conducting this research study, the methods that have been chosen, and the steps that have been taken to interpret the collected data, are designed to be sensitive to the presence of multiple voices and meanings attributed to social phenomena.

A number of previous studies that have considered professional status have utilised quantitative research methods. Typically, these studies have developed rankings of the relative status of different medical specialities (e.g. Rosoff & Leone, 1991;

Schwartzbaum & McGrath, 1973; Album & Westin, 2008). These studies have conceived of status as an objective characteristic that can be measured. However, the findings of these studies have been largely descriptive rather than explanatory, and therefore, have contributed relatively little to an understanding of how professional status is constructed. Therefore, I have chosen to use qualitative methods because they are aligned with my underlying core theory about status being socially constructed, and because they offer the potential to develop a deeper understanding of the social relationships within professional groups.

This chapter will begin with an overview of the research design including the theoretical basis of its methodological approach. It will then consider the specific research methods that have been used in this study, namely semi-structured interviews and a case study approach. Finally, the chapter will describe the steps taken to analyse the data derived from these methods including the analysis of the semi-structured interviews and the case study materials.

3.1. Research Design

The research design uses qualitative methods and draws upon semi-structured interviews and a case study approach, in particular. These data collection methods have been chosen to address each of the research questions respectively. The question of how the medical profession constructs professional status is addressed through the use of semi-structured interviews with doctors and other key informants. On the other hand, the second research question, which considers the role of professional status within processes of organisational change, is addressed through a case study approach. Case studies provide an opportunity to interpret phenomena within specific processes of organisational change and to further extend and develop theory.

Figure 1 provides an outline of the research approach over the period of data collection and analysis. The research approach began with a consideration of existing literature followed by a period of data collection involving the undertaking of semi-structured interviews and collation of secondary materials relevant to specific case studies. The interview data was coded to develop a data structure and inform the theoretical framework. Finally, the case study material was interpreted, and the theoretical framework and research findings were further developed.

2011	
	Literature Review
2012	
2013	
	Interviews & Case Study Data Collection
2014	
2015	**Interview Data Analysis** / **Development of Theoretical Framework**
2016	
	Case Study Analysis
2017	

Inductive Iterative Theorisation
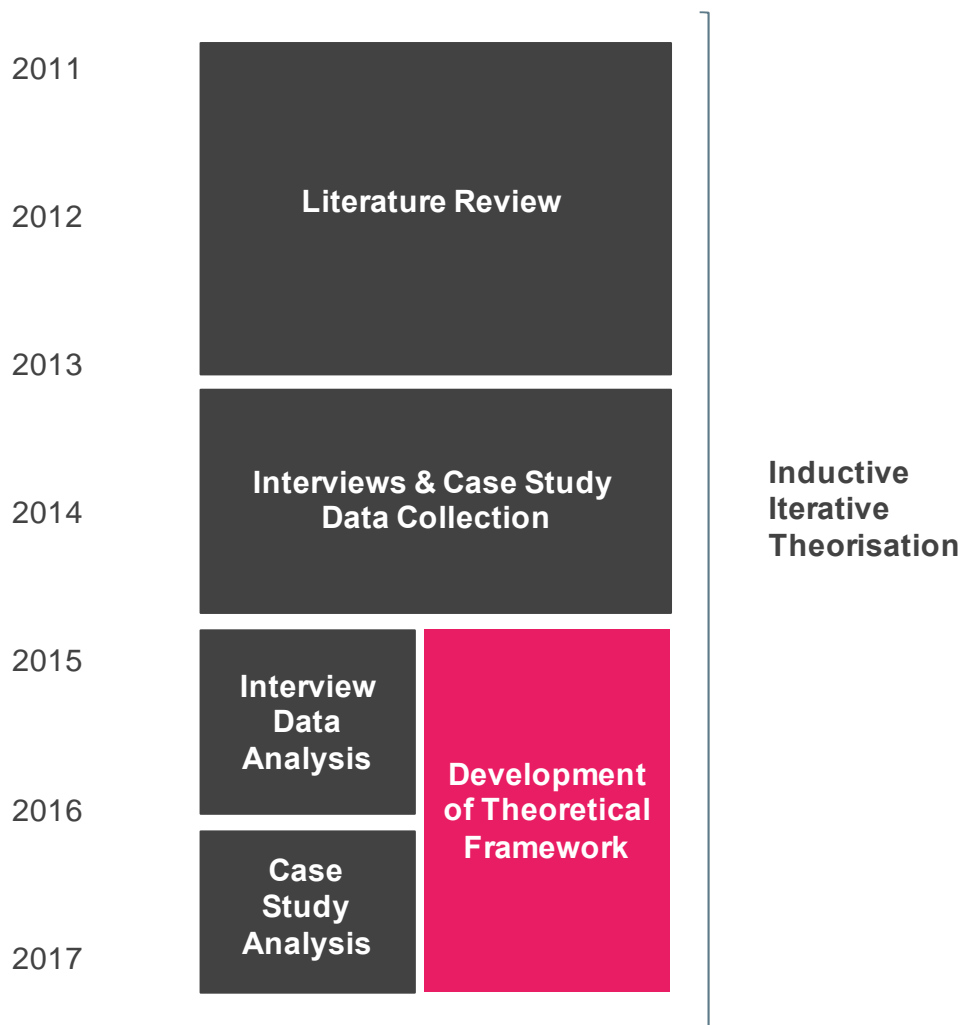
The unit of analysis throughout this research study are groups of doctors. These groups are defined by criteria including their relative seniority, specialism and organisational locus. The doctors that have been interviewed and that have provided the data for this study are exclusively hospital consultants or general practitioners. The research data is not derived from interviews with junior doctors.

The doctors that have been interviewed identify with a particular specialism. These specialisms and sub-specialisms are defined by the General Medical Council (2017) for doctors practicing in the UK. Their organisational locus refers to the hospital or healthcare setting that the doctor practices within. For instance, they may practice within a teaching hospital, general hospital or in the community within general practice. It is the relative status of these groups that is the focus of this research study. Moreover, this research study does not concern itself with the relative status

between other occupations or professions, but rather, how the members of the medical profession understands its internal relations.

In considering the research design, I have been mindful of the need to ensure the quality of research outputs. The standards and terminology used for judging the quality of the research method differs between positivist and interpretivist research. In positivist research, terms such as 'reliability', 'validity', and 'generalisability' are part of the lexicon. However, the aim of interpretivist research studies is to ensure its 'trustworthiness'.

According to Lincoln & Guba (1985: 290, 301-316), trustworthiness involves establishing credibility (rather than internal validity), transferability (rather than external validity or generalisability), dependability (as opposed to reliability) and confirmability (rather than objectivity). They define 'trustworthiness' as 'how can an inquirer persuade his or her audiences (including self) that the findings of an enquiry are worth paying attention to, and worth taking account of? The most important criterion is '**credibility**': confidence that the phenomena being studied has been accurately recorded. Lincoln and Guba provide a series of techniques that, if deployed, make it more likely that credible findings will be produced:

- **Prolonged engagement and persistent observation** – to ensure that the researcher has had sufficient time to learn and understand the culture, social setting and phenomenon of interest. As an established hospital manager, I have been advantaged by a familiarity with the subject matter and the terminology used within health care environments that may seem impenetrable to the uninitiated. The fact that I had a working relationship with some of the participants may also have contributed to richer data. The interviewees may have been more comfortable talking to me, and, therefore, may have been more candid. I could also make judgements about how best to engage with senior medical professionals – the hooks that would attract them to be involved in the research project.

- **Triangulation** – the use of different research methods and different informants providing a range of voices and diverse perspectives. The use of purposive

sampling in this research study has ensured the presence of informants from different organisational contexts and professional groups. Furthermore, the use of a case study approach, in addition to semi-structured interviews, has provided the opportunity to study the phenomenon of professional status in a real-world context.

- **Peer debriefing and member sense checks** – to undertake an external check on the enquiry process through peer scrutiny and checking of research outputs with informants. I have sought opportunities throughout the data collection and analysis process to seek the views on the emergent findings and interpretation of the data with colleagues working as consultants. This feedback has provided a formative influence on the outputs of the research study.

- **Negative case analysis** – to refine the working hypothesis as more and more information becomes available; to identify elements of the data that contradict patterns or explanations. The original assumptions at the commencement of the research process was that professional status would be based on the degree of knowledge and practice specialisation; the doctors with the highest professional status would hold a body of esoteric knowledge and would perform a narrow range of clinical practice. However, as the data collection and analysis progressed, there were completely divergent conceptions of professional status that turned this assumption on its head. The focus of the research process has been on producing credible findings that can accommodate this duality of perspectives.

The second criterion is '**transferability**'. This means that the researcher needs to provide the 'thick description', to give sufficient detail about the context of the study and the phenomenon being studied to enable an assessment about the applicability of the research findings to other settings. The researcher has ensured that the case studies presented in this thesis are contextualised and presented with a detailed chronology of significant events.

The third criterion offered is '**dependability**'. This means that the research findings are consistent and could be repeated. The strategy recommended to researchers is

to employ 'overlapping methods'. This research study employs both semi-structured interviews and a case study approach.

The final criterion is '**confirmability**'. This means that the researcher needs to ensure that, as far as possible, the findings of the research are derived from the thoughts and experiences of the informants rather than their own interests and preferences. The recommended approach is to use triangulation of different data sources. This ensures that the outputs of the research are rich, comprehensive and well-developed. This research study is utilising a range of data sources including semi-structured interviews and secondary sources related to the three case studies.

The research also needs to demonstrate **'reflexivity'** by recognising the effect of the researcher at every stage of the research process. It is recognised that an interview is a co-construction between the interviewer and interviewee (Mann, 2011: 9-10). The orientation of the interviewer will inevitably have been reflected in the stance taken in the interview process. In the case of this research, my role as a hospital manager may provide an advantage in terms of access to interview participants and documentary materials, but may bring my managerial culture, norms and values into a co-construction process.

Finally, the researcher is recommended to provide an '**audit trail**' providing a transparent description of the approach taken to the research study. This ensures that there is a clear methodological description to allow the integrity of the research outputs to be tested.

3.2.   Data Collection

The majority of the data for this research study was collected using semi-structured interviews. This method has been termed 'the workhorse of qualitative research' (Packer, 2011: 43). This is because of its ubiquity within qualitative studies. The use of semi-structured interviews in this research was based on a desire to encourage the interviewee to provide their own account, in order to provide a deeper understanding of the topic.

The use of this method allows the researcher to collect relevant data, whilst retaining the opportunity for the interviewee to have sufficient latitude to delve deeper into or depart from a topic. This may provide the researcher with serendipitous insights that contribute towards much richer source data. According to Brinkmann & Kvale (2014: 27), the purpose of the qualitative research interview is to understand themes of the lived daily world from the subject's own perspectives. Although the structure comes close to an everyday conversation, it involves a specific approach and technique of questioning.

The selection of prospective participants for the semi-structured interviews was based on '**purposive sampling**'. According to Bryman (2012: 416-418), purposive sampling is a non-probability form of sampling that does not require the sampling of research participants on a random basis. Rather, the goal of purposive sampling is to sample cases / participants in a strategic way, so that those sampled are relevant to the research questions that are being posed.

Firstly, the interpretivist lens that is being used throughout this study allows for the existence of more than one reality and multiple, sometimes contrasting, voices. Therefore, purposive sampling was used to select medical professionals from a range of medical specialties including those that are traditionally considered higher and lower status in the literature. The majority of candidates were chosen from medical and surgical specialties. This is because the predominant focus in the literature has been on these specialties, and, therefore, there is greater scope to build upon existing relevant theory; taken as a whole, these specialties represent the

biggest constituent of consultants in a general hospital. I was also more familiar with these specialties, facilitating access to participants and secondary materials.

A number of the interview participants were also chosen because they held dual identities. For instance, candidates were chosen that had 'manager-hybrid roles', working both as a professional and in a management capacity at a national and a local level (McGivern *et al*, 2015). Furthermore, candidates were chosen that straddled more than one clinical specialty. These participants have offered the opportunity to explore how the participants construct their professional status whilst maintaining dual roles. This approach to sampling is intended to help develop novel theory.

Secondly, the purposive sampling of prospective candidates was also based on the seniority of doctors, which has excluded junior doctors and non-training grades, and has focussed on consultants and general practitioners. This is because the construction of professional status will be different for a doctor in training compared with an established doctor. Moreover, this sampling strategy acknowledges that there are marked demographic and generational changes that are happening to the medical workforce (Christmas & Millward, 2011: 5, 24). This study, therefore, reflects a snapshot of the thoughts and perspectives of current medical professionals. Similarly, public appraisal of the relative status of the medical profession is excluded from this study. This is because the perspectives of the public are divergent from that of the medical profession (Abbott, 1981: 819).

Finally, the purposive sampling of prospective candidates was focussed in the same organisational locus. The sampling reflects a cross-section of consultants working in a particular locality. This sampling strategy is intended to help inform the development of case studies related to organisational change. The sampling included doctors that were known to have been involved with these changes – either having led the case for change or reflecting on the experience of the change at the sharp end. A number of interviews were also held with managers and senior clinicians from other professional groups to provide additional context and their own perspectives.

Ethical approval for the research project was sought through Warwick Business School and the internal research committees at the participating organisations. Based on the NHS Health Research Authority guidance, research involving NHS or Social Care staff recruited as research participants by virtue of their professional role does not need to be reviewed by the UK Health Department's Research Ethics Service. The research project did not involve any contact with patients or patient identifiable information.

As part of the invitation to participate in the research project, each prospective candidate was provided with a consent form and a participant information sheet (see Appendix 11.11). Each participant was consented prior to the commencement of each interview. The participant information sheet detailed how the participants data would be stored and how it would be used. The participants were given the option to decline having the interview audio recorded, however, no concerns were raised by any of the interviewees.

In selecting prospective candidates, I was advantaged by having prior acquaintance with most individuals, having worked within the locality. This may have been an advantage in securing a positive response to the invitation to participate in the research. For instance, there was an acceptance rate of 78% in response to invitations to participate in the research. This rate of acceptance compares favourably to two relevant studies that have also derived data from semi-structured interviews with consultants. McGivern & Ferlie (2007: 1369-1370) invited seven hundred consultants to participate in a semi-structured interview exploring experiences of appraisal eliciting forty-four volunteers (6%). Similarly, Korica & Molloy (2010) approached eighteen surgeons inviting them to participate in a semi-structured interview to explore their relationship between new technologies and professional identity with nine participants (50%). These studies highlight the particular challenge of obtaining access to senior medical professionals.

In total, there were fifty-one invitations issued to participate in the research study. The prospective participants were emailed an invitation to participate in the research study. Table 1 provides a breakdown of the responses to these invitations:

Table 1: Breakdown of Invitation to Interview Responses

Outcome	Number	Percentage
Accepted	40	78%
Declined	11	22%
Total	51	-

My prior acquaintance with the interview participants may also have a disadvantage in that interviewees may have been less at ease. It may have been easier for the interviewees to discuss matters with a stranger. However, I sought to overcome this risk by using open interview questions and allowing the interviewee ample opportunity to tell their story. In total, forty interviews were undertaken between March 2013 and December 2015. The length of the interviews ranged from brief interactions to dialogues of two hours. The interviews were conducted in private in the offices of the interview participants. The interviews were recorded on a digital dictaphone and were later transcribed. An outline list of interview questions was used to frame the interviews and provide structure to the interaction (see Appendix 11.10).

The original intention was to complete more interviews. However, the quantity and quality of data was considered to be sufficient at forty interviews. The study had reached the point of 'theoretical saturation' (Eisenhardt, 1989: 545) and there would be diminishing returns from engaging with further participants. The transcribed data from the semi-structured interviews amounts to 220,000 words (see Appendix 11.2, 11.4, 11.6 and 11.8). Table 2 provides a summary of the interview sources divided into professional group:

Interview Sources	Number
Consultant Surgeons	10
Consultant Physicians	14
Other (Non-Medical)	9
General Practitioners	3
Consultant Anaesthetist	1
Consultant Oncologist	1
Consultant Radiologist	1
Consultant in Public Health	1
Total	40

The majority of the interview participants were members of the medical profession, either consultants or general practitioners. However, interviews were also conducted with other participants including senior managers, nurses and allied health professional roles. These interviews served to provide additional context and interpretation of social phenomena from the perspective of other roles and professional groups.

3.2.1.   Case Study Approach

The research study also utilises a case study approach. According to Eisenhardt (1989: 534-541), a case study approach can be used 'to provide description, test theory or generate theory'. In the context of this research study, a case study approach has been used to develop and extend theory derived from the semi-structured interviews, with a specific focus on the role of professional status within processes of organisational change. The development of theory has been achieved through recursive cycling between the case data and emerging theory (Eisenhardt & Graebner, 2007: 26).

The choice of case study was also based on purposive sampling (Bryman, 2012: 416-418). There were three criteria used to select case studies. Firstly, the cases have been chosen because they are 'particularly suitable for illuminating and extending relationships and logic among constructs' (Eisenhardt & Graebner, 2007: 27). In other words, the cases have been selected for their potential to elaborate and extend theory.

Secondly, the cases have been selected because they provide real-world examples of change that have occurred across organisational boundaries, because this is where status differences are more likely to be invoked and become visible. Organisational boundaries define a profession's access to material and non-material resources such as power, status and remuneration, and in instances of boundary contestation, the status and centrality of actors influences their response to change (Bucher *et al*, 2016). As such, they offer a rich source of data regarding the role of professional status and its formative impact upon professional and organisational boundaries.

Thirdly, the case studies were contemporaneous with the period of the research study. There was a degree a pragmatism about the opportunities that were available for study. The case study data was a mixture of retrospective accounts of change, a consideration of current issues, and thoughts about the future. There has been no attempt to provide a live account of a case study from the beginning to the conclusion of an organisational change. This is because change is seldom sufficiently discrete

to be treated in this way, and the subject of this study is professional status rather than theory about organisational change *per se*.

Three case studies were selected, hereafter referred to as the 'Vascular', 'Cardiology' and 'Respiratory' case studies. Table 3 provides a summary of the subject of each case study and the key themes that will be explored.

Table 3: Summary of Case Studies

Vascular Case Study
- The centralisation of emergency vascular surgery to a smaller number of specialist centres.   - The loss of vascular surgery services from a significant number of smaller hospitals.   - The centralisation of vascular services from two to one general hospital site.   - The consolidation of the two clinical teams on one site, and the incorporation of a third, smaller hospital, within the jurisdiction of the centralised vascular service.   - The introduction of highly specialist minimally invasive surgical procedures at the jurisdictional boundary between two professional groups.   - The loss of jurisdiction over these procedures by one professional group
Cardiology Case Study
- The extension of emergency services for heart attack.   - The fear of losing all emergency services to larger specialist centres if they cannot be established on a 24/7 basis.   - The leveraging of investment in a service that, on the face of it, presented a significant financial loss for the organisation.   - A jurisdictional dispute about where high value facilities should be located between the clinical teams working on two different hospital sites.

	Respiratory Case Study
	- The integration of a community-based and hospital-based specialist nursing and physiotherapy teams. - The loss of jurisdiction and control over the hospital-based team by the respiratory consultants working in the general hospital. - The consequential unwillingness of some respiratory consultants to engage with, and refer to, the newly integrated team.

The data for the case studies was collected in two different ways. The majority was derived through the semi-structured interviews undertaken between March 2013 and December 2015. However, throughout this data collection period, secondary materials related to the case studies have also been collated to enhance the narrative and provide additional context to each case study. Although there were no issues faced with accessing these materials, the quantity of data collated presented a significant challenge in the stages of analysis. Table 4 provides a summary of the secondary sources collated for each case study. A detailed list of the collated materials is provided in Appendix 11.3, 11.5, 11.7.

Table 4: Secondary Data Sources

Case Study	Sources (n)	Words (total)	Description
Vascular case study	40	53,337	- Minutes of working groups - National service specifications - Business cases - Correspondence between

			organisations
Cardiology case study	11	79,781	- National publications - Public consultation documents - Professional body publications including audit findings - Correspondence between clinical team and acute trust executive management
Respiratory case study	11	12,099	- Press releases - Commissioner presentations - Public consultation documents

An immediate observation from these collated secondary materials is the presence of common threads. There is clear evidence in all three cases that there was an extensive effort to both plan for, and consult upon, the proposed changes. Furthermore, the stimulus for change, in all three cases, was a combination of top-down national policy, evidenced through policy documents and guidelines, and bottom-up local sense-making from the clinical teams. These case studies provide a rich source of data to explore themes related to the role of professional status within processes of organisational change.

3.3. Data Analysis

The approach to data analysis and theorisation was informed by the methodology outlined by Gioia *et al* (2012: 17-18). This provides a systematic and iterative approach to the development of new concepts from qualitative data. This 'holistic approach' is designed to bring 'qualitative rigour' to the conduct and presentation of inductive research, and to strike the balance between the often-conflicting need to develop new concepts inductively while meeting the requisite standards for rigour.

Although this approach is a form of grounded theory, it does allow a constructivist view and prior theoretical review to guide research – this is qualitatively different to classic grounded theory studies (see Glaser, 1998; Lincoln & Guba, 1985). It is built upon a number of key assumptions including an assertion that participants need to be viewed as knowledgeable agents: 'namely, that people in organisations know what they are trying to do and can explain their thoughts, intentions and actions.' Therefore, it is important that the terms captured are informant-centric to prevent the appropriation of externally defined or established concepts that are not demonstrably reflected in the interview data.

The role of the researcher is one of a 'glorified reporter' whose main role is to give an adequate account of the informants' experience. This effort, to give voice to the informants, is rewarded with 'rich opportunities for discovery of new concepts rather than affirmation of existing concepts.' The goal of the researcher is to conduct the research in a way that imposes qualitative rigour, and to present the research findings in a way that demonstrates the connections among data, the emerging concepts, and the resulting theory. This is achieved by reporting both voices – the first-order, informant-centric terms and codes and the second-order, researcher-centric concepts, themes and dimensions.

The data analysis was undertaken in two phases. The first phase involved taking a systematic and iterative approach to analyse the semi-structured interview data in order to develop a theoretical framework. The second phase of the data analysis involved the use of the case study data to further extend and develop this theory using real-world examples of change that have occurred across organisational

boundaries. The following sections provide a detailed account of the two phases of the data analysis.

3.3.1. Semi-Structured Interviews

The semi-structured interview transcripts were analysed and coded using NVivo. According to Packer (2011), the act of coding is accomplished through the practices of abstraction and generalisation. This divides an interview transcript into separate units, removes these units from their context, identifies abstract and general categories among these units, extracts the content of these categories, and describes this content in formal terms. The coding of the transcripts was undertaken in three stages – the identification of first-order concepts, the grouping of these concepts into second-order themes, and, finally, at a further level of abstraction, the identification of aggregate dimensions.

The first stage of the data analysis started with open coding (Locke, 2001) of interview transcripts, in order to identify informant-centric terms and codes. For instance, the sentence: 'all doctors are not the same; some are brighter than others', was coded as representing the concept, 'differential academic capabilities.' During the initial stages of analysis, there was a profusion of concepts identified. This was consistent with the assertion of Gioia *et al* (2012) that 'a myriad of informant terms, codes, and categories emerge early in the research [...] the number of categories tends to explode on the front end of a study [...] and the sheer number of categories initially becomes overwhelming' (2012: 20).

Similarly, Pettigrew (2010: 281-283) observed that 'the overwhelming weight of information, from the task of structuring and clarifying, from the requirement for inductive conceptualization [risks] death by data asphyxiation - the slow and inexorable sinking into the swimming pool which started so cool, clear and inviting and now has become a clinging mass of maple syrup.' Pettigrew acknowledges that in the early stages of the data analysis, the researcher needs to increase complexity in order to appreciate the richness of the subject matter. However, in order to make the data manageable, the data needs to be simplified. This, in turn, requires further verification through more data collection and then additional simplification through

framework building and pattern recognition. Therefore, from the initial plurality of concepts that were identified, I was able to whittle this down to forty-five '**first-order concepts**'.

The process that was taken to determine these concepts was not linear, but undertaken on a continuous, iterative basis as the interviews were completed. As stated by Gioia *et al* (2012: 20), 'it is somewhat artificial to parse the interviewing and the analyses, as they tend to proceed together.' During the coding process, wherever possible, an effort has been made to capture the language and descriptions used by the interview participants.

The second stage of the coding process involved axial coding (Strauss & Corbin, 1990) to identify similarities and differences between the concepts in order to refine the categories into a more manageable number of '**second-order themes**'. These themes are less descriptive. They are researcher-centric categories operating on a more theoretical level. For instance, the first-order concepts of 'differential academic capabilities' and 'differential practical capabilities' were grouped together under the theme 'academic & practical capability of individuals.'

According to Gioia *et al* (2012: 20), these emerging themes 'help us to describe and explain the phenomena we are observing', whilst focusing attention on, 'nascent concepts that don't seem to have adequate theoretical referents in the existing literature.' During this process, the emerging themes were compared with initial expectations from the literature, leading to the retention of some, and the merging or abandonment of other themes (Locke, 2001). The forty-five 'first-order concepts' were arranged into twenty-three 'second-order themes'.

The third staging of the coding process involved the 'first-order concepts' and 'second-order themes' being further distilled into researcher-induced '**aggregate dimensions**'. For instance, the 'second-order themes' of 'control of jurisdiction' and 'freedom to practice' were further distilled into the aggregate dimension of 'autonomy'. The 'second order themes' were distilled into eleven 'aggregate dimensions'. The concepts, themes and aggregate dimensions that have been identified form a data structure.

There are some recognised risks or limitations associated with the Gioia methodology. According to Langley & Abdallah (2011: 217) this method leads to the development of process models of how people make sense over time. However, these models sometimes describe phenomena at a high level of aggregation, to the extent that a complete understanding of 'how and why things occur in the everyday from one moment to the next is to a degree glossed over.' This may lead to a de-contextualisation and the loss of the association between particular themes.

This method also risks the production of a singular narrative in which differences in perspective are subsumed and not elaborated in depth. For these reasons, this research study does not slavishly follow the Gioia approach but is using it as a methodological guide. The overall research design, blending both semi-structured interview analysis with a case study approach, is also designed to avoid the production of a single dimensional account.

3.3.2.   Case Studies

The case study data analysis has taken two forms: within-case analysis and cross-case analysis. According to Eisenhardt (1989: 540), within-case analysis typically involves detailed case study write-ups. These are often simply pure descriptions, but they are central to the generation of insight because they help researchers cope in the analysis process with the volume of data.

The overall idea of within-case analysis is to become intimately familiar with the subject as a discrete entity. This provides the opportunity for the researcher to consider the unique patterns of each case before developing them into generalised patterns across cases. Moreover, it offers researchers a rich familiarity with each case, which, in turn, accelerates cross-case comparison. The detailed within-case analysis for each case study is presented in Chapters Five, Six and Seven. The key themes that have emerged from the case study data are identified and are related to the role of status within processes of organisational change.

According to Eisenhardt (1989: 540), the tactics for cross-case analysis are driven by the reality that people are notoriously poor processors of information; they leap to conclusions based on limited data; they are overly influenced by the vividness or by more elite respondents; they ignore basic statistical properties and they sometimes inadvertently drop disconfirming evidence. These characteristics mean that the researcher may reach premature and even false conclusions as a result of these information processing biases.

The key to counteracting these tendencies is to look at data in many divergent ways. For instance, to select categories of dimensions, and then to look for within-group similarities coupled with inter-group differences. These dimensions may be suggested by the research problem or existing literature. This approach forces investigators to go beyond their initial impressions. In so doing, it improves the likelihood that the researcher will develop accurate and reliable theory, and that they will capture novel findings which may exist in the data. This cross-case analysis is presented in Chapter 8. The aim of the cross-case analysis is twofold:

- To provide a comparative analysis of the presence of themes related to professional status. To identify where there are similarities and differences in the observed phenomena.

- To consider the role of professional status in relation to organisational change. To demonstrate how professional status influences how doctors respond to change.

The cross-case analysis is presented in both narrative and tabular form. The use of comparative tables is designed to aid analysis, identify patterns and connections between the data (Miles and Huberman, 1994). This additional stage of data analysis provides an opportunity to further develop the theoretical framework and to assure the trustworthiness of the research findings.

* * *

In summary, the design of this research study utilises qualitative methods and is informed by the philosophy of constructivism. The research data has been collected using semi-structured interviews and a case study approach. These methods have been chosen because of their suitability in addressing the research questions. The selection of the interview participants and case studies was based on purposive sampling. The research study presents three case studies concerning change at different organisational boundaries. The approach to the data analysis involves open coding of first-order concepts, the grouping of these concepts into second-order themes, and finally, the identification of aggregate dimensions. The case study analysis has taken two forms including within-case analysis and cross-case analysis focusing on elaborating themes related to organisational context.

Chapter Four

Analysis & Findings – Professional Status

4. Chapter Four: Analysis & Findings – Professional Status

This chapter will demonstrate how the process of data collection and analysis, outlined in the previous chapter, has been translated into a data structure, and how this forms the basis of my theoretical model. Firstly, there will be a detailed exploration of each of the key themes that have emerged from the data. In total, eleven key themes have been identified from the data, including:

- Capability
- Specialisation
- Breadth
- Emergency

- Lifestyle
- Technology
- Craft
- Material Value

- Ethos
- Organisational Standing
- Autonomy

For each theme, a detailed description and exemplary excerpts from the interview transcript data will be provided. Secondly, the data structure will be outlined demonstrating the progression from the coded data to a higher level of analysis. Thirdly, the theoretical model will be presented with an explanation of how it frames how doctors construct professional status. There will be a detailed description of the model including the relative contribution of different themes, and the introduction of the concept of 'contributory' and 'mitigating' themes.

4.1. Capability

One of the ways that doctors construct professional status is based on their relative academic and practical capability. Essentially, the greater the capability of an individual or group, the higher their corresponding professional status. The theme of 'Capability' can be sub-divided into three categories:

- Capacity to Perform
- Attributes to Succeed
- Application to Progress

These categories were identified during the thematic coding of the data. Table 5 provides a summary of some of the words and phrases identified in the initial open-coding and grouped into the three categories. These words provide an indication of the way that the interview participants have articulated the theme of 'Capability' and how these have been subsequently grouped thematically.

Table 5: Words associated with Capability

Capacity to Perform	Attributes to Succeed	Application to Progress
Brighter	High achievers	Hard work
Intelligent	Driven	Dedication
Cleverest	Arrogant	Motivation
Intellectual	Dynamic	Competition
Cerebral	Ego	Qualification
Better	Machismo	Commitment
Faster	Superiority	
	Type A	
	Assertive	
	Forceful	
	Alpha Male	
	Gung-ho	
	Aggression	
	Brash	
	Perfectionist	

'Capacity to Perform' is the innate academic and practical aptitude of an individual clinician. In other words, how clever are they and what skills can they master? 'Attributes to Succeed' are the personality characteristics of individuals. How driven are they, and do they believe in their own capabilities? 'Application to Progress' is the effort and focus of individuals. How accomplished has an individual become; what qualifications have they achieved, and how effectively have they competed for

opportunities? On the basis of this data, the construction of professional status could be based on a clinician having the innate capacity to assimilate knowledge and practical skills; they will be endowed with attributes that predispose them to seek advancement and achievement; they will have applied themselves to secure the most desirable training opportunities, and appointment to the most desirable roles. The following sections explore each of the three sub-categories in more detail.

4.1.1. Capacity to Perform

The following excerpts provide an indication of how the participants discussed the differing intellectual capacity of groups. These gradations of intellectual capacity may not be immediately apparent to those outside of the profession. Indeed, all doctors, because of the exacting entry requirements to train at medical school, are outwardly intelligent. However, within the profession, there is an appreciation that there are degrees of intelligence between individuals and groups.

All doctors are not the same; some are brighter than others.

(Consultant Colorectal Surgeon)

The medical consultants that people most wanted to be were thought the cleverest […] like the renal physicians. […] It always seemed to be such a cerebral medical specialty.

(Consultant Geriatrician)

Although the intelligence and practical skills of groups were articulated as discrete variables, the status of a specialty was often described in terms of the intersection between these themes. The implication being that the ranks of the highest status specialties are filled not only with their cleverest, but also the most able clinicians. The following excerpt is one of many reflections on this subject.

Cardiac surgeons and neurosurgeons, very clever people doing very technically difficult surgery, it's […] respect from colleagues, that very few people can probably do that as well as they can, because it's a mixture of both hand-eye coordination and brainpower.

The following excerpts provide further articulation of the perceived differences in practical capacity. The participants referred to a wide range of practical skills and abilities. They tended to emphasise the importance of a practical skill that has a strong association with their own specialty. In other words, the participants elevated their own status by emphasising the importance of skills germane to their specialty. For instance, a consultant anaesthetist emphasises the relative strength of the 'people skills' of anaesthetists compared to surgeons. The professional status of an anaesthetist would traditionally be regarded as lower than a surgeon.

[Anaesthesia] used to be a Cinderella specialty. […] Everyone historically said anaesthetists […] don't need to talk to patients. Ironically, […] anaesthetists probably have got better, more sophisticated people skills […] than surgeons.

(Consultant Anaesthetist)

There are similar reflections offered by members of other traditionally lower status specialties, such as geriatricians and acute physicians, that emphasise the importance of practical skills such as team working and communication. These are qualitatively different to the reflections offered by traditionally high-status specialties that tend to emphasise the importance of technical skills. The following excerpt is offered by a cardiologist regarding the training programme to become an interventional cardiologist (i.e. that can perform minimally invasive procedures); the capacity to learn these particular skills is either there, or not.

There will be some people who really want to do intervention, and if they have enough insight, they'll quickly realise if they don't have the skills required. The ones that don't have insight are filtered out pretty quickly because their trainers will just see that they're not able to do what they're supposed to do.

(Consultant Cardiologist)

Furthermore, the interview participants reflected upon the relative capacity of clinicians working in different organisational contexts. For instance, a consultant colorectal surgeon working in a general hospital appraises the practical skills of a

counterpart working in a teaching hospital. The participant equates working in a teaching hospital with having weak practical skills. The participant suggests that consultants working in the teaching hospital have needed to supplant practical skills with research activities. The obverse being that surgeons working in general hospitals have strong practical skills. The interview participant asserts that, in their eyes, the status of practical skills is greater than research activities.

When I look at who works in our teaching hospitals [...] I wouldn't let them cut my dog up let alone me. [...] Some of the research people, have traditionally done it because they're not a very good operator, so that reduces their kudos.

(Consultant Colorectal Surgeon)

4.1.2. Attributes to Succeed

The interview participants described a range of different attributes relating to professional status. These attributes were ascribed to particular individuals and groups of clinicians. The following excerpts are derived from interviews with consultants working in traditionally high-status specialties. The participants described characteristics that were related to a drive for achievement and success.

People who are very type A personalities will get driven, they generally are very high achievers right from the start. And they want to do the best, they will not tolerate mediocrity, so they will aim for excellence at every stage.

(Consultant Cardiologist)

Some are a lot more dynamic than others. I mean physicians are generally slow-paced compared with surgeons.

(Consultant Colorectal Surgeon)

The following excerpts are derived from interviews with consultants working in traditionally lower status specialties. It is possible to discern a measure of resentment being articulated by these consultants towards the traditionally high-status specialists. This certainly isn't an affirmation by the participants of the high

status of these groups. Indeed, the attributes that they are said to often exhibit include words with negative connotations including ego, arrogance and machismo.

Thinking back to med school and junior jobs in hospital, there's quite a lot of ego in terms of 'I'm going to be a brain surgeon' or 'I'm going to be a heart surgeon.'

(General Practitioner)

Working in the teaching hospital there's more noise, they'll tell you how marvellous they are, constantly.

(Consultant Anaesthetist)

The surgeons [...] think they're the most important thing, and they've got this machismo [...] attitude, [...] it's all about the surgeons.

(Consultant Anaesthetist)

Respiratory medicine [...] departments are not characterised by a sort of mutual competitiveness and aggression, so they're more kind of laid back. A conference of respiratory physicians would feel more like kind of a golf club and less like a kind of Formula One event.

(Consultant Respiratory Physician)

Finally, the following pair of excerpts are interesting because they both refer to the attribute of assertiveness. This characteristic may be best understood as an expression of an individual or group's high professional status. In other words, the reason that they are able to exhibit, or indeed, get away with, certain behaviours are because of their relative power and status within the organisation. The first excerpt refers to assertiveness as a negative attribute, whereas the second excerpt suggests that it is something to be valued. It should be noted that the negative appraisal is provided by a traditionally low-status geriatrician, and the positive appraisal by a traditionally high-status cardiologist.

The sensing, touchy feely type […] there are definitely more of us doing geriatrics in that ilk. And fewer of the completely type A personalities that are shouting and screaming and swearing.

(Consultant Geriatrician)

[Cardiologists] tend to have a lot of surgical characteristics, they tend to be quite assertive, they tend to be quite forceful. They're usually reasonably intellectual because of the challenge of getting there in the first place. […] They tend to challenge each other quite a lot and be very competitive […] vying with each other for supremacy […] a lot of alpha males fighting each other.

(Consultant Cardiologist)

The last excerpt is interesting because the participant is making an appeal to the characteristics and behaviours exhibited by traditionally high-status specialists. In other words, cardiologists are high status, because they are as assertive as surgeons, who are archetypically high status. The desirability of certain attributes is subjectively determined by the participants. Again, there does seem to be a tendency to emphasise attributes that are germane to a doctor's own specialty. In doing so, they are trying to elevate their own professional status vis-à-vis other groups of clinicians.

The contradictory interpretations of the external manifestations of these attributes – be they characterised as assertiveness and forcefulness, or, shouting, screaming and swearing – is determined by the relative power of the specialties. The negative appraisal of these characteristics is likely to be because they are in direct conflict with the attributes valued by the traditionally low-status specialties i.e. team working and communication. In contrast, the traditionally high-status specialties are more likely to emphasise the competitive nature of their social interaction. Indeed, the characterisation, provided by the consultant cardiologist, in the excerpt above, is evocative of almost gladiatorial conflict. Again, it is interesting that some of the language used is highly gendered. Words such as 'alpha male' and 'machismo' are aggressively masculine.

4.1.3.   Application to Progress

The following excerpts provide an indication of how application and achievement are conceived as expressions of professional status. The themes articulated by the interview participants can be neatly summarised by the following excerpt:

There is without a question a pecking order. And it's based on […] how difficult it is to get into that field [and] how hard does the field work.

(Consultant Ophthalmologist)

The following excerpts relate to the difficulty of entering a clinical field. The participants offered reflections on the importance of passing exams and gaining qualifications. An obvious prerequisite for exam success is the intellectual capacity of the individual clinician. A distinction is drawn regarding the level of attainment required to secure a role within a particular organisational locus compared with a general hospital and a teaching hospital (note that services such as cardiothoracic surgery are only located in a small number of highly specialist centres).

In terms of the number of the exams you have to pass as a hospital doctor, you have automatically elevated yourself.

(Consultant Acute Physician)

To become a cardiothoracic surgeon, you typically have to be doubly qualified in medicine and surgery. […] People are aware that the hurdles to get there, they just command respect […] thanks to their qualification.

(Consultant Ophthalmologist)

Cardiothoracic surgery is not the only specialty that requires individuals to be 'doubly qualified'. For instance, oral and maxillofacial surgery requires double qualification in dentistry and medicine. This means that an individual must apply themselves in order to sit two undergraduate degrees. The commitment and demands of this training programme serve to elevate the status of this specialty and its constituents. There are similar references about the need to gain further qualifications at a sub-specialty level. For instance, the following excerpt is provided by a consultant

orthopaedic surgeon that specialises in hand surgery. This sub-specialty deals with the fine, delicate bones of the hand and wrist.

Hand surgery is very difficult to get into. [...] Colleagues are either from trauma orthopaedics or from plastics. They have a combined interest in hand surgery. [...] You have to have additional three years of training.

(Consultant Orthopaedic Surgeon)

The interview participants made a number of references to competition for training programmes and posts. An equation is drawn between competition for entry to a clinical specialty and its status. The existence of competition is attributable to the relative scarcity of roles in certain clinical fields. The general availability of roles in specialties such as emergency and acute medicine are indicative of the lower status of these specialties.

If you enter a specialty where anyone can get a job such as [emergency medicine] it's always going to be a Cinderella to something where you had ten of you applying for each job, and you had to fight through, and inevitably where there's competition, you will breed a group of people who are of high quality.

(Consultant Colorectal Surgeon)

It is interesting that the interview participants offered many reflections about competition through the prism of failure. In this context, the positioning of a consultant within a particular specialty may be indicative of their low status and lack of attainment. The specialties associated with the lowest attainment are emergency medicine, general practice and public health.

Figure 2 (adapted from GMC, 2014:112) summaries the medical training paths for doctors entering general practice and specialty training. The old and new systems refer to the introduction of the Modernising Medical Careers reforms. These were introduced for any doctors training after 2005 and have created a more structured model of career development. In both the old and new systems, the training path for general practice is shorter than specialist training.

Figure 2: Medical Training Path
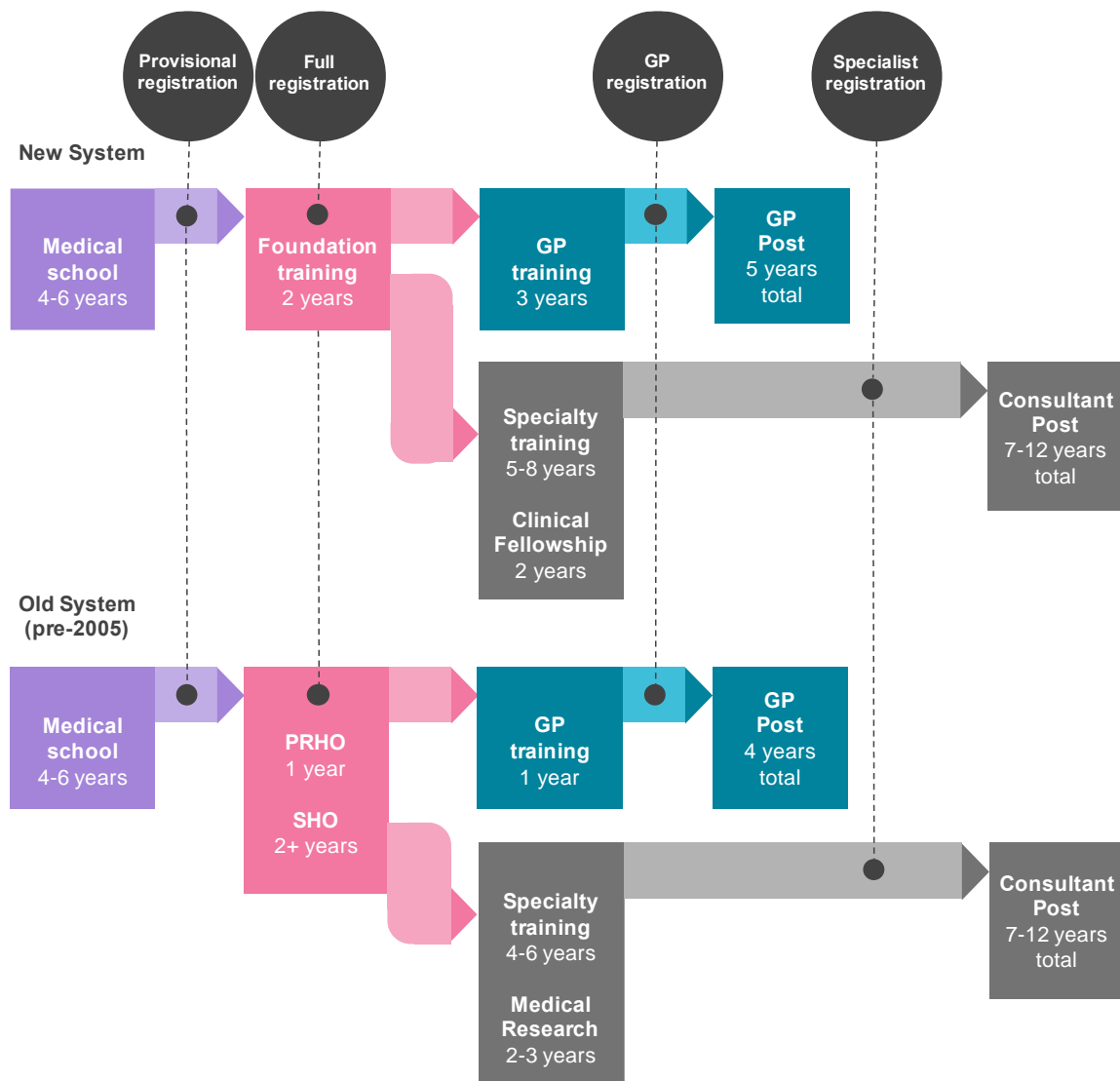
A doctor's chosen specialty is partly determined by their ability to attain a level of competence and qualification in a particular clinical field. The implication of the excerpts below is that some consultants are working in their second, or third choice, of specialty.

Many [emergency medicine] consultants used to be failed orthopods […] they go up so far, realise they can't cut the mustard, and then take a side step.

(Consultant Respiratory Physician)

GPs […] are failed medics, they couldn't do the exams.

(Consultant Acute Physician)

Most people think that public health doctors are failed doctors, they couldn't do anything else.

(Chief Executive Officer)

In the old days, Geriatrics was very much a sort of failed 'ologist of some sort. [The term] Geriatrician was […] really derogatory.

(Consultant Geriatrician)

Finally, the interview participants referred to the concept of hard work. This was expressed in several different ways. The first excerpt refers to the need to work longer and harder to achieve the requirements of a specialist training programme. The need to gain exposure to an operating theatre environment means that, other activities peripheral to this endeavour, must be accommodated outside normal working hours.

The training programmes for interventional cardiology involve early starts and late finishes, […] because you want operating experience and it's the same for surgeons. […] All the other activity that you are meant to do, like looking after patients, do your paperwork, admin, is spread out to the other ends of the day, outside operating hours. So, you tend to work longer and you're very much goal driven. […] Otherwise you just fall off that particular wagon.

(Consultant Cardiologist)

This except makes another comparison between cardiology and surgery. The status of the consultant cardiologist is being partly constructed by drawing a comparison with traditionally high-status surgical specialties. In order to become an interventional cardiologist, you need to have the requisite capacity and attributes and application. However, there is an acknowledgment that this application means that the doctor must accept certain compromises in their life to reach their goal. This is the sort of articulation of a 'work hard, play hard' lifestyle offered by professionals working in other fields such as law and investment banking.

Moreover, the following excerpt makes clear that this hard work continues beyond the training programme. There is a need to continuously better oneself. The interview participant emphasises the work ethic of the specialty, and also the dynamic nature of its knowledge base – it is always developing and expanding. It is not possible to become a consultant and rest on your laurels. According to Christmas & Millward (2011), the very idea of being 'up to date' is becoming increasingly obsolete given the fast changing and vast field of medical knowledge.

There's always a […] threshold that you have to keep up with, to maintain your knowledge as being current and contemporary. You can't just sit back and say right, I've learned it now and that's it.

(Consultant Cardiologist)

In many ways, the interview participants describe a remarkably meritocratic system. The status of a doctor relates to their level of attainment. Their attainment being a product of their effort and ability. It is important to note that one of the defining features of the medical profession is the plethora of examinations that shape the early stages of medical careers.

The following excerpts relate to the nature of the doctor's working life. The concept of hard work is described as determining the choice of specialty made by doctors in training. In these excerpts, the consultants are asserting that their own specialty works harder than others – for the consultant acute physician, this is an assertion that they work harder than GPs; for the consultant ENT surgeon, it is that surgeons work harder than physicians; for the consultant in intensive care medicine, that they work harder than consultant anaesthetists.

If you listen to the juniors or medical students 'so what do you want to do?' 'Ah, I don't want to do [...] hospital medicine because it's so hard work, I'll be a GP because it's an easy life.'

(Consultant Acute Physician)

Surgeons [...] do lots of things in theatre and physicians are just people doing ward rounds once every three weeks.

Intensive care has always been a hard graft and a lot of people are put off it. It's either your bag or it isn't. So, people go into anaesthesia and they don't want to do intensive care because you're going to be up all night.

The second excerpt is interesting because it manages to diminish the status of a physician by stating that they *just* do ward rounds – as opposed to 'lots of things in theatre' – and paint them as workshy by arguing they only do this activity infrequently. The obverse being that the surgeons do things that are much more valuable and do not shirk the hard work required to get them done. Therefore, the construction of status owes as much to the nature of the work as the way in which it is delivered.

*   *   *

In summary, the theme of 'Capability' was expressed by referring to the 'Capacity to Perform' which means that individuals are able to effectively assimilate knowledge and practical skills, the presence of 'Attributes to Succeed' predispose an individual to advancement and achievement, and their 'Application to Progress' enables them to secure the most desirable training opportunities and sought-after roles.

4.2. Specialisation

The theme of 'Specialisation' was very pronounced in the data. The participants described a direct relationship between the degree of knowledge or practice specialisation and professional status. The greater the specialisation of an individual or group, the higher their corresponding professional status. In this context, generalists, such as GPs, will have a lower status compared with specialists that focus on a narrower range of clinical knowledge and practice.

It should be noted that the degree of specialisation is culturally specific. For instance, the General Medical Council (2011) reported significant international variation in the number of recognised specialties and sub-specialties. The UK recognizes 61 specialties, compared with 30 in Canada and in the region of 80 in the USA. Moreover, the USA has at least 120 sub-specialties, dwarfing the UK's 40 sub-specialties. A third of the countries sampled did not formally recognize any sub-specialties. The number of recognised specialties and sub-specialties is subject to continuous change. In short, the reflections offered by the interview participants will be reflective of the specialties and sub-specialties around which their practice is organised. The reflections provided by the participants can be sub-divided into two categories: 'Pursuing Specialism' and 'Eschewing Generalism'.

4.2.1. Pursuing Specialism

The interview participants articulated how the presence of specialisation can be used to affirm the status position of an individual or group. For instance, there are references to the increasing complexity of the patients that are cared for by hospital specialists. The more routine patient cohort has been pushed down to general practitioners.

More and more secondary care is focusing in on the top end complex people, and [...] the routine work, because it's so much more common, the GPs see it much more. [We are] more super-specialised if you like.

(Consultant Diabetologist)

The increasing complexity of the work being undertaken by the hospital specialists provides them with greater scope to develop sub-specialist expertise. This means that some consultants will only see patients with particular diseases or requiring certain types of treatment. This may increase the need for onward referral between hospital specialists working within the same clinical team. The development of sub-specialisation may lengthen the referral chain.

The following excerpt describes the growing specialisation within ENT surgery. Increasingly, the skills of a general surgeon are becoming outmoded. Greater specialisation produces a virtuous circle, because as the scope of clinical practice becomes narrower, the mastery of the knowledge and skills of that area of clinical practice are enhanced (Abbott, 1981). In other words, rather than being a jack of all trades, you become a master of one.

When I was a trainee […] we had a consultant, who would do a big ear operation followed by a big head and neck cancer operation on the same list. That just doesn't happen now because it's all sub-specialist, as it should be.

(Consultant ENT Surgeon)

The interview participants also articulated a desire to become increasingly sub-specialised by dropping activities that may seem peripheral to that endeavour. For instance, the following three excerpts describe a desire to drop the general activities of a particular specialty to focus on a sub-specialist area of practice.

It's quite easy to become a subspecialist in cardiology and […] not do a lot of the ordinary general cardiology anymore.

(Consultant Cardiologist)

Some of my colleagues would […] love to drop the wards, […] they would be happy just doing endoscopy or bronchoscopy. Others say they would just want to do clinic.

(Consultant Geriatrician)

Keeping up these people's skills sets will be a challenge […] people will say well, 'that's not within my skill set, I'm not doing it often enough, maybe I shouldn't do it'. […] Generic skills are taken away from colleagues over time because they're not doing enough.

(Consultant Orthopaedic Surgeon)

The reference to dropping activities relate to activities that are less specialist fields of practice. To 'drop the wards' would be to eschew a relatively troublesome field of practice. This is because the timely admission and discharge of patients from hospital is reliant on other actors both within and without the hospital; the issues that arise may often be outside of a doctor's direct control and impotence does not aid the construction of professional status. The last excerpt draws similar parallels with the character of general trauma activities. The essential principle being, the less and less generalist work that a doctor undertakes, the less skilled they become to perform generalist activities.

Finally, the participants expressed an acute awareness of how specialisation has resulted in the shifting status of different specialties. For instance, the following excerpt describes how increasing specialisation has detracted from the glamour of general surgery. The gain in status of a number of specialties has come at the cost of the concept of *general* surgery. It is important to note that it is not suggested that the increasing specialisation of specialties like cardiology and gastroenterology are detracting from the status of surgical specialties like cardiac surgery or neurosurgery. Rather, it is the concept of *general* surgery that is under threat.

The glamour of [general] surgery has probably declined in the last ten, twenty years. […] Partly because there isn't much general surgery going on. […] The glamour that traditionally surgeons carried […] has been taken away and has come to some of these procedural medical specialties.

(Consultant Cardiologist)

Medicine was medicine […] and surgery was surgery, and there was quite a divide between the two. And now obviously with things like gastroenterology and cardiology […] even respiratory medicine, there is a lot more interventional stuff that has almost become more surgical.

The outmoding of *general* surgery has resulted from the increasing specialisation of other surgical specialties like upper and lower gastrointestinal surgery. This has, in turn, raised the status of these specialties as their practice has become increasingly differentiated. Previous generations would have trained as general surgeons and subsequently developed areas of specialist interest e.g. breast surgery. However, it is increasingly the case that training programmes are producing surgeons with specialist rather than general surgical skills (GMC, 2017). There are still a good number of traditionally trained general surgeons. Some of these individuals, particularly in smaller hospitals, still contribute to emergency surgery on-call duties. However, their numbers will dwindle because of generational change. In time, only upper and lower gastrointestinal surgeons will provide emergency surgical services.

There is a strong argument [to question] why […] a breast surgeon, in the middle of the night, is expected to open up a perforated gut, but in the cold light of day would go nowhere below the diaphragm. […] Those days are gone, and those people are gone. […] In the middle of the night who do you want to be on-call, you want someone that can open up a belly, because in the middle of the night you are not going to come in with a breast abscess, […] you need a gut surgeon to be on-call.

(Consultant Respiratory Physician)

It is conceivable that within a team of breast surgeons there will be a mixture of those that trained as general surgeons and more recent appointments that have trained exclusively in breast surgery. Depending on their respective training paths, there may be different constructions of identity within the same team. Moreover, there may be differing notions of their respective status.

The decision to specialise is often a conscious choice. Moreover, the interview participants demonstrated a keen awareness that the shape and complexion of medical specialties is subject to continuous change, and of the consequential risks and opportunities that pertain to professional status. The general direction of travel, at present, is away from generalism and towards increasing specialisation. The

advent of a new technology or techniques may presage the birth of a new specialty and the death of another. Alternatively, hard economics may drive a shift away from increasing specialisation – a generalist model is often cheaper. At these junctures, the respective status of these specialties will be reconstructed.

The final excerpt provides a succinct articulation of the dilemma regarding future changes to the model of specialisation. Stroke medicine is a fairly new specialism. This field of clinical practice has traditionally been filled by consultant neurologists or consultant geriatricians. However, there has been a gradual shift towards stroke medicine being recognised as a specialty in its own right. The interview participant originally trained as a consultant geriatrician.

I just suddenly thought, oh gosh, have I completely specialised only as a stroke physician, what happens if they get rid of stroke as a disease and they cure it. But I don't think that will happen before I retire. Hopefully after I've retired and then they can cure me of my stroke.

(Consultant Stroke Physician)

The consultant is reluctant to put all their eggs in one basket. There may be an association between the sustainability of the jurisdiction of a given specialty and professional status. It is conceivable that a specialty that remains a mainstay of clinical practice has a higher professional status than one that looks like its future is indeterminate or hangs in the balance.

4.2.2.   Eschewing Generalism

There were a significant number of reflections offered by the interview participants that were disparaging about the value of generalist roles. These reflections mainly related to general practice. However, they also extended to other specialisms such as acute and emergency medicine. Generalist roles tend to be situated in a community setting, or at the front door of the hospital.

Figure 3 describes the typical pathway that most patients follow when attending the hospital on an unplanned basis. Patients will either arrive at, or will be transported

by an ambulance, to the emergency department. They may also be directed to the emergency department by their GP. The emergency department will either admit a patient to an assessment unit for further tests and observation, or directly to a specialist unit. GPs will often refer patients directly to the assessment unit. The patient may be transferred from the assessment unit to a specialist unit.

Figure 3: Patient Pathway for Unplanned Hospital Attendance (simplified)
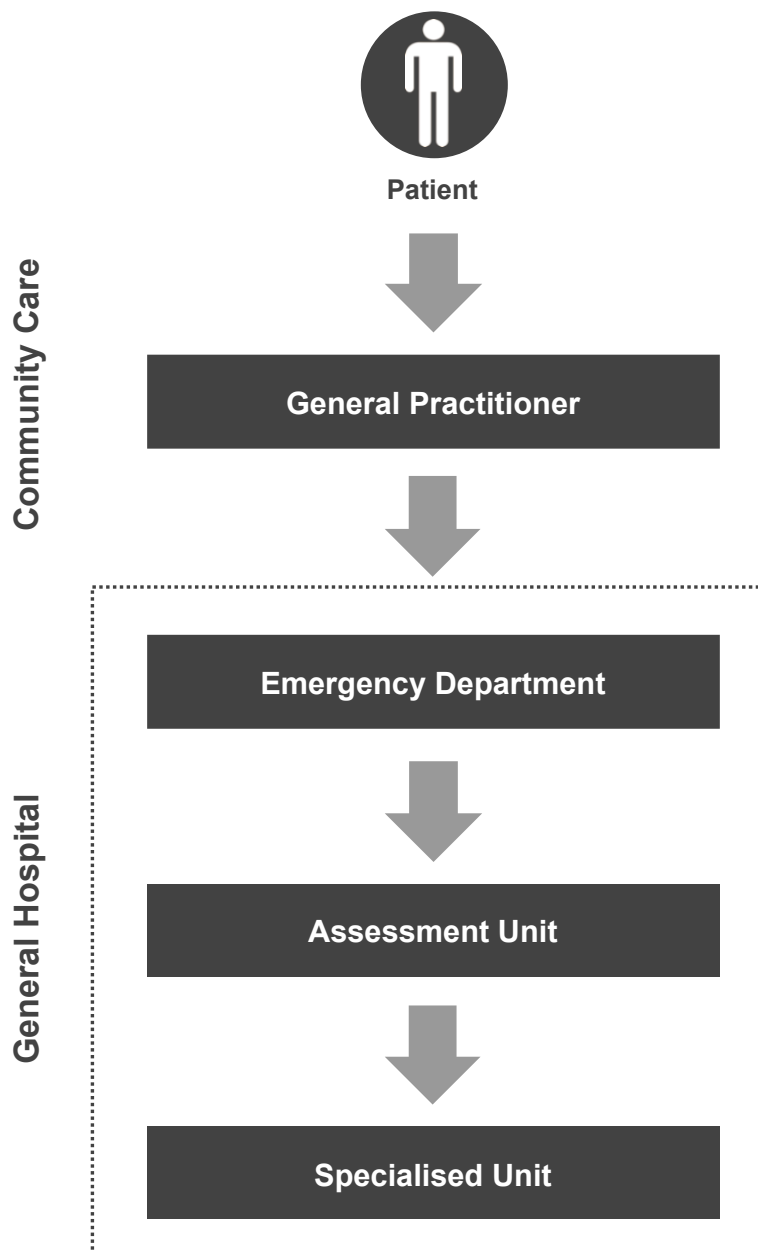
In order for a patient to be admitted under a hospital specialist, there are three gatekeeping functions – the GP in the community, and at the front door of the hospital, the consultant in emergency medicine in the emergency department, and the consultant acute physician or general physician on the assessment unit. At each successive stage of onward referral, the patient becomes more professionally pure (Abbott, 1981). It is very rare for patients to be admitted to a specialist unit without having been triaged by one or more of these gatekeeping functions. The exclusiveness of the specialists' field of clinical practice, is in contradistinction to the fact that patients can access a generalist opinion without let or hindrance.

The interview participants were highly sceptical about the ability of generalists to be 'all things to all people'. This was attributed to the exponential growth in medical knowledge (Christmas & Millward, 2011). It is a significant challenge for generalists to assimilate this wealth of knowledge and be aware of any recent developments. It is much easier to master a body of knowledge, and keep your finger on the pulse, if you focus on a narrow range of clinical practice.

The publication of referral guidelines and systematic reviews by organisations like the National Institute for Health and Care Excellence (NICE) may offer a measure of support. However, these protocolised crutches may also be a double-edged sword as there is evidence of the impact of 'evidence-based medicine' threatening professional autonomy and status (McLaughlin, 2001; Adams, 2000). Nevertheless, the generalist grasp of the depth of medical knowledge will always be a fraction of the expertise offered by their specialist colleagues. The following two excerpts underline this sentiment. These excerpts demonstrate how mastery of medical knowledge is used to construct the relative status of hospital-based specialists vis-à-vis community-based generalists. The mastery of knowledge and practice is associated with professional status. The specialisation of clinical practice may be seen as a necessary pre-requisite to achieving this mastery.

There is the old adage that the GPs know [...] less and less about more and more until they know nothing about everything, whereas with specialists it is the other way around.

(Consultant Acute Physician)

People have different views of general practice, I'm not its biggest fan, […] it's an anachronism. […] I don't believe that there is such a thing as general practice, it's a bit like general surgery, it doesn't exist, it shouldn't exist […] it's outmoded, you can't be all things to all people. You can go in to the internet and get more information about your condition than a GP can within half an hour, because they have got to deal with so many things.

(Consultant Colorectal Surgeon)

The second excerpt is interesting because it suggests that the knowledge of the GP is even inferior to what can be gleaned from the internet. Moreover, it also signals that the balance of power between the patient and general practitioner may have changed. If patients are able to come to their appointments armed with details about treatments that they have found on the internet, this undermines the esoteric nature of professional knowledge. The general practitioner may be ignorant about these treatments, particularly if they have emerged, as a product of recent research, at the frontiers of medicine. The traditional model of public deference to members of the medical profession may be diminished.

The interview participants also questioned the value of the practical skills of the generalists. In the context of lacking specialised skills and knowledge, the interview participants raised concerns about whether generalists were able to effectively triage, diagnose and filter patients. This is more pertinent given that these are the functions that a generalist should perform proficiently; it is their *raison d'être*.

I see an awful lot of stuff that is been held back in general practice, that never should be, and equally I see a lot of rubbish that should never get to us, so I don't think they're doing triage well.

(Consultant Colorectal Surgeon)

The problem is that the general practitioners are now disconnected from diagnostic knowledge and the diagnostic skills and the diagnostic equipment that you need to make those judgements. […] There is nobody left to triage the patients really into the greater and greater specialisation that exists.

(Medical Director)

[Surgeons are] there to do something, not to simply empathise. […] The GP […] is mostly […] a witness to someone's suffering.

(Consultant Ophthalmologist)

The last excerpt emphasises the point by suggesting that the generalist is rendered impotent by their lack of specialist knowledge and skills. They can only passively 'emphasise' with patients or just be a 'witness' to their suffering. The lack of an ability to do something, and to do it well, diminishes the status of the general practitioner. However, the interview participants did not reserve their criticism of generalist roles to general practice. They also raised questions about the value of emergency and acute medicine. These specialisms were painted as being qualitatively different to other medical specialties. The defining feature is the lack of specialisation in these roles.

Being at the front door of the hospital, both consultants in emergency and acute medicine manage a cohort of undifferentiated patients. The implication is that patients that are referred to a specialist have already been through successive stages of triage. They are more likely to fulfil the criteria of being a *bona fide* speciality patient requiring specialist care and management. The flotsam and jetsam are filtered out by the front door, triaged by more generalist roles, such as consultants specialising in emergency and acute medicine.

They have to have slightly disordered psychology to do [emergency medicine]. You get a real kick from it, […] saving a life […] but then there is no follow-up, there is no context, there is none of that. And that's fine for somebody who's young, the moment you get a bit older […] that becomes very difficult to handle.

(Consultant Cardiologist)

Acute medicine still doesn't have an identity. […] What's the role of an acute physician, it's very, very difficult to understand. […] You have to have a very odd mind-set to want to do acute medicine, because you're neither completely at a front door and doing traumatic things that they do in [the emergency department], nor are you actually ever really the ones that sort of the problems out, you're in the midst, almost like a triage role,

which I don't really understand why people do it. And I don't understand what the gratification is.

<div align="right">

(Consultant Cardiologist)

</div>

The above excerpts making interesting references to 'odd mind-set' and 'disordered psychology' of consultants specialising in these front door specialties. The primary reservation is the lack of continuity in patient care. These roles are characterised as ungratifying and performing a more superficial role, servicing the needs of other specialties by sorting and sifting patients for onward referral. These doctors at the end of the referral chain, have the benefit of being able to appreciate the context of the patient's admission and to retain a level of continuity for their care.

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In summary, the theme of specialisation was expressed in terms of the 'Pursuing Specialism' and 'Eschewing Generalism'. Doctors are able to inform their construction of professional status by increasing their specialisation. This means that they can focus on a narrower field of practice. The trend towards specialisation does not happen in isolation and the narrowing of focus for one specialty will require others to pick up their 'dropped' activities. This is a zero-sum equation. There was also a strong disparagement of generalism, in particular general practice. It is interesting that although specialists used generalists to help construct their professional status – to emphasise what they are not, or why their practice is more effective – they are completely dependent on the function of generalists to filter and refer patients into their field of expertise.

4.3. Breadth

The interview participants articulated the theme of 'Breadth' as having an important role to play in their construction of professional status. The theme of 'Breadth' can be sub-divided into two sub-categories: 'Promoting Breadth' in clinical practice, and its obverse, 'Demoting Specialisation'. These sub-categories were identified during the thematic coding of the data. Table 6 provides some of the key words and phrases identified in the initial open-coding with their antonyms and grouped into the two sub-categories. These words provide an indication of the way that the interview participants have articulated the theme of 'Breadth' and how these have been subsequently grouped thematically.

Table 6: Words associated with Breadth

Promoting Breadth	Demoting Specialisation
Holistic	Atomistic
Discriminating	Undiscriminating
Variety	Uniformity
Outward facing	Inward facing
Integrated	Dislocated
Patient-centric	Clinician-centric

'Promoting Breadth' refers to the virtues of maintaining a breadth to a doctor's clinical practice. It also highlights the different characteristics of doctors working in these fields. 'Demoting Specialisation' refers to the perception of generalists that specialists have comparatively inferior skills and capabilities, particularly in relation to diagnosing and differentiating patients. The following sections explore each of the two sub-categories in more detail.

4.3.1. Promoting Breadth

There are a number of references that promote breadth in clinical practice as an important counterpoint to the theme of specialisation. Firstly, the following excerpt is reflective of a number of references to the enhanced diagnostic skills of a generalist. The specialist, sitting in their 'ivory tower' has limited need to hone their diagnostic skills. The generalist, by virtue of the fact that they interact with a wide range of patients, needs to be able to quickly and effectively filter and sort patients, some of whom will have unidentified acute illnesses. In order to do so, they will need to draw upon a much wider body of knowledge compared to your average specialist.

I see patients every day. I see a lot of them. I have got to have a breadth of knowledge. […] In terms of my clinical ability and know-how, I probably see myself as maybe even above them. [...] If there was a report from me versus a report […] from some super-specialist […] I would wipe the floor with them, in terms of my opinion being much more valid and valuable than theirs.

(Consultant Acute Physician)

Secondly, the interview participants placed emphasis upon the need to maintain a holistic approach in their clinical practice. Rather than focussing exclusively on a narrow field of clinical practice, there needs to be a broader appreciation of the patient, their mental wellbeing and social situation. The following excerpts are interesting because they indicate that the consultant geriatrician is positioning themselves as the patient's advocate. The inference in the first excerpt is that other specialists are prodding and poking the patient unnecessarily, and it would be kinder to let the patient die with dignity. This suggests are greater degree of circumspection and self-awareness compared to other specialties. The second excerpt suggests that other specialists are loath to try and address a patients' complex social situation to facilitate their discharge. On the other hand, the consultant geriatrician refuses to wash their hands of this situation, and even enjoys the challenge that it presents.

In elderly care a lot of the people get better, but if they die you help them die […] you make sure that you save them from people testing them and treating them inappropriately.

You can get someone that all the medics or the surgeons would write the notes would be await geriatrics, await rehab, await community hospital and they'd write that day after day even if the patient doesn't need that. But often, going in with the geriatrician hat on you go, 'actually no, they don't need that, speak to the daughter, you speak to the social worker and you can come up with a different route.' […] That sort of problem solving I really enjoyed.

<div align="right">*(Consultant Geriatrician)*</div>

Furthermore, the interview participants referenced the need for softer skills, in particular, team working. There is a greater emphasis placed upon these types of skills in the front door specialties like emergency and acute medicine. This may be because these specialties have greater interaction with the wider hospital system and other interfacing services. The following excerpt goes so far as to characterise specialists as being 'slightly autistic' in their unwillingness to engage with the whole system.

To be a good A&E doctor […] you have got to understand team working. […] So those generic skills, […] are much better honed than the [...] specialists who […] can be slightly autistic. [...] Look at the lot here, they are not interested in being a team player, and […] that actually diminishes their place in that hierarchy because they don't work that well as part of a whole system.

<div align="right">*(Consultant Acute Physician)*</div>

The corollary of this focus on team working and outward looking orientation is that these services are portrayed as being more integral to the wider functioning of the hospital. The very specialist services, in comparison, are seen as having fewer linkages to other services. The following excerpt describe these doctors as the quiet majority or the 'hidden backbone of the hospital'.

The majority of hospital consultants are anaesthetists. […] We're the sort of hidden backbone of the hospital. […] It's a sort of nobody really knows what we do but they couldn't do without us specialty. […] We're not headliners are we, definitely not.

This outward facing orientation is also described as making these doctors more open to different ways of working, especially utilising the potential and skills of the wider multi-disciplinary team. The following two excerpts are from a consultant acute physician. They describe a willingness to develop extended roles such as nurse practitioners. The consultants with the broader skill set are also described as leading the multi-disciplinary team from the front, rather than just 'swanning around'.

The hyper-specialists […] think 'well how come somebody else can do it, it has taken me fifteen years?'. [...] Pan-disciplinary, multi-disciplinary things are often developed by generalists, partly because […] that kind of, 'I haven't written ten PhDs in my life to give up this piece of kit to a physio!'.

(Consultant Acute Physician)

They have worked to be cardiologists and have a gold-plated plaque on their door […] and have that status. […] When you get to a consultant, actually I can sit in my office, swan around a little bit, bloody important. […] That's diminished status because you are there actually delivering care rather than just […] sitting at the back, […] leaving your troops to do the work.

(Consultant Acute Physician)

The specialist is portrayed in the above excerpts as aloof. This detachment is described as reducing their status. There are clearly divergent constructions of professional status. The conventional conception of a high-status clinician would be the maintenance of jurisdiction regarding a field of clinical practice. However, the construction of professional status offered by the consultant acute physician suggests that it is linked to how they interact with the wider multi-disciplinary team. In this sense, the transfer of jurisdiction to a non-medical professional actually serves to raise the generalist's status.

Finally, the interview participants also drew upon breadth in clinical practice to emphasise the range and complexity of their activities. In the following excerpt a consultant ENT surgeon compares their status with 'sexy specialties' such as cardiothoracics and neurosurgery. The important point is that the surgeon has to

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have a considerable deftness to be able to switch between procedures that are so dissimilar – a high turnover, simple operation, compared to a major, complex surgery.

In medical school, you get very little exposure to things like ENT, so it's very low profile. And the brash sort of sexy specialties like cardiothoracics and neurosurgery do get that reputation. […] The complexity of work varies throughout the specialties and actually people who have got the range of operations that say a surgeon does, ENT has one of the highest […] because we just do a huge amount of stuff […] from 30 second grommet to 12-hour major head and neck procedures.

(Consultant ENT Surgeon)

There is a duality contained in this last excerpt. The consultant is a specialist but values the maintenance of breadth in their clinical practice. This is a good example of the presence of both the theme of 'Specialisation' and 'Breadth'. In their construction of professional status, the surgeon is able to draw upon both themes and to avoid the risk of an excessive presence of the theme of 'Specialisation'.

4.3.2. Demoting Specialisation

The interview participants demoted the status of specialist clinicians by referring to the theme of 'Breadth'. The following excerpt laments the uniformity of specialist practice. It is described as restrictive, mechanistic and limited. It is notable that the first excerpt is disparaging about interventional cardiology. These specialists are typically understood to have high professional status.

I don't want to be an interventional cardiologist because the thought of spending all day whamming needles in people, a trained monkey could do that!

(Consultant Acute Physician)

Furthermore, the specialist is described as having limited diagnostic abilities. They see patients that have been pre-selected through successive stages of referral, and as such, patients are presented 'on a plate' to specialists. The following excerpts are

interesting because they mock the specialists for not knowing what a 'normal patient' looks like. They are also reliant upon the diagnostic skills of other clinicians. They simply wouldn't have the skills to sift through an undifferentiated group of patients. Arguably, the clinical risk associated with a group of undifferentiated patients may be much higher than a patient that has been passed through a referral chain. The undifferentiated patient has yet to be diagnosed; the nature of their malady and acuity of their condition is unknown. The desire to work at the front door of a general hospital is almost presented as a badge of pride.

I wanted to work in a [general hospital], does that mean you are better than these [...] specialists who are sitting in an ivory tower, who haven't seen [...] a normal patient for years? They have just [...] gone up that referral pattern and they are seeing someone with rhubarb disease and that's the only thing they see.

(Consultant Acute Physician)

In a tertiary centre, a lot of the work would have already been pre-selected as being up your alley by somebody else.

(Consultant Respiratory Physician)

These reflections paint specialists as disinterested in the wider functioning of the hospital or healthcare system. There are portrayed as having a more transactional outlook. They are in many ways self-limiting. These characteristics may contribute to a diminishment of their professional status.

* * *

In summary, the theme of 'Breadth' was expressed in two ways: Firstly, the promotion of breadth in clinical practice, and an emphasis on the different skills and characteristics of doctors working in these fields. Secondly, the demotion of the contribution from specialist roles.

4.4. Emergency

The interview participants made reference to the theme of 'Emergency'. These references came in two different forms: the balancing of 'Life and Death', and the nature of 'Emergency and Acute' practice.

4.4.1. Life & Death

Firstly, a number of references were made to the inherent risks associated with surgery and anaesthesia. There is a recognition that surgery could have unintended consequences. It is also acknowledged that surgical interventions, especially if they are performed on an emergency basis, are designed to save lives.

Some of it […] is old fashioned, […] Aortic aneurism repair, that ruptures you're dead. […] Superman. I save lives.

(Chief Executive Officer)

Anaesthetics is unique because you're doing things to somebody which puts their life at risk, every time you give an anaesthetic. […] Every patient, potentially, you could kill.

(Consultant Anaesthetist)

Moreover, the nature of a surgical intervention requires a particular mind-set. Surgeons are described as 'arrogant' and 'accepting of risk'. The implication being that not everyone is cut out to be a surgeon. It takes a special kind of character to perform the feats that they do. The descriptions offered by the interview participants border on the heroic.

Brain surgeons and heart surgeons are arrogant […] because they deal with life and not life (sic) of their patients on a regular basis. And if you wouldn't be arrogant then you wouldn't dare to do this type of surgery.

(Consultant Orthopaedic Surgeon)

Because you are doing procedures that [...] have a risk and have complications associated with them, [...] on the whole, people who have gone into GI surgery [...] accept risk in what they do.

(Consultant Upper GI Surgeon)

The references to inherent risk are not restricted to surgeons. Indeed, a number of descriptions are offered about the important role performed by consultants in intensive care medicine. These descriptions emphasise the fact that they deal with the sickest patients in the hospital, and the decision often rests with them as to whether or not to withdraw treatment from a patient and let them die. In some of the descriptions this aspect of their role verges on a god complex. The emphasis in the following two excerpts is that the agency of the intensive care doctors determines whether or not a patient lives or dies.

You're going to be dealing with the sickest people in the hospital. And usually intensivists are slightly maverick. [...] They're going to take more chances because you know how sick somebody can be before they die. Whereas if you're a general anaesthetist, you don't want to kill people, you just want to keep the status quo, you want to keep homeostasis and you want everybody to get better.

(Consultant in Intensive Care Medicine)

I think of some of my [intensive care medicine] colleagues, the big machismo, the big 'I am' and doing the ward round. [...] 'Yes, that one is going to die [...] turn that off.'

(Consultant in Intensive Care Medicine)

The consultants in intensive care medicine are critical about their consultant colleagues, working in other disciplines, because of their reluctance to make these decisions about when is the right time to not intervene and let patients die. The other consultants are portrayed as referring the difficult decisions to the intensive care consultants. They are deriving status from their willingness to make the tough decisions; to be the ones with whom the buck stops. They also describe themselves as the team that their consultant colleagues look to when something has gone wrong. Their status is informed by their clinical authority.

4.4.2.   Emergency & Acute

There were a number of references related to the nature of working in emergency and acute care. These focussed on the virtues of working with emergency services – the rapidity of diagnosis and treatment. The interview participants talked about the banality of working in a non-emergency / non-acute environment. The agency of the consultant is presented as diminished because not much happens quickly, if at all. The excerpts below make a recurring reference to impotence; to be faced with a patient that they cannot cure or treat in a meaningful way. There is an association between emergency care and a bias for action in a number of clinical specialties. This has an important bearing on the construction of these doctors' professional status.

Emergency doctors are more focused, and the attention span probably is short-lived. [...] When I did medical specialty for six months and I had to go to the wards to see the same patients every day 'how is your belly ache? Did you open your bowels? How do you feel, better?' [...] Every day the same questions, the same patients. [...] I found it a bit boring.

(Consultant in Emergency Medicine)

I would rather be in A&E. I see the patient, I treat the patient, I may or may not see the patient again, so I don't have to see the same patient continuously complaining about the same thing. [...] It's the possibility to sort them out quickly. [...] When you see the patient improving in front of your eyes and you can help somebody. [...] It's nice when you see you can close a wound.

(Consultant in Emergency Medicine)

[Surgeons] like a quick answer. [...] Particularly with emergencies. There is nothing better than when someone comes in, you say right, you have got appendicitis, we will do this, and you will be home tomorrow. [...] The surgical mentality generally is probably a bit more impatient for a diagnosis than the medical mentality. [...] Our most challenging patients [...] are the ones who come in and have got pain and you investigate, and you cannot find a cause for the pain. Because that doesn't fit comfortably with us in terms of 'yes, I want you in a box and I can do this to you.'

(Consultant Upper GI Surgeon)

Most people go into medicine chasing the Holy Grail, which is the acutely ill young adult with the mono-pathology. […] They can spend their whole careers chasing that opportunity to make a difference to someone's life due to their skills and experience. And the reality is that they are multi-pathology care of the elderly.

(Consultant Ophthalmologist)

These excerpts highlight the curative nature of emergency treatment. A patient that attends the emergency department with a wound can be sutured; a patient with an appendicitis can have an appendectomy. It is more difficult to discern the agency of a consultant in the case of a patient that is admitted with 'acopia' – an inability to function in their home environment because of social or psychological reasons. The immediacy and impact of emergency care is, therefore, an important component in the construction of professional status. The last excerpt is interesting because it suggests that there is a disconnect between the desire of a doctor to construct their status on the basis of their specialist skills, and the harsh reality that most patients are increasingly elderly and infirm. The scope to cure or even just to treat the patient is diminished.

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In summary, the theme of emergency was expressed in terms of life and death situations and working in an emergency or acute environment. In situations where a doctor holds a patient's life in their hands, they are providing a clear demonstration of their agency and the power of the medical profession. This is akin to a god-like status over the lives of their patients. An emergency or acute working environment provides the doctor with opportunities for rapid, active treatment of patients. This affords the practitioner with personal gratification, because of the scope to provide curative or ameliorative effect that they have in delivering care for their patients.

4.5. Lifestyle

The interview participants referred to the theme of 'Lifestyle' primarily in terms of finding the right work-life balance. This subject was associated with an individual's choice of medical specialty and the organisational context where they work. This choice has an important bearing on how a doctor constructs professional status based on lifestyle choices. These choices can take a positive and negative form. They can be an active choice for something (e.g. family) or a reaction to something (e.g. working hours). The following sections with firstly explore how choice of 'Work-Life Balance' informs the construction of professional status.

4.5.1. Work-Life Balance

The following two excerpts concern the active lifestyle choice to train as a GP. The first excerpt is from a GP who unapologetically frames this choice as a conscious decision to accommodate family life. However, the second excerpt, from a hospital consultant, is more barbed; the choice is framed as being for individuals that have 'different ambitions and priorities in life'. This may infer that individuals who make their work subordinate to other priorities serve to diminish the importance of their work. Moreover, they suggest that the individual choosing a career in general practice is seeking a comfortable career, they 'like being on holiday a lot', and, are content to not excel, and have less ambition and drive.

I did not like the hospital culture. […] You had to work the long hours and […] I wanted to get married and have kids. […] A lot of it was lifestyle.

(General Practitioner)

GPs […] may have different ambitions and priorities in life. They've got a good job, [...] but they like being on holiday a lot.

(Consultant Cardiologist)

The following two excerpts frame the choice of career as a reaction to the conditions of the working environment. The first excerpt describes the working conditions of anaesthesia, and the second excerpt describes the working conditions in emergency

medicine. The former is described by a consultant in intensive care medicine as 'nice', 'sociable', 'planned', and witheringly, 'quite light'. The working conditions of anaesthesia are qualitatively different to intensive care medicine. The consultant in intensive care medicine constructs professional status with reference to anaesthesia – the intensive care doctors are cut out to work in a much more demanding field of practice.

The second excerpt indicates that there is difficulty attracting doctors to train in emergency medicine because of their antisocial working pattern. Emergency medicine's unattractiveness may be partly explained with reference to its working pattern. However, the consultant in intensive care medicine derives their professional status partly from the demands of a comparably heavy working conditions. These divergent conceptions underline the extent to which professional status is interpreted and socially constructed.

Anaesthesia has always been […] quite a nice job, […] fairly sociable hours and […] you've got a very planned day, […] you're in a nice environment, you're working in a team. […] It's quite light.

(Consultant in Intensive Care Medicine)

Why aren't people […] picking emergency medicine. […] Well, they work shifts, they work weekends.

(Chief Executive Officer)

The conditions of the working environment were also considered in relation to on-call duties i.e. a requirement to work outside normal working hours, when they could be called back to the hospital in an unplanned manner. The following three excerpts refer to the demands of the on-call rotas – how frequently the doctors have to perform on-call duties, how onerous it is to work on these rotas, and how frequently are the doctors called back to the hospital whilst on-call. The first excerpt is from a consultant ENT surgeon who describes the consultants working on the cardiothoracic rota as 'up all night', 'stroppy' and 'miserable'. In comparison, ENT surgeons are described as 'upbeat' 'chilled' and 'relaxed'. The presence of an onerous on-call rota can be interpreted as having a negative impact upon the professional status of a specialty.

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ENT surgeons tend to be more upbeat and relaxed, not so stroppy as others. […] If you're a cardiothoracic surgeon, up all night, you're just going to be miserable. […] We are a little bit more chilled out. [...] You still got like pain of being on-call and not being able to go out or be close to the hospital […] but we don't get called in very often. […] That makes a big difference because it is a good lifestyle choice.

(Consultant ENT Surgeon)

The following excerpts describe how the presence of either an onerous or frequent on-call has a negative impact on the attractiveness of the specialty. For instance, the ability to find a specialist role working within a medical specialty, but without on-call duties provides the doctor the positive characteristics associated with becoming a hospital specialist, but without the 'grim', negative characteristics attributable to poor work-life balance. Furthermore, the conscious decision to choose a career in a speciality like radiology is partly explained by the low frequency, less onerous on-call (NB. one in twenty-eight means twenty-eight people on the rota sharing the duties). The status of a specialty is understood as relating to how hard they work. However, this can have a positive or negative impact on professional status depending on whether the on-call duties are too onerous or frequent.

The popular specialities […] are things like oncology and palliative care […] where you do medicine but you're not on-call; just because the on-call is so grim.

(Consultant Diabetologist)

You don't go into radiology to do a one in six on-call, you go into radiology because you […] do one in twenty-eight […] and I can do it from home. […] People don't go into radiology to be up in the middle of the night.

(Consultant Vascular Surgeon)

Finally, lifestyle was described as having a formative influence on the choice of organisational context where a doctor works. This is described as a challenge to the conventional wisdom that the most capable doctors will choose to work in a teaching hospital. The following three excerpts reflect a similar sentiment that the teaching

hospital requires a doctor to work too hard and to the exclusion of other priorities such as: family, material gain through private practice, or simply sufficient leisure to pursue other outside interests.

The traditional, if you are really good, you stay with teaching hospitals, has gone, because some people are taking the lifestyle choice, saying 'god, I don't want any of that, it's a load of nonsense.'

(Consultant Colorectal Surgeon)

I had the choice which job to take. […] Starting up a service was much more attractive, still offered me some quality-of-life in a wealthy area, rather than being in a tertiary centre working my butt off and being up through the night for the extra kudos.

(Consultant Cardiologist)

I enjoyed working in a [teaching hospital] but it was not sustainable for me. […] There is a balance […] in terms of what you can do with your family, with your extra time, or even private practice.

(Consultant Orthopaedic Surgeon)

These excerpts suggest that there may be more than one way to achieve status within an organisational context – one interpretation would be to work at a teaching hospital and to work one's 'butt off' for the 'extra kudos'. In contrast, it is possible to attain status, whilst maintaining a work-life balance, by using the greater leisure and freedoms afforded to a doctor in a general hospital.

* * *

In summary, the theme of 'Lifestyle' was expressed in relation to the choice of 'Work-Life Balance' determining the specialism and organisational locus where a doctor works. This was expressed as an active choice of specialty, working patterns and intensity. It was noted that there is a generational shift in norms and expectations regarding the balancing of work and family life.

4.6. Technology

The interview participants articulated the theme of 'Technology' as having an important role to play in their construction of professional status. The theme of 'Technology' can be sub-divided into three sub-categories: as a 'Commodity to Acquire', as a 'Tool to Wield' and as an 'Shaper of Practice'. These sub-categories were identified during the thematic coding of the data.

'Commodity to Acquire' refers to the intrinsic value of technology in providing an object to inform shared identity, and to signal the degree to which their practice is specialised and set apart from other groups. 'Tool to Wield' refers to the utility of technology in a doctor's clinical practice. In particular, how sophisticated technology has enhanced the clarity, precision and capability of their interventions. 'Shaper of Practice' refers to the capacity of technology to transform the mode and efficacy of clinical practice. The following sections explore each of the three sub-categories in more detail.

4.6.1. Commodity to Acquire

Firstly, there were a number of reflections that suggested that technology was a commodity to be valued *per se*. It is used as an object to help construct a sense of collective identity for a group of consultants working within a particular specialty or sub-specialty; it is used to set them apart from other groups. It is used to emphasise the specialist nature of their clinical practice. The following two excerpts provide a good representation of these interpretations.

[In intensive care] there's lots of clever gadgets and gizmos. […] Some surgeons in particular come in and […] they're a bit rabbit in the headlights.

(Consultant in Intensive Care Medicine)

Dermatology, what's out there, a few ointments, […] it's not very technical.

(Consultant Cardiologist)

It should be noted that the two participants regularly interact with a considerable amount of technology in their clinical practice. The first excerpt suggests that technology is an object that can be exclusive, and therefore be sufficiently mysterious to intimidate the uninitiated. The second excerpt focuses on the other end of the spectrum and describes the specialty, characterised by an absence of technology, in derogatory terms.

According to Thye (2000), who considered the nexus between status and power, exchangeable objects controlled by high-status actors are perceived to be more valuable when relevant to positive status characteristics; this confers power to high-status actors in the relations with low-status actors, because they are consequently chosen as the preferred exchange partner. Furthermore, high-status actors, because of this power differential, are able to obtain the greatest share of resources.

4.6.2.   Tool to Wield

There were many reflections about technology as a tool to be wielded. These reflections took a number of different forms: precision, clarity, interventional approach and invasiveness of intervention. For instance, the interview participants that often use sophisticated technology in their practice, emphasised the precision of their interventions. The following excerpt describes the approach by a consultant cardiologist to an arrhythmia (irregular heartbeat) that can be isolated to a particular part of the heart and treated by ablation (surgical removal of body tissue), cardioversion (shocking of the heart back into rhythm), or a cardiac device (an implantable pacemaker with the facility to shock a patient). This is juxtaposed with the approach of a consultant practicing general medicine to a patient presenting with shortness of breath. Their approach could be described as 'spraying and praying' – to offer the patient a non-specific treatment in the hope that it will improve their symptoms.

Dealing in arrhythmia […] you can pin down the nature of the problem, it is within this part of the heart, and there is a way of treating it, by ablation, or cardioversion, or a device, within general medicine, you present with shortness of breath, and you figure it

that the chest x-ray is abnormal, but then isn't that much precision, it could be an infection, but it could be respiratory failure […] we will give you some antibiotics. It is more general, it is not as focused.

(Consultant Cardiologist)

The precision of these interventions also enhances the scrutiny from peers, patients and in some circumstances the wider public. This is qualitatively different to the administration of some general or non-specific remedy. For instance, the outcome of surgical procedures will be recorded, and a growing number of surgical specialties publish their surgical outcomes publicly. Given the number of competing variables, it would be hard to provide a similar account of whether or not an antibiotic has worked for a patient that may or may not have had a chest infection. The following two excerpts describe the sense of scrutiny felt by consultants that undertake surgical or semi-surgical procedures.

A lot of it is to do with the precision of what you do and knowing that you are going to be scrutinised, […] each procedure I do is recorded, I can be tracked down, […] if you treat a chest infection with antibiotic A or B it might work, it might not work.

(Consultant Cardiologist)

As soon as you've become a consultant you know absolutely where you are nationally against the cataract service standard. You know if you're average, above average or below average. […] You know which centile you're in.

(Consultant Ophthalmologist)

A related theme to precision is the clarity of the procedure. The following excerpt describes what first attracted the participant to their chosen specialty of ophthalmology. They characterise their first interaction with the specialty as stepping from the dark into the 'light'. The ophthalmologists were open and welcoming to them as a medical student; the use of a slit lamp (an instrument that combines a focussed light source and microscope used to examine the eye) transported them from the vagaries of general medicine to the clarity of diagnosis and intervention in ophthalmology. Moreover, the nature of an intervention, such as cataract surgery, was more often than not curative or symptom alleviating.

Everywhere you went as a medical student, everyone hated you, you were never welcome [...] And then, […] it was a sunny day and we entered into this ward where the light was streaming in. […] Everyone looked really happy. […] And they said, 'Oh, great to see you' and a guy grabbed me and said, 'Come and look at this', sat me down in front of a slit lamp and said, 'have a look at that corneal ulcer.' And, this is against a backdrop of previously throughout my medical/clinical career people said, 'listen to this murmur', I heard nothing; or 'feel this crepitus', I'd see nothing; 'look at this extraordinary rash', the patient was just a massive blob and I had no idea. And then suddenly I looked down in this microscope, there was this cornea and in massive detail there was this ulcer, exquisite view, I was like 'oh, what do you guys do?' 'oh, eye surgery.' […] They said, 'oh yes, we do this operation in particular', which was cataracts. 'And is that successful?' 'Oh yes, nearly all the time.'

(Consultant Ophthalmologist)

The key propositions related to the theme of 'clarity' can be summarised as follows:

- To be able to determine what is wrong
- To be able to determine what needs to be done
- To be able to administer what needs to be done
- To have been likely to have done some good

If a doctor is unable to make a clear diagnosis, then it would be impossible to be able to determine definitively what needs to be done. The alternative would be to prescribe treatment and hope for the best. Assuming that a doctor has clarity of diagnosis, there also needs to be a determination of what needs to be done. It is conceivable that a doctor could make a diagnosis without knowing what to administer as treatment.

The greatest status can be constructed from being able to diagnose the problem, determine the remedy and to be able to administer this treatment. The alternative may be to defer to another specialist to perform the treatment. Finally, it is important that there is clarity of outcome and that it has been positive. If the outcome is not positive, then it may be argued that the diagnosis and determination of what needs to be done were made in error.

The interview participants also suggested that the nature of their treatment or intervention had a bearing on professional status. This interventional approach should involve the minimum amount of damage to the patient. Most forms of surgery or procedures involve some degree of trauma to the human body i.e. cutting into the body or performing a procedure that is invasive or alien to the patient.

The following excerpt is provided by a consultant urologist. It is interesting that the interventional approach that has been advocated isn't a surgical procedure. There isn't necessarily a correlation between the ability to perform surgical procedures and professional status. Rather, the interview participant emphasises the importance of finding better, more innovative ways to alleviate symptoms. The doctor describes how urologists have explored alternatives to surgery including drugs, psychological therapies, laser treatments, cryotherapy (freezing) and radio frequency ablation (shock waves) to break down and remove tissue. The abiding impression left by the doctor is that the approach is patient-centric. The professional status of the doctor is constructed on the basis that they continue to innovate in the best interests of their patients.

If somebody presents to me with […] bladder outlet obstruction, […] at the beginning of my career twenty-five years ago, most men would have an operation. We've seen a huge shift away from standard operations […] to drug therapy, […] behavioural therapy as well. […] The surgical intervention hasn't been accepted as the gold standard, we've moved on from that through lasers, which has been successful, things like cryotherapy, radio frequency ablation, which haven't been successful, but at least the speciality has tried, thinking how could we make this less invasive, how can we make this better for patients.

(Consultant Urologist)

The traditional approach to surgery is an 'open' surgical procedure. This involves making a large incision to access the area of interest. For instance, a laparotomy is performed by making a large incision in a patient's abdominal wall to gain access to the abdominal cavity. This procedure may be performed in response to some kind of trauma e.g. internal bleeding. It is reserved for situations where there is no

alternative e.g. exploratory procedures for unknown pain or for life-saving emergency surgery. The preferred approach for planned surgery is a laparoscopy (also known as 'keyhole' surgery). This is a form of minimally invasive surgery in which a light source and instruments are inserted into the patient's abdomen through small incisions. The use of laparoscopy is preferred because it limits the damage to a patient's body with better outcomes and fewer complications (minimal trauma, reduced pain, shorter length of hospitalisation). The introduction of minimally invasive surgery occurred in the late 1980s and 1990s.

The use of minimally invasive approaches for gall bladder, spleen and appendix surgery have now become routine practice (Gawande, 2012). However, new forms of minimally invasive surgery continue to be developed together with refinements of the existing tools and techniques. There are a number of key points to note regarding the association between interventional approach and professional status:

- Any form of minimally invasive surgery introduces additional technical difficulty for the surgeon e.g. the lack of direct or unaided vision into the body cavity.

- Where the use of minimally invasive approaches has not yet become routine practice, there are situations where a surgeon's preference will dictate whether an open or minimally invasive procedure is performed.

- The development of minimally invasive approaches provides an opportunity for surgeons to blaze a trail at the frontiers of what is technically possible. These approaches offer the possibility to be set apart in terms of their clinical practice. There is an acknowledged pressure to adapt and develop practice.

- There is a movement called Natural Orifice Transluminal Endoscopic Surgery (NOTES) which aims to produce scar-free surgery by passing instrumentation through the body's natural orifices such as the mouth, nose, urethra and anus, rather than through the belly, bladder etc. The aim of this surgery is to produce scar-free surgery for aesthetic purposes, but it does present additional technical difficulties for the surgeon. A related approach is single-port

laparoscopy whereby a surgeon performs the procedure through a single incision, typically the patient's navel (i.e. as opposed to separate ports for the camera and instrumentation). Again, this introduces an additional technical challenge for the surgeon – further material to inform their construction of professional status.

- It would have taken a certain mind-set to perform these procedures in the early stages of their development. It is a matter of perspective as to whether this represents maverick behaviour or self-belief. In the early stages of development, the use of an 'open' procedure may have had equivalent or even better outcomes. It should also be noted that for every innovation that has entered routinised practice, there would have been other techniques that have fallen by the wayside.

There were a number of references made by the interview participants to the invasiveness of intervention. This refers to the ability to reach the hard to reach places in a patient's body and not kill them! In past decades, there have been incredible advances in technology and clinical practice that have allowed doctors to perform feats that would have previously been seen as unfathomable. It is instructive that routine surgery is now performed on the heart and brain which would have been considered far too risky a generation or two ago. The following excepts indicate that there is kudos associated with the ability of doctors to undertake invasive interventional procedures.

If you do interventions you feel somehow more superior, I would imagine a gastroenterologist feels superior to a respiratory physician. […] I'm sure the cardiologists feel superior to the elderly care physicians.

(Consultant Colorectal Surgeon)

It is interesting that the medical specialties that are increasingly undertaking 'semi-surgical' procedures are regarded as having a higher professional status (i.e. cardiologists and gastroenterologists). In the following excerpt, the interview participant appeals to the semi-surgical aspects of cardiology in describing the specialty's relative status in comparison with other medical specialties. Being

considered a doctor working for a 'bog standard' medical specialty suddenly becomes *infra dig*. The second excerpt refers to the differences between stroke medicine and cardiology; both specialties deal with treating the harm caused to patients by blood clots – the former still relies on thrombolysis (clot busting drugs) as its primary strategy, whereas cardiology has developed sophisticated methods to clear a clot from the heart using a balloon catheter device.

Cardiology is no longer perceived as a medical specialty because it is so interventional.

(Consultant Cardiologist)

[Stroke] thrombolysis, which is what we used to do twenty years ago in cardiology. [...] You come in with a stroke, you get a blood thinner, it might work, it might not work.

(Consultant Cardiologist)

It is interesting that these semi-surgical medical specialties seem to be setting themselves as a breed apart from other medical specialties. The development of these technologies is having a disruptive effect on the nature of clinical practice, the jurisdiction between different clinical specialties and the allocation of resources between different professional groups. There is no cheap or easy way of accessing the dark recesses of someone's internal organs without sophisticated medical imaging, medical devices and support from a highly specialised multi-disciplinary team.

4.6.3.   Shaper of Practice

Finally, technology is a shaper of clinical practice. This means that it has the capacity to transform the mode and efficacy of clinical practice. For instance, it informs an active rather than passive orientation (i.e. it enables the practitioner to intervene), it enhances the capacity of the intervention to the curative (i.e. it can resolve the patient's symptoms), and it is a demonstration of the progressive nature of a doctor's clinical practice.

The following excerpts relate to how technology informs an active rather than passive orientation. The excerpts demonstrate a bias towards surgical or semi-surgical specialties rather than outpatient-based medical specialties. Surgery is described as being 'more active' and 'practical'. On the other hand, medicine is portrayed in derogatory terms as 'too much thinking', 'really dull' and 'quite boring'. For these interview participants, the active orientation of their practice is used to construct their professional status.

[Surgery] just feels a bit more active. [Medicine] is too much thinking all the time.

(Consultant Orthopaedic Surgeon)

I went on medical house jobs and I thought it was really dull, and […] thinking well I need to be a surgeon, because medicine is really quite boring.

(Consultant ENT Surgeon)

Neurologists, they have so few interventions. […] They have to be turned on by thinking, whereas actually most cardiologists don't think at all. […] Most cardiologists are just very practical.

(Consultant Cardiologist)

A related theme to the active orientation of a doctor's practice is whether there is a curative nature to their intervention. The curative element of their practice serves as an affirmation of their skills and provides the practitioner with instant gratification. The following excerpts are from consultant cardiologists describing the curative nature of the treatments that they offer:

The reason cardiology is very attractive is that you do things to people and they get better. […] In very intellectual specialties like neurology […] how much can you do for people? You can give them pills, but actually most of them you can't make any better.

(Consultant Cardiologist)

You come in with a heart attack, you go straight to the lab, that's the artery, […] you open it up, you've cured it, so it's instant gratification for you as an operator, and it is instant treatment for the patient. […] That attaches kudos to what you do.

(Consultant Cardiologist)

It's boys with toys. […] You do things to people, and they get better […] they're really grateful.

(Consultant Cardiologist)

Finally, the progressive nature of clinical practice has a bearing on how professional status is constructed. These reflections concern the efficiency of processes and effective use of resources. They also focus on the presence of innovation and evidence a problem-solving mind-set. These reflections are very much about being the best that you can be.

The increased demand within the resource envelope has meant that we've had to industrialise our processes. […] We're the best unit in the country.

(Consultant Ophthalmologist)

I actually saw urology as very much a frontier speciality. […] Moving away from all the standard procedures that you read about in the standard text books. […] Whereas in urology what I found is a much more open view, saying this is our problem, is there any other way of dealing with this?

(Consultant Urologist)

Urologists tend to be […] geeky. We like kit, we like technology. […] We're always looking at what other people are doing to see how is that going to help us in our practice. […] If you're thinking in terms of somebody in life outside medicine, who was equivalent, maybe a mechanical engineer, […] a fiddler, a potterer.

(Consultant Urologist)

The following excerpt is a salutary reminder of the risks to an individual's professional status concerning the progressive nature of clinical practice. As already mentioned, the pursuit of new ways of working or new tools and techniques requires

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a certain mind-set and risk appetite. Sometimes the risk taking required to push the frontiers of a specialty doesn't pay off. This can have a catastrophic impact on the professional status of a doctor. The excerpt refers to a surgeon developing a new technique, which looked like it had the potential to improve patient care, based on the available evidence at the time.

Unfortunately, this technology did not work as intended, and it has actually caused harm to patients because they have required repeat procedures to rectify the failed initial procedure. This inadvertent harm to patients has resulted in a significant loss of status for the individual as their practice cannot be construed as effective or progressive. There is a degree of pity offered by the interview participant – an acknowledgment that anyone can back the wrong horse in pursuit of progressive practice.

And poor [surgeon] decided at one point he was going to be the surgeon who'd do the biggest ever series of [type of procedure] and he was going to write it up and that was going to make his reputation for being the […] most experienced surgeon with [this type of procedure], which of course was going to be the best ever. So, he has the largest series of [repeat operations] ever in history of [specialty]. He's cocked up […] by backing the wrong horse he inadvertently chose badly for his patients. […] He bears the weight of it. […] He did not make this decision without thinking about it or based on anything other than best evidence at the time.

(Consultant Ophthalmologist)

There is a suggestion that emergent technologies represent a high stakes gamble. If successful, there is considerable scope to increase a doctor's status. However, if the technology back fires, there can be disastrous implications for their status and their standing with their peers.

*   *   *

In summary, the theme of technology plays an important part in a doctor's construction of professional status. This was expressed by the interview participants in one of three ways: technology as a 'Commodity to Acquire', as 'Tool to Wield', and as a 'Shaper of Practice'. As a commodity it represents the degree of a doctor's

sophistication in the delivery of their clinical practice. As a tool it enhances the clarity and precision of practice, and the extent to which the practitioner can reach the otherwise impossible to reach places of the body, with minimal damage caused to the patient. As a shaper of practice, it speaks volumes about the curative, active and progressive orientation of a doctor's practice.

4.7. Craft

There were relatively few reflections concerning the theme of 'Craft'. However, the reflections contained in the interview transcripts still provide a useful insight into how professional status is constructed. These reflections centred upon appeals to the core identity of doctors as craft practitioners. This was especially true of the interview participants that were surgeons. However, physicians were also keen to emphasise that medicine was often as much of an art as a science. The object of concern for the physicians wasn't the supplanting of the role of the surgeon with technology, but the encroachment of 'cookbook medicine' diminishing the interpretive role of the practitioner (Genuis & Genuis, 2004).

4.7.1. Appeal to Core Identity

There is the age-old distinction between the bookish physician, who from the beginning of the 18th century was distinguished as a gentleman with a university education that dealt with internal diseases, and the uneducated surgeon, heralding from the barber-surgeon class, who derived their income from shaving, cutting hair and drawing teeth, and who used the tools of their trade to undertake surgical procedures (Duffin, 2000: 224; Zetka, 2001). Although these caricatures are woefully unrepresentative of the modern-day medical profession, the contention that physicians and surgeons are different breeds still persists; note the continued use of the salutation 'Mr' or 'Miss' / 'Mrs' / 'Ms' for a surgeon (Loudon, 2000).

In the following excerpt, an interviewee considers the difference between physicians and surgeons. The implication of their remarks is that a surgeon couldn't think of anything worse than becoming a physician. The ability to use their hands, and to perform their craft, has a clear bearing on their sense of identity and self-worth. The trade-craft of a surgeon is represented as far superior to that of a physician.

Surgeons […] consider themselves luckier than medics. […] We are aware we couldn't be medics. […] If a surgeon lost the ability to use his hands, the question is then, could he retrain to be […] a physician? No, […] most of us would rather […] become dustbin

A doctor's core identity as a craft practitioner may be under threat from the growing technical sophistication of medicine. The result may be to supplant the role of the doctor in performing certain tasks. This may have a profound impact on the craft aspect of their practice, and hence their identity and professional status of the practitioner. For instance, there is a growing interest in the application of artificial intelligence (AI) to radiology (Saurabh & Topol, 2016). Computer algorithms are being developed to interpret x-ray images that typically require interpretation by a senior doctor.

There is no suggestion that the introduction of AI will result in fewer radiologists, at least in the short term. It is likely that they will develop new fields of clinical practice as routinised practices are picked up by computers. According to Abbott (1991), expertise can be embodied in commodities such as machines. However, commodification has never killed professions; it reshapes, but it does not remove. Therefore, the introduction of this technology will stimulate a need to reconstruct professional role identities and their respective professional status.

The following excerpt plays down the threat posed to professional role identities associated with the introduction of sophisticated technologies – in this case the use of a laser in ophthalmic surgery. The technology is presented as no better than conventional surgery performed by a trained, competent surgeon. Although the laser doesn't have the training lag required to school a doctor to perform this surgery, there will always be technical steps that will be beyond the reach of a machine. There is no substitution for the surgeon's hands.

We can actually do some […] surgery using a laser, but it's slower, more costly. […] If a surgeon can do [the surgery] after several years of training, they are as good as the laser and faster. But the laser can do it on day one. […] The laser will never do the whole operation.

(Consultant Ophthalmologist)

A more profound threat to the role identity of surgeons is the emergence of robotic surgery. Surgeons' skills are increasingly being mediated through some form of technology. The palpable nature of traditional surgery, with the wielding of a scalpel, the cutting into a patient's body and the feel of their tissues and organs, is being replaced, in part, my minimally invasive techniques. For instance, in laparoscopic (keyhole) procedures a surgeon manipulates the patient's anatomy indirectly with instruments passed though incisions in their body – sometimes referred to as 'chopsticks'. The surgical robot, referred to by its proprietary name, the 'da Vinci Surgical System', represents the apotheosis of this process. Figure 4 provides a representation of these comparative surgical approaches.

Laparotomy (open surgery)
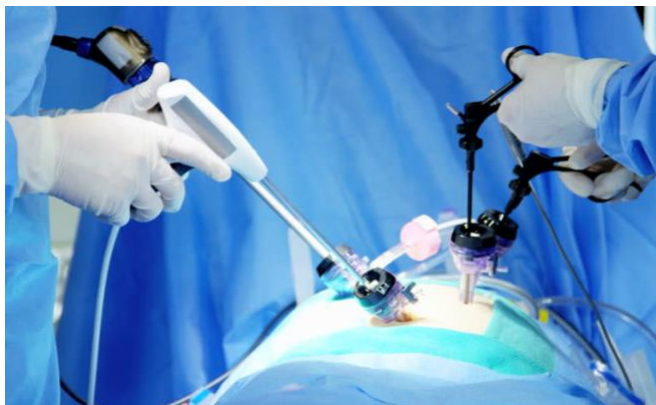
Laparoscopy (keyhole surgery)

Robotic (da Vinci Surgical System)

The emergence of robotic surgery and the growing technological sophistication of the field is challenging some of the traditional ways of working. This has had a significant impact on the relationship between the surgeon, their craft, and the patient. However, the following excerpt is interesting because it indicates how technological objects can be used in the construction of divergent conceptions of professional status.

I can't for the life of me think of a reason why anybody would buy a robot. […] They cost millions. […] I am not aware of the evidence being so compelling.

(Consultant Respiratory Physician)

For some, the use of technology is an expression of their technical sophistication. For others, technology will always be secondary to the craft skills of the practitioner. In some cases, the technology is seen as a wasteful indulgence.

*   *   *

In summary, some of the interview participants referenced the theme of 'Craft' in their construction of professional status. The growing technological sophistication of medicine poses a threat to doctors' professional role identities, and their construction of professional status resting on their skills as a craft practitioner. In response, to this growing technological sophistication, there is evidence that some doctors make an appeal to their core identity as a practitioner, playing down the role of technology and emphasising the importance of their craft skills. For instance, the technology was be portrayed as wasteful, inferior, or no substitute for a surgeon's hands.

4.8. Material Value

The interview participants articulated the theme of 'Material Value' as having an important role to play in their construction of professional status. The theme of 'Material Value' can be sub-divided into three sub-categories: 'Value of Resources', 'Monetary Value' and 'Imputed Value of Organs / Patients'. These sub-categories were identified during the thematic coding of the data. 'Value of Resources' refers to the cost of equipment and facilitates associated with a doctor's practice e.g. wards, theatres, equipment etc. 'Monetary Value' refers to the value of earnings that a doctor can enjoy in particular specialties. How much a doctor earns, and how much money they have got, was presented as a crude pecking order.

'Imputed Value of Organs / Patients' refers to the symbolic nature of some organs that are invested with particular significance e.g. brains and hearts. The socioeconomic standing of patients associated with a doctors practice are also presented as important signifiers of professional status. The following sections explore each of the three sub-categories in more detail.

4.8.1. Value of Resources

Firstly, there were references to the basic cost of equipment associated with doctors' clinical practice. This was particularly apparent in procedural specialties like cardiology that use costly equipment and clinical supplies to perform a procedure. The following excerpt using the word 'expensive' three times in a single sentence. The doctor concerned was very determined to emphasise the value of the resources supporting their clinical practice.

> *The equipment needed is expensive, we have got expensive equipment, you have got expensive companies providing it.*
>
> *(Consultant Cardiologist)*

The next excerpt provides further elaboration of this theme, albeit the reference to the value of resources is less pronounced. For this interviewee, it is the quantity and

scarcity of the resources that is more important. The bed base (i.e. the number of hospital beds that they have jurisdiction over) is a totemic expression of hierarchy.

The more beds you had, the more powerful you were, ergo the higher up the totem pole you were. […] More beds means you're busier, you're more in demand. […] The bigger the bed base you have, […] consultants in years gone by, that's how they […] measured their worth within the organisation. […] 'Well, I've got to manage three hundred beds'. […] An old-fashioned quantification of hierarchy.

(Divisional Director)

The control of hospital beds is described as a proxy for an individual's status within an organisation. Again, this points to divergent conceptions of professional status as doctors may just as easily pride themselves on their efficiency and ability to manage patients with a lower length of stay, allowing for a smaller bed base.

4.8.2. Monetary Value

Secondly, there were many references to the monetary value that can be attributed to an individual doctor or speciality. This earning potential is exemplified with the following excerpts. These express a straightforward relationship between status and how much a doctor can earn in their practice.

In many of the procedural specialties, what drives a lot of people's ambition is how much money they can make.

(Consultant Respiratory Physician)

What actually counts towards the specialty being ranked higher in terms of prestige is […] how much money you earn as a consultant.

(Consultant Cardiologist)

A massive one is money. […] Some specialities earn more than others and that influences status. […] While not everyone may like cosmetic plastic surgeons, they command respect because of what they earn.

(Consultant Ophthalmologist)

The above excerpts allude that there is a differential opportunity to generate earnings depending on a doctor's chosen specialty. The procedural based specialties are identified as having greater earning potential i.e. surgeons, gastroenterologists, cardiologists etc. However, the following excerpt provides an interesting reflection on the relative status of orthopaedic surgeons. Their earning power is high, however, in the eyes of many surgeons they have a lower professional status. This is attributed to their portrayal as 'people that chop a lot'. The connotations being of someone lacking in sophistication and finesse.

The interviewee states that it not just what you earn, but how you do it. The implication being that the training programme for an orthopaedic surgeon is less 'rigorous and difficult and long'. The rewards associated with orthopaedics is presented as unjust. Their level of earning is not related to the exceptional skills of the surgeon, but to something baser like the vagaries of the market, or simply, happenchance.

There will be some specialties in which you earn a lot of money and the prestige is higher. Having said that, orthopaedic surgeons tend not to be regarded […] particularly highly. They are looked at […] as people that chop a lot and yet they have quite high earnings relative to other consultants. […] It's not just about what you earn, it's how you do it. […] If your training is found to be rigorous and difficult and long, then […] that's seen as being a just reward.

(Consultant Cardiologist)

The interview participants provided evidence that they were rallying against what some regarded as unjust reward. The following excerpt neatly encapsulates these sentiments. The interviewee is suggesting that the differential rewards received by some doctors is incompatible with their own conception of professional status. The GP, who the doctor regards as being a lesser doctor, having undertaken less rigorous and demanding training, was receiving a greater wage than the hospital specialist.

I have had a consultant say, […] at that time GPs were paid more than hospital consultants, […] 'you know it's like paying fourth division footballers more than the

premier league. […] We have sat through all of these bloody exams and we are getting paid less than those people sitting on their arse.'

(Consultant Acute Physician)

These reflections would indicate that the higher paid a consultant, the better they should be and the harder they should work. The lower paid a consultant, the less capable and idler they become. This is a remarkably simple calculus.

4.8.3.   Imputed Value of Organs / Patients

Thirdly, the interview participants remarked upon the value placed upon symbolic organs and the consequential elevation of the status of medical specialties that are associated with these organs. The most frequent references were in relation to hearts and brains. The heart is associated with emotion, affection and love, and the brain with consciousness, knowledge and our sense of self. The implication being that the status of cardiologists, heart surgeons and neurosurgeons is greater by association with these symbolic organs.

Sauder (2005) offer an interactionist approach to the study of status. This approach focuses on the central importance of meaning, and how this meaning is invested and communicated through the use of status symbols. These symbols (i.e. hearts and brains) are observable markers of social position and provide a shared understanding of social stratification. According to Goffman (1951), status symbols are boundary makers integrating those within the same status category (i.e. heart surgeons or brain surgeons) while reifying the difference between those of different statuses.

The earning potential of specialists dealing with symbolic organs, as a consequence of patients being more worried about their hearts or brains, and therefore more willing to part with their cash, is the greater too. However, it is interesting that neurologists, as medical doctors of the brain, are absent from this list. This may indicate that the key is whether an individual is associated not only with a symbolic organ, but also with a procedural specialty.

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There is the glamour attached to cardiac surgery and neurosurgery. That will never change.

<div align="right">(Consultant Upper GI Surgeon)</div>

Does cardiology have more kudos and prestige? […] Yes, it does, because as a patient you are more worried about your heart, your brain.

<div align="right">(Consultant Cardiologist)</div>

The contention that cardiac surgeons and neurosurgeons should be regarded as having an elevated status was challenged by a couple of interviewees. The following excerpt is from a colorectal surgeon. The heart surgeons are maligned because they 'only do a couple of operations'. Furthermore, the interviewee displays a degree of envy about the indeterminacy of brain surgery; the specialty retains its 'mysticism'. On the other hand, the outcome of bowel surgery is far more determinable, and therefore, the surgeons are more susceptible to scrutiny. The implication may be that you need to be better at surgery given that there will be a broader appreciation of the quality of the outcome. There is a conscious acknowledgment that, nonetheless, brain surgeons would look down upon general surgeons. However, this does not mean that the bowel surgeon would subscribe to the same image of themselves.

There is a certain amount of kudos to […] cardiac surgery because it's the heart, even though they only do a couple of operations, and neurosurgery still has that element of mysticism. […] I did a bit of neurosurgery […] and the patients are eternally grateful, despite the fact they can't use one side of the body at the end of the operation, which I think the rest of us are slightly envious of, because […] if something goes wrong for us, we are criticised, whereas in brain surgery, you've done your best, and no one quite understands it, despite the fact you can spend your day digging around in junket, it's still got that kudos. […] As bowel surgeons, would they be critical and demeaning of us? Yes, probably. Would we somehow feel inferior to them? No, I don't think so.

<div align="right">(Consultant Colorectal Surgeon)</div>

Furthermore, there is evidence of a self-awareness of some surgeons that their specialty has little of the glamour of cardiac surgery or neurosurgery – there is no association with symbolic organs, and in some cases any organs at all. Vascular

surgery is a good example of a specialty that is not focussed on a particular organ. The following excerpt is from a vascular surgeon who describes themselves as a 'vulture' preying on people from lower socioeconomic groups that have a poor lifestyle and consequently vascular pathology. In this unflattering portrayal, the vascular surgeon is painting himself as a bottom-feeder relying on patients living in ignorance and poverty.

It's social strata that's the overriding impact upon healthcare. […] People at the lower end of the social spectrum just don't look after themselves. […] You go and work on a machine all day, it's having a couple of pints and a fag with a pie, […] you can't afford other bits and pieces. […] You watch your TV […] and that's where you get your enjoyment in life. […] Who's to blame? Blame me. […] I'm a vulture that picks off the vulnerable of society because I'm a vascular surgeon.

(Consultant Vascular Surgeon)

The above excerpt is undoubtedly unflattering, but it also may be inaccurate. Many vascular surgeons do have a healthy private income focussed on cosmetic procedures such a varicose vein removal. In a similar way to organs of symbolic value, patients are prepared to pay the market price for cosmetic procedures. However, there are no references in the interview material that would suggest that plastic surgeons are able to construct a high status beyond their earning potential. This may suggest that practicing on organs that have a symbolic or aesthetic quality may be necessary, but not sufficient, and that these must be paired with other qualities such as technical difficulty to maintain the construction of a doctor's professional status.

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The theme of 'Material Value' was described in three different ways: 'Value of the Resources', 'Monetary Value' and 'Imputed Value of Organs / Patients'. These themes were used in the construction of professional status. For instance, the 'Value of Resources' described the cost of equipment and facilities associated with a doctors practice. Furthermore, 'Monetary Value' was used to express the earning power and wealth of doctors / specialties. Finally, the 'Imputed Value of Organs /

Patients' was used to describe the symbolic value of certain organs and the socioeconomic standing of patients associated with a doctor's practice. The associated value of these organs and patients are thus reflected in the doctor's professional status.

4.9. Ethos

The interview participants articulated the theme of 'Ethos' as having an important role to play in their construction of professional status. The theme of 'Ethos' can be sub-divided into two sub-categories: 'Professional Ethos' and 'Public Service Ethos'. These sub-categories were identified during the thematic coding of the data. 'Professional Ethos' refers to the governing codes of behaviour and conduct of the profession. 'Public Service Ethos' refers to the governing purpose and motivation of professionals. The following sections explore each of the two sub-categories in more detail.

4.9.1. Professional Ethos

There were a variety of references to professional ethos. These included responses to perceived unethical behaviour pertaining to private practice. The first excerpt below relates to an inducement by a GP to a consultant geriatrician to extort money from patients for seeing them unnecessarily.

I've got a friend, […] he's a GP, he said 'oh, I've got lots of little old men that I could send to you, you could see them just to tell them that they're okay.' I said, 'why would I want to take money off them just to tell them they're okay.' That is just so wrong.

(Consultant Geriatrician)

The second excerpt relates to the perception of a respiratory physician that gastroenterologists have artificially created a demand for endoscopy meaning that the hospital has to pay them 'an awful lot of extra money' to undertake additional lists. In both these instances, the interviewee has demonstrated their disdain for these practices. The implication may be that the doctors that are behaving unprofessionally, and unethically, have forfeited their professional status.

There are specialties that contribute a lot of revenue to the hospital. […] They can be more demanding because they know that ultimately if the hospital doesn't permit them […] then the hospital will suffer. And that I think breeds a kind of arrogance. […]

Gastroenterologists have got most hospitals over a barrel because there is massive entirely manufactured increased demand through bowel cancer screening. […] Excess waits are penalised financially, so it becomes in hospitals' interest to pay gastroenterologists an awful lot of extra money to work extra sessions.

(Consultant Respiratory Physician)

The last excerpt is interesting because the implication is that the actions of the gastroenterologists, in manufacturing a demand, have increased the power that they have within the organisation vis-à-vis the hospital management. However, it is clear that the increase in relative power within the organisation is not the same thing as an increase in their intra-professional status. The following excerpts provide the obverse perspective, that acting professionally can increase one's professional status. The first excerpt states that the doctor will undertake additional clinics without expectation of payment. The needs of the patient are presented as the key consideration. This kind of selflessness is also reflected in the second excerpt. This states that decisions about recruitment of new consultant colleagues was based entirely on what was best for the department. This was achieved by recruiting the best, without any ignoble considerations concerning protecting one's own private practice.

If there's a big wait for my lung cancer patients, I'll just do an extra clinic and I wouldn't expect anyone to pay me.

(Consultant Respiratory Physician)

We are an extraordinarily lucky unit in the skills mix of our people. […] Whenever [consultant ophthalmologist] had the opportunity to recruit a colleague, he recruited the best. […] He never ever tried to recruit someone who wouldn't threaten his private practice.

(Consultant Ophthalmologist)

It is conceivable that a criterion, albeit unspoken, for the appointment of a new consultant colleague, may be the extent to which they threaten the earning power of other colleagues. New consultant colleagues may only be appointed if they do not

pose a disruptive threat to the referral patterns and status of other doctors' private practice.

4.9.2. Public Service Ethos

Secondly, the references to public ethos were also varied. These references emphasised many doctors' higher calling to medicine. These doctors were not in it for the money and actively eschewed private practice. The following two excerpts are provided by a consultant geriatrician and a consultant respiratory physician. It should be noted that specialties like geriatrics are not procedure-based specialties.

Some people […] are just in it for the money. […] Hardly any geriatricians do private practice […] it just doesn't sit right with a lot of us, […] that's not what we are here for, we are here to sort patients out.

(Consultant Geriatrician)

These doctors may be attracted to work in these particular specialties because the absence of private practice chimes with their core values. They are motivated to work towards the public good and orientated to the wider functioning of the hospital. They are less likely to be narrowly concerned with material gain.

Respiratory physicians […] see themselves as integral to the […] functioning of the hospital. […] Cardiologists would ideally […] spend all the day […] in private cath labs and they're more reluctant to get engaged.

(Consultant Respiratory Physician)

There were a number of other reflections about the pernicious influence of private practice on doctors' motivations. For instance, the following two excerpts refer to the desire to acquire new skills or expertise in a field that can be used to build private practice. The first excerpt relates to bariatric (weight loss) surgery. The second refers to the 'golden nugget' of a surgical robot for the use in urological surgery. In both instances, the suggestion is that the doctors are jostling for position to control these types of procedures. Again, the implication is that in the pursuit of money over other

higher forms of motivation, the doctors serve to forfeit their professional status in the eyes of their peers.

People who were the pioneers of bariatrics in this country have done very well privately. […] People think, [...] 'well, if I do bariatrics it will pay off in private work.'

(Consultant Upper GI Surgeon)

In terms of motivations for things, I'm afraid you have to look at the private sector. […] If the urological surgeon wants to get the golden nugget to buy a robot, he needs to be able to say, 'well, I'm doing this robotic surgery all the time.'

(Consultant Respiratory Physician)

Finally, the following excerpt provides an account of the motivation of radiologists where a growing number of doctors are, upon qualification, placing both feet firmly, and exclusively, in the private sector. These doctors have none of the bonds associated with the traditional doctor-patient relationship (Parsons, 1951). The interviewee describes them as working in 'reporting houses'. The connotations, like a typing pool, are of routinized, low-grade practice. The loss of the public standing has a direct impact on the professional status of these doctors.

In surgery, the traditional route is you increase your private practice as you establish your service, but I was hearing today around radiology, that something like twelve to fifteen percent of the radiologists, come out of training, and are going straight into full-time private practice. And because you don't need to build up a relationship with patients, you're doing effectively subcontracted work, […] you're working in reporting houses.

(Director of Operations)

In terms of the professional status of these doctors, the pecuniary advantage they have gained working in private practice has been more than outweighed by their loss of public service ethos. In other words, their practice has been directed at the furtherance of their own interests, and not to a greater good of society. This naked

self-interest has a deleterious effect on the perception of their professional status by their peers.

* * *

In summary, the theme of 'Ethos' was presented in two different forms: 'Professional Ethos', governing codes of behaviour and conduct, and, 'Public Service Ethos', governing the purpose and motivation of professionals.

4.10. Organisational Standing

The interview participants articulated many references to the theme of 'Organisational Standing' and the important role it plays in their construction of professional status. The theme of 'Organisational Standing' can be sub-divided into two sub-categories: 'Size and Sustainability' and Recruitment and Retention'. These sub-categories were identified during the thematic coding of the data. 'Size and Sustainability' refers to the presence of a critical mass of services, the ability of the organisation to provide the appropriate resources to support a doctor's practice, and the opportunity, as part of a larger team, to sub-specialise. 'Recruitment and Retention' refers to the ability to attract high-calibre individuals. The following sections explore each of the two sub-categories in more detail.

4.10.1. Size & Sustainability

The references concerning the size of a hospital focussed on the viability of smaller organisations. Smaller hospitals may not have a critical mass of services. Therefore, the loss of a particular service can have a disproportionate effect on the viability of other interdependent services. This organisational vulnerability means that there will be less competition for posts working at these hospitals. The calibre of consultants working on these smaller sites was often called into question by the interviewees.

Furthermore, smaller sites have fewer doctors per specialty, which means that the shared responsibility to staff services will be the greater and this will result in a more onerous working pattern. Consequently, this has an impact on the desirability of lifestyle working in these smaller organisations. They will have insufficient operating volumes for complex surgery to maintain skills and competencies of its doctors. This means that there will be a more limited breadth and complexity of procedures undertaken on these sites. The following excerpt provides a useful summary:

Something like [general hospital] with three consultants. […] You have a problem attracting quality people there. […] Who wants to do one-in-three and just do day care surgery. […] You don't do the major stuff, so you have to send everything away. […] Those small hospitals, […] you've got to worry about their viability.

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On the other hand, working in a larger hospital affords the opportunity to sub-specialise and to extend the field of clinical practice. These larger clinical teams are also more likely to be working at the forefront of medicine. There is a greater chance of securing substantial investment in emergent technologies e.g. a surgical robot. As the following excerpts note, there is status to be gained from working as part of a big team.

There is a kudos for […] being in a big team […] that meets all the national standards.

(Director of Strategy)

One of the main reasons why I started bleating on about the robot […] was the feeling that […] if we didn't have a robot as our figurehead […] we would become an also ran. Having the robot in doesn't just make […] services firmer or more robust, […] other sub-specialities are reinforced. […] The robot was an absolute sine qua non for the development of this centre.

(Consultant Urologist)

The following excerpt describes the opportunities for sub-specialisation associated with working in a larger hospital. The interviewee also questions whether an increase in specialisation is always pursued in the best interests of the patients, or whether the increasing specialisation is about serving the interests of the clinicians. It is significant that this reflection is offered by a medical director. There may be a balance to be struck between these two positions. However, if increasing sub-specialisation within the context of a larger team is pursued for the interests of the doctors alone, it is conceivable that this may lower their professional status. For instance, if services were centralised in a large hospital with the concomitant improvement in the working conditions for doctors, but an increase in travel times and potential for worsening outcomes for patients.

Because of the advance of medical knowledge […] it's impossible for everybody to be competent in the full range of the things they need to do within a given specialty. […] By

pulling groups of people together to get to a critical mass […] you then got the opportunity to develop further expertise. […] What is really difficult to work out is […] at what point does it stop adding value for the patient, and at what point does the driver become the added value for the specialist or for the clinician, which is a slightly heretical thing to say.

(Medical Director)

There is a downside associated with working in a larger hospital. The competition for posts is much greater compared with smaller, less viable hospitals. The presence of larger teams means that the doctor may become 'a smaller fish in a bigger sea'. The status of an individual doctor may be subsumed within the larger team. The competitive nature of appointments to these larger hospitals will mean that the general level of competence and ability with be greater. In terms of an individual's ability to make their mark in an organisation, change becomes a matter of consensus building with a number of colleagues.

In [larger] centres you can subspecialise to a greater degree, which is a great attraction for some colleagues. […] That makes it more competitive if you have a particular interest. There are drawbacks though, […] the analogy is you become a smaller fish in a bigger sea. […] Generating change […] is much more difficult because you have to work with a lot more colleagues and accommodate a much wider range of opinions. […] It's much more difficult to translate your personal drive into the institutional focus.

(Consultant Cardiologist)

Finally, there was also evidence that the sustainability of organisations is associated with the presence of acute services. The following excerpt suggests that acute services have developed a status of their own. The implication may be that working in an organisation that does not offer acute services may be regarded as an inferior organisation. The interviewee expresses frustration that the association with acute services seems to trump specialised services.

Being an acute site has developed a status nationally. […] Yet bizarrely if you look at the high-status hospitals in the UK, there's absolutely no linkage to being an acute site. […] Jimmy's in Leeds, […] Great Ormond Street, Royal Marsden, Papworth, […] if you

think around the country most of them are specialist sites, they're not acute sites. […] People think you've got to be on an acute site to be worth anything. […] Actually, if you ended up with an acute site, and a site with […] very specialist services, the very specialist services site would be the gem to work in. Because […] there's an awful lot of dross comes in to an acute site. […] The specialist site, weirdly, is probably the jewel in the crown. […] But convincing people of that is quite difficult.

<div align="right">

(Medical Director)

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This excerpt is interesting because of the dichotomy that has been drawn is between acute and 'very' specialist services. The organisations referred to as 'high-status' are all tertiary centres or teaching hospitals. It is likely that the perspective of particular doctors concerning these organisational attributes, will depend on the characteristics of their own practice that they draw upon to construct their professional status. A highly specialist doctor will be disinterested in the presence of acute services if their practice depends on referral pathways independent from these services.

4.10.2. Recruitment & Retention

The references to the recruitment and retention of high calibre individuals focussed on tertiary centres or teaching hospitals. These focussed upon the need for doctors to demonstrate the requisite capability, particularly in terms of research activities, to secure a role at one of these organisations. The following two excerpts refer to the need to be 'academically minded' and peer recognised for their research activities. The second excerpt also refers to their capability in 'taking on things which other people can't take on' and the platform that a post at a tertiary centre provides doctors in pursuit of outside interests.

To get into a tertiary centre […] there is quite a pressure on research. […] You have got to be that academically minded, you can't largely get a job in a teaching hospital […] unless you've got an academic background, you have to be able to churn out papers once in a while.

<div align="right">

(Consultant Acute Physician)

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Tertiary centres, […] there is a fair bit of complex stuff, taking on things which other people can't take on, that gets due respect. […] If you want power, let's say, be called a big thing at the Royal College […] then you have to be in a tertiary centre.

(Consultant Orthopaedic Surgeon)

A number of the interviewees expressed frustration at the elitism of the tertiary centres. There was clear resentment about the idea that the teaching hospitals were the 'best'. However, there were also suggestions that the perceived superiority of the teaching hospital compared to the general hospital was invalid. It was claimed that the status gap between these organisations is not as pronounced as it once was.

Oxford and Cambridge are always perceived as […] the best places ever. […] You have got to finish your days here or else you have failed in life. […] I am sure that the people in the teaching hospitals will say it's the best because that's where they are.

(Consultant Geriatrician)

That thought, that you are a second-class consultant if you are not in a university teaching hospital has long gone.

(Consultant Upper GI Surgeon)

It used to be old boys network, I think may be increasingly less so now.

(Consultant Acute Physician)

These excerpts are interesting because they suggest a much more rigid hierarchy of organisations in the past. The present day, looser arrangements have resulted in greater status ambiguity. For instance, it may not be safe to assume that only the brightest and best work in a tertiary centre; there may be equally high calibre doctors working in general hospitals. The following two excerpts are interesting because they concern the relative calibre of consultants working in a teaching and general hospitals. The first excerpt suggest that some doctors make an active choice to avoid working in teaching hospitals. General hospitals can provide the opportunity for a

doctor to enjoy their work, yet to still partake in research and teaching activities. The organisational hierarchies in teaching hospitals are presented as more rigid.

The second excerpt suggests that working in a general hospital, and not as part of a larger team, means that the doctors have to be more self-sufficient, and, frankly better to manage on their own. These two excerpts both indicate that there may be divergent conceptions of professional status – for some, there is status associated with working in a tertiary hospital, for others there is a badge of pride for working independently in a general hospital.

We […] appoint […] new consultants every year. […] A number of them have got teaching hospital calibre CVs, […] and they say, 'I don't want to go to the carnage of all the egos in a teaching hospital, all these alpha males charging around. […] I want to go somewhere, enjoy my work and practice medicine. And if I still want to do a bit of research or do some teaching I can do it in a big organisation like this.' For some, there will still be the, 'I must be in an Oxford or in Cambridge or Guy's.' For a small minority, that status is very important. […] I'm not necessarily convinced anymore that teaching hospitals consistently cream off the brightest and best.

(Chief Executive Officer)

The challenges are very different [in a teaching hospital]. You probably need to be much better at what you do for being in a [general hospital], surviving and providing a safe service because you are just on your own.

(Consultant Cardiologist)

This recalibration of the relative standing between doctors working in tertiary centres or teaching hospitals and general hospitals only extends as far as larger organisations. There isn't necessarily a parity of esteem with consultants working in smaller general hospitals. This is partly because the presence of other themes will diminish in a smaller general hospital i.e. the doctors will be less capable, there will be less scope to specialise etc.

* * *

In summary, the theme of 'Organisational Standing' has a significant role to play in the construction of professional status. This theme was presented in two ways: the 'Size and Sustainability' of services, and the 'Recruitment and Retention' of high calibre individuals. On the one hand, the larger an organisation, the greater the critical mass of the service, and the greater the scope to develop specialist expertise. These larger organisations are also able to have their pick of the bunch of candidates for roles. On the other hand, larger organisations diminish the impact of individuals, as they become a smaller fish, in a bigger pond. There are clearly divergent constructions of professional status, and these relate to the characteristics of the interview participant's own organisational locus – for some there is status associated with working in a large, prestigious teaching hospital, and for others for working independently in a general hospital.

4.11. Autonomy

The interview participants articulated the theme of 'Autonomy' as having an important role to play in their construction of professional status. The theme of 'Autonomy' can be sub-divided into two sub-categories: 'Control of Jurisdiction' and 'Freedom to Practice'. 'Control of Jurisdiction' refers to the ability of doctors to maintain professional boundaries, to control access to resources within their sphere of influence, and to be referred to as the key decision maker. 'Freedom to Practice' refers to the ability of doctors to be independent, to determine the shape of their clinical practice, and to be highly individualistic. The following sections explore each of the two sub-categories in more detail.

4.11.1. Control of Jurisdiction

The majority of references to the control of jurisdiction relate to general practice. The interview participants described general practice's organisational form as comprised of small self-governing units. In the following excerpt, the interview participant states that this organisational form means that there is 'no control'. The absence of control is used by GPs to inform their identity and their construction of professional status.

General practice isn't uniform. There's no line management, there's no control. […] Practices tend to be quite diverse and individual and different; […] capacity, capability, and to be brutal sometimes their willingness to cooperate.

(General Practitioner)

This lack of control is attributed to the maintenance of professional boundaries. These boundaries create difficulties in coordination between organisations, even if these organisations are other GP practices. The analogy used in the following excerpt likens GPs to 'tigers that are magnificent beasts', that as solitary animals, tend to 'hang out on their own.' The drawing of professional boundaries around GP practices limits interference and challenge from without; its insulates the GPs from other professional hierarchies. In their local GP practices, they are unassailable.

It's professional boundaries […] the way we've been brought up. We are quite territorial. […] We don't all sit around together to try and solve problems. […] I use the analogy of an animal, […] in primary care there's a lot of tigers that are magnificent beasts, […] but they kind of hang out on their own. […] We need to turn into a pride of lions or […] zebras and wildebeests because they are herd animals and there's a different mind-set.

(General Practitioner)

The theme of control was also evinced by hospital consultants. The following excerpt refers to individuals developing spheres of influence and control. The maintenance of these spheres informs a doctor's conception of their professional status. If they are the authority on a particular subject or are able to control access to a particular resource, this provides them with the material to construct their identity and professional status. The implication is that any change that threatens to upset this bastion of control may be met with fierce resistance.

Strong personalities can build up very big spheres of influence and control. […] You basically did what you liked for a long time, whether that was good, bad or indifferent. […] People are worried that they lose the control of things.

(Consultant Upper GI Surgeon)

It is difficult to consider the theme of control without considering the subject of delegation. To surrender control of a resource, service or patient care is often fraught with difficulty. A doctor's willingness to yield control will be based on their appraisal of whether there will be a deterioration in the quality of care compared to what they have provided. The yardstick for optimal management of patients is often the doctor themselves. This may lead to an unwillingness to acknowledge that any other practitioner can provide equivalent or better care. The following two excerpts provide a testament to the difficulty that doctors have delegating to others:

They've got to have confidence that the system they are discharging that patient to is competent and safe. […] I wouldn't want to release my patients. Delegation is one of the hardest things to do. […] The comfortable thing is to hang on to them and keep an eye on them and check that everything is okay with them.

I [used to] do all the baby jabs, all the cervical smears, all the antenatals. I'd go […] and deliver babies! […] I've done everything. Now I am the general physician, […] I am the detective. Midwives do all the antenatal. My specialist nurses do all the baby jabs. […] But letting go, […] was really hard. […] Some people […] cope with that better than others. And even today there are GPs in this county who […] still do some of those smears, baby jabs, which they probably shouldn't be doing.

(General Practitioner)

The interviewees suggest that a doctor is more likely to surrender control to a practitioner that has a parity with their own status. This may mean that doctors will be unwilling to transfer the care to other non-medical practitioners, such as nurses, which they may regard as 'a lesser quality than a consultant.' The following excerpt suggests that when GPs refer into the hospital, they are unwilling to accept an opinion from a nursing role. This is irrespective of whether the GP would happily delegate tasks to the nurses working under their supervision within their practice. It would undermine the professional status of the GP to accept that a nurse would have specialist skills or knowledge that would exceed their own.

GPs are happy to delegate work to other members of the practice, but when they refer up they […] see that seeing a nurse is of a lesser quality than a consultant. […] 'I wouldn't have referred to a nurse because actually I know what I am doing, a nurse doesn't.'

(Consultant Acute Physician)

Similarly, if a doctor refers to another doctor, or delegates tasks or responsibilities to another doctor, this needs to be couched as a request rather than an instruction. This is because for one doctor to tell another what to do undermines the semblance of status parity; it effectively would acknowledge the subordination of one doctor to another. The following excerpt relates to the response of a consultant radiologist being 'told' to undertake an investigation by another doctor.

Radiologists […] have a chip on their shoulder because they think they are being told to do stuff rather than requested, 'you know you are requesting me to do it, you are asking me, not telling me.'

<div align="right">

(Consultant Acute Physician)

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Finally, the interviewees referred to the seniority of colleagues as informing their relative status. Seniority was defined as the consultants that had been in post the longest. These doctors are respected, have a proven track record, and can exert influence through an extended network. The senior-most consultants have the greatest ability to block or promote change. The following excerpts provide some reflections on seniority. The first excerpt concerns the influence exerted by senior consultants. The second excerpt reflects their response to change and their ability to control the environment if it conflicts with their personal agenda. The third excerpt suggests that big departments will have a 'pecking order', and that it is the senior-most individuals that determine the direction and pace of change.

Senior consultants will tend to have a lot more influence. […] The bigger departments [are] based around the guys who are in post and have been there for a long time, will tend to make the important decisions. […] They carry more weight. […] Their influence in the hospital tends to be greater because they know more people. […] Most people will defer to a senior colleague because seniority is usually a sign of greater experience and we tend to respect our senior colleagues. […] They've got a proven track record in what they do. They're already respected in their fields and so if they say something should be a certain way then a lot of other people fall into line.

<div align="right">

(Consultant Cardiologist)

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Resistance […] always comes from the seniors. Because they want to guard their patch till they retire, they don't want to change. […] If you can sort them out and say alright you'll be looked after, this will not affect you, don't affect your life too much, then resistance will go.

<div align="right">

(Consultant Orthopaedic Surgeon)

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I go in as the junior consultant, in a big department, there will definitely be a pecking order and my chance to influence the direction for that organisation is probably limited.

<div align="right">

(Chief Executive Officer)

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These excerpts are interesting in that they suggest that there is an informal hierarchy within the medical profession based on seniority or longevity. These seniors are presented as the key decision makers about whether or not to embrace or resist change, behind whom other consultants follow. There is also a suggestion that there will be stubborn resistance to anything that threatens to undermine fiefdoms that have been built up over a long career.

4.11.2. Freedom to Practice

There were recurring themes concerning freedom to practice, including the active choice by doctors to choose a specialty or organisational locus that would provide them with a satisfactory degree of independence. For instance, the organisational form of general practice, which is structured as a serious of 'little organisations', lacking in oversight and control, provides doctors with an ability to set their own agenda, to work with relatively little interference, and, frankly, as the following excerpt suggests, 'to get away with things.'

A lot of these people want autonomy. They don't want to be told what to do and they want to be their own bosses. […] Primary care is kind of quite a hard beast to control, because you've got lots of little organisations with fiercely independent people in each one. […] There's a hierarchy, I'm a doctor, I'm a partner, this is my business, people work for me. […] Some of it is about status and power and control. […] Secondary care there is probably more transparency and openness and challenge, whereas in primary care it's very opaque. And behaviours, you can get away with things because you can.

(General Practitioner)

Furthermore, the following excerpts describe the decision to work in a general hospital as opposed to a teaching hospital, expressed partly as an opportunity to be freer to determine the shape of their clinical practice. These excerpts are offered by a consultant that moved from a teaching to a general hospital. This decision was seen as 'bonkers' by their teaching hospital colleagues, because it forfeited the status afforded by working in a teaching hospital, and to choose to work in a run-of-

the-mill general hospital. However, it is clear that the freedom afforded by a general hospital allows a consultant to carve a niche that is sympathetic to their skills and interests.

Going down the hierarchical tree, people talk to you as if you're bonkers, why have you gone to there. […] Some people undoubtedly want to work somewhere like [a general hospital] because they'd like to be more general than they'd be permitted to do in a teaching hospital, they'd like to be more free to determine […] what they're going to do.

(Consultant Respiratory Physician)

Some of my colleagues here, have […] explicitly come to a […] hospital like this so that they would be free to do a little bit of everything. […] I would like to move to a situation where we have fewer people doing lung cancer and doing it better, trying to get anybody to give it up is bloody hard work. […] They all quite like the what it brings.

(Consultant Respiratory Physician)

Finally, a number of interviewees discussed to freedom of practice through the prism of individualism. This characteristic leads doctors away from working 'collectively' and to determine their own way of doing things. This means that there is often resistance to outside direction, even if it is couched in terms of guidelines or based on evidence. To be unfettered by outside interference and to follow one's own agenda, are also important markers of professional status. The following three excerpts elaborate upon this theme of individualism.

The way we've been trained is very individualistic. […] We don't think collectively. […] People resist that in healthcare because that's taking their autonomy away.

(General Practitioner)

It's always about individuals' ambition. […] Everyone is eventually an individual. There are very few Nelson Mandelas and Mother Teresas around. Most of us are individual bastards.

(Consultant Orthopaedic Surgeon)

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You want me to change my behaviour, you want to change my practice. […] I'm now being put out of my nice routine which works for me. […] That's very emotional for a human being and if the person can't see there is something in it for them […] it could be status, so it's playing to an ego, […] it could be kudos. […] People will say to you, 'I'm always doing it for the best interest of patients', and I'm not being unkind, but most human beings, 'it's what's in it for me?'

(Chief Executive Officer)

The last excerpt is interesting because it suggests that patients are used as a rhetorical device to mask self-interest. There is a consistent theme that the response to change is felt at a very individual level, and that the process of change can be a lot smoother, if it can be aligned to these personal interests.

*   *   *

In summary, the theme of 'Autonomy' was expressed in two different ways: 'Control of Jurisdiction' and 'Freedom to Practice'. There is a relationship between organisational form and the extent to which a doctor can control their jurisdiction. These can encourage the formation of spheres of influence, enclosed by professional boundaries, which insulate doctors from outside interference. Doctors can be reluctant to delegate or transfer the care of patients outside of these boundaries and beyond their direct control. There is evidence that the spheres of influence developed by the senior-most doctors are particularly inviolable. Some doctors choose their specialty or organisational locus based on the freedom to determine the shape of their practice. Doctors are often highly individualistic and pursue their personal interests.

4.12. Data Structure

The following section explains how this data structure has been used to inform a theoretical model to account for how doctors construct professional status. It is important to emphasise that the process of coding, developing the data structure and translating it into a theoretical model, was not a linear process. This was an iterative process that involved the cycling between the emerging theory and the research data.

Following Gioia (2012), the process of coding the interview transcript data identified forty-five first-order concepts. These were subsequently analysed through an iterative process which considered similarities and differences between the concepts. This process resulted in the identification of twenty-three second-order themes. Finally, these second-order themes were distilled into eleven research-induced aggregate dimensions that have been explored above.

The first-order concepts, second-order themes and aggregate dimensions highlighted through the coding process have been arrayed in a data structure (Table 7). An extended version of the data structure is presented in Appendix 11.1 with exemplar data excerpts for the purposes of elucidation. The presentation of this data follows the suggestion of Pratt (2009: 860) to include different data in both the body of the paper and in tables. In addition to what he called 'power quotes' or 'proof quotes' in the body of the paper, the supplemental quotes provide evidence to illustrate the findings.

Table 7: Data Structure

First-Order Concepts	Second-Order Themes	Aggregate Codes
Differential academic capabilities	Capacity to perform	Capability
Differential practical capabilities	Capacity to perform	Capability
Competition for specialist training / jobs	Attributes to succeed	Capability
Driven, dynamic character types	Attributes to succeed	Capability
Motivated and hardworking character types	Application to progress	Capability
Specialised nature of knowledge and practice	Pursuing specialisation	Specialisation
Disparagement of generalist roles	Eschewing generalism	Specialisation
Breadth of knowledge and practice	Promoting breadth	Breadth
Strength as diagnostician	Promoting breadth	Breadth
Devaluing contribution from specialists	Demoting specialisation	Breadth
Balancing Life and death	Life and death	Emergency
Immediacy of intervention	Life and death	Emergency
Emergency and acute practice	Emergency and acute	Emergency
Nature of the job affect desirability of lifestyle	Work-life balance	Lifestyle
Desired lifestyle informs organisation/specialty	Work-life balance	Lifestyle
Technical sophistication	Commodity to acquire	Technology
Clarity of clinical intervention / outcome	Tool to wield	Technology
Focus and precision of intervention	Tool to wield	Technology
Interventional approach	Tool to wield	Technology
Invasiveness of intervention	Tool to wield	Technology
Active versus passive orientation	Shaper of practice	Technology
Curative nature of treatment / intervention	Shaper of practice	Technology
Progressive nature of clinical practice	Shaper of practice	Technology
Valuing craft skills of practitioner	Appeal to core identity	Craft

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Value of associated resources	Value of resources	Material Value
Market forces and market value	Monetary value	
Earning potential of individuals		
Wealth of specialty / specialists		
Organs in upper body with symbolic value	Imputed value of organs / patients	
Socio-economic standing of patients		
Espousal of professional ethos	Professional ethos	Ethos
Espousal of public service ethos	Public service ethos	
Size of unit	Size and sustainability	Organisational Standing
Sustainability / critical mass of service		
Clinical prowess of service	Recruitment and retention	
Ability to attract / retain high quality individuals		
Prodigiousness of research activities		
Academic prowess of department		
Territorialism and control	Control of jurisdiction	Autonomy
Professional deference		
Informal markers of seniority		
Principal rather than supporting role	Freedom to practice	
Exclusivity of clinical practice		
Freedom to determine clinical practice		
Individualism		

4.13. Theoretical Model

The following section outlines a theoretical model that builds upon the data structure and provides a framework to help understand how doctors construct professional status. The model incorporates a number of precepts including the following:

- In accordance with the interpretivist paradigm, the model permits divergent conceptions concerning the same subject matter. There is no singular truth or objective criteria that determines relative professional status.

- The data suggests that senior doctors are loath to acknowledge that they have a lower professional status than their peers. For instance, doctors practicing as hospital consultants or GPs have attained a level of seniority and status. However, there is little in the way of a formal hierarchy to govern relations between peers. Therefore, the relationships between these doctors is socially constructed. The data also suggests that it is common for doctors to draw upon themes that play to their own strengths.

- The presence of a themes can differ by degree and emphasis. A doctor does not have to rely on a single theme, it is possible for status to be constructed by drawing on one or a combination of themes.

- The model acknowledges that the construction of professional status is dynamic. The salience of particular themes will ebb and flow over time.

- The themes that have been identified are an analytical distinction and it is acknowledged that in reality they are all related to one another. For instance, 'Organisational Standing' describes the size and sustainability of an organisation. A large organisation with a critical mass of services is more likely to be able to invest in 'Technology' and items of 'Material Value'.

4.13.1.   Contributory & Mitigating Themes

The eleven researcher-induced aggregate dimensions outlined in the data structure above are to a certain extent interrelated. It was observed that they can be sub-divided into two categories: 'contributory themes' and 'mitigating themes'. The 'contributory themes' include 'Capability', 'Specialisation', 'Emergency', 'Technology', 'Material Value' and 'Organisational Standing', and the 'mitigating themes' include 'Breadth', 'Lifestyle', 'Craft', 'Ethos' and 'Autonomy'.

A contributory theme is used by a doctor to build their construction of professional status. For instance, the 'Capability' of a doctor can indicate their relative capacity to assimilate knowledge and skills, their drive and competitiveness, and their work ethic. Alternatively, the 'Specialisation' of a doctor indicates the extent to which their practice is characterised as specialist and esoteric. These characteristics have been identified in the research data as being prized by doctors and regularly used in their construction of relative professional status.

On the other hand, the mitigating themes, although relevant, do not necessarily directly relate to doctors construction of professional status. For instance, the mitigating theme of 'Lifestyle' is concerned with the choice of a doctor to work in a particular organisational setting. These lifestyle choices do not have a bearing on the construction of professional status *per se*. Similarly, the mitigating theme of 'Ethos' refers to the governing codes of behaviour and conduct of the profession. Again, as an independent characteristic, this theme does not have a significant bearing on the construction of professional status.

However, both 'Lifestyle' and 'Ethos' were articulated by the interview participants as counterpoints to the contributory themes of 'Emergency' and 'Material Value' respectively. Indeed, five pairs of contributory and mitigating themes can be identified – each pair containing a contributory and mitigating theme. The only exception being the contributory theme of 'Capability', which has no mitigating theme presented as a counterpoint. The rationale for pairing these themes together was based on the interrelationships between themes observed in the data. An iterative

approach was taken to mapping the interrelationships between the themes are how this could be best represented within the theoretical model.

Although the presence of 'contributory themes' helps a doctor to construct their professional status, this becomes more difficult to maintain when there is an excessive presence of these themes. The definition of 'excessive' is when the strength of presence of a theme means that the veridicality of their construction becomes unsustainable, or that it excludes the presence of other related themes.

For instance, the contributory theme of 'Emergency' has positive connotations with managing life and death situations and playing an active part in the treatment of acutely unwell patients. Again, these characteristics are valued and used by doctors in their construction of professional status. However, if there is an excessive presence of this contributory theme, the doctor will have a more demanding working pattern. This may exclude the opportunity to develop their 'Capability' through research activities or earn 'Material Value' through private practice.

Similarly, a doctor may use the theme of 'Specialisation' to inform their sense of professional status. A doctor that specialises in a particular field is the custodian of an esoteric body of knowledge. However, if a doctor becomes too specialised, their field of practice may become too narrow and they will lose some of their skills as a diagnostician. In other words, they will no longer have the skills to sort the wheat from the chaff. This may lower their perceived status in the eyes of some peers, particularly those that draw upon other themes for their own sense of status.

Furthermore, a doctor may construct their professional status with reference to the contributory theme of 'Material Value'. They may enjoy a considerable income from private practice. However, an excessive presence of this theme may lead to the doctor being maligned in the eyes of their peers as mercenary or unethical. This may lead to a diminishment of their perceived professional status. However, if the doctor was also able to draw upon the mitigating theme of 'Ethos', they can maintain or enhance the construction of their professional status with resort to a professional ethos. In other words, the doctor may earn a packet, but they can demonstrate that it does not compromise their professional ethos and principles.

It is possible to summarise a number of additional principles underlying the theoretical model:

- The themes can be sub-divided into 'contributory themes' and 'mitigating themes'. The former having a direct bearing on the construction of professional status. The latter, whilst relevant, have been presented as a counterpoint to a contributory theme.

- The contributory and mitigating themes can be arrayed into five pairs. Each pair contains a contributory and a mitigating theme.

- When there is an excessive presence of a contributory theme, this may serve to diminish the construction of professional status. In these circumstances, a construction can be maintained by drawing upon a corresponding mitigating theme.

- There is an optimal level for a contributory theme to be present. It may be possible to characterise the optimal presence of a theme as consistent with the goldilocks principle – not too little, not too much.

It is conceivable that doctors who maintain the constructions of the greatest professional status are able to draw upon both contributory and mitigating themes to ensure they strike an optimal balance: a doctor that is highly capable, that is highly specialised, but maintains some breadth to their practice; that regularly deals with emergency life and death situations, but not to the extent that this impacts on their work-life balance; that uses a range of technologies in their clinical practice, but not to the extent that they diminish the importance of the craft skills of the practitioner; that has significant earning potential, but that can demonstrate a guiding professional ethos; and that works as part of a big team within a large hospital environment, but not to the extent that they become a small fish in a big pond.

These eleven themes are the reference points that doctors use when constructing professional status. The theoretical model is presented overleaf (Table 8) including

a description of characteristics if the themes are present, if they if they are in excess, and the characteristics of the corresponding mitigating themes. There is a striking similarity between these themes and research conducted by Castellani & Hafferty (2006) into forms of professionalisation that have emerged following the challenge to medicine's longstanding position of professional dominance. They claim that this led to the emergence of seven competing clusters of medical professionalism (nostalgic, entrepreneurial, academic, lifestyle, empirical, unreflective and activist), and ten key aspects of medical work (autonomy, commercialism, social contract, social justice, professional dominance, technical competence, interpersonal competence, lifestyle ethic and personal morality).

Table 8: Theoretical Model for Construction of Professional Status

Contributory Theme	If Present…	If Excessive…	In Mitigation…	Mitigating Theme
Capability	Differential academic and practical capacity Possession of attributes and application			
Specialisation	Esoteric nature of specialist knowledge Eschewing generalist practice	Loss of strength as a diagnostician Excessive narrowing of field of clinical practice	Discriminating and holistic outlook Varied, integrated and outward-facing practice	Breadth
Emergency	Balancing risks in life and death situations Immediacy and excitement of emergency and acute practice	Incompatibility of working patterns with work-life balance Lack of continuity and follow-up	Active choice to promote outside interests Characteristics of the role engender satisfaction	Lifestyle

Technology	Possession of technology as an exclusive commodity Tool to be wielded and a shaper of practice	Technology as an extraneous indulgence Diminishment of agency and routinisation of practice	Appeal to core identity as craft practitioner No substitution for craft skills of practitioner	**Craft**
Material Value	Value of resources and earning potential Imputed value of symbolic organs / patients	Mercenary behaviour in clinical practice Skewing of opportunity, incentives and unjust rewards	Professional ethos governing behaviour Public service ethos governing motivation	**Ethos**
Organisational Standing	Size and sustainability of service Recruitment and retention of high calibre individuals	Compromise with others diminishes personal impact Loss of relative standing, power and deference	Freedom to practice and independence Control of jurisdiction, influence and seniority	**Autonomy**

In summary, a theoretical model for the construction of professional status has been presented. Within this model, there are eleven themes, which include six contributory themes, and five mitigating themes. These themes have been explored in detail indicating where there is a relationship between contributory themes (which contribute to the construction of professional status) and mitigating themes (which help to maintain the construction of professional status in the context of an excessive presence of the contributory theme).

The following chapters will present three different case studies to explore the role of professional status within processes of organisational change. These cases studies will consider the different themes associated with status that have been discussed in this chapter. In addition, the cases will also draw out additional observations, that are relevant to these particular case studies, which will be linked back to the overarching theoretical model.

Chapter Five

Vascular Case Study

5. Chapter Five: Vascular Case Study

'Winners & Losers'

The following case study relates to the centralisation of vascular surgery services in a regional locality in England. This was part of a nationwide reconfiguration of vascular services. The stimulus for change came from the professional body, the Vascular Society, to address the high mortality rates for types of vascular surgery in the UK, by creating specialist centres to improve clinical outcomes. Consequently, there was a move to centralise vascular services, and to focus expertise in a smaller number of units.

The outcome of this process was to halve the number of hospitals offering these services. Where the closure of unviable services was not practical, networks of 'hub and spoke' service provision were developed. The corollary of this process has been the expansion of services at a number of 'hub' hospitals, the diminution of services at 'spoke' hospitals, and the complete loss of local services elsewhere. This is very much a story of winners and losers.

At a local level, the case study charts the formation of a vascular 'hub' in an organisation split across two hospital sites, which have maintained independent vascular services for many years. The formation of a vascular network resulted in transfer of all vascular services to one hospital. A third hospital, in an adjacent, but separate organisation, was incorporated within the network, its status being relegated to that of a 'spoke'.

In order to clearly distinguish between these three hospital sites, they will henceforth be referred to as the 'hub hospital', the 'sister hospital' and the 'spoke hospital' (see Figure 5). The two previously independent consultant teams that once worked on either the sister hospital or hub hospital site, but now who both work on the hub hospital site supporting the vascular network, will be referred to as the 'former sister hospital' and 'former hub hospital' teams respectively.

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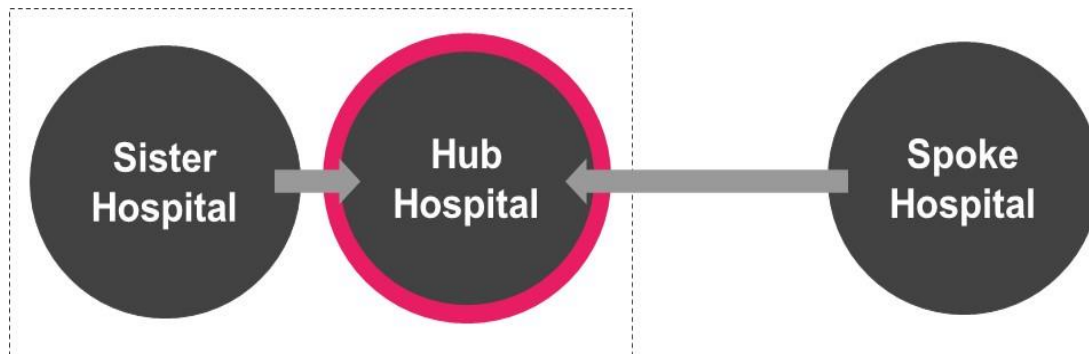
Finally, there has been a low uptake in the UK of minimally invasive endovascular surgical techniques, as opposed to conventional types of 'open' surgery (Vascunet, 2008). Endovascular surgery is a rapidly advancing field that straddles a professional boundary between vascular surgery and interventional radiology. Figure 6 explains the difference between open surgery compared to a minimally invasive technique (EVAR). EVAR involves the placement of a stent in the aorta (the largest artery in the body) inserted via a wire and catheter device. The relative efficacy of this technique is still the subject of considerable debate within vascular circles. There is some evidence that it may contribute to reduced length of stay and improvements to quality of life.

Figure 6: Comparative Surgical Approaches for Aneurysm Repair

Open Surgical Aortic
Aneurysm Repair
(OPEN)

Endovascular Aortic
Aneurysm Repair
(EVAR)
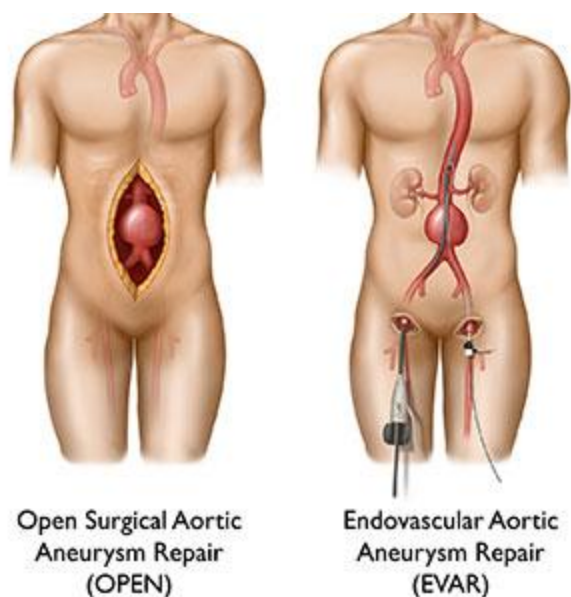
EVAR is an emergent technique that few vascular surgeons are competent to perform. These procedures are normally undertaken by a vascular surgeon with the support of an interventional radiologist. The jurisdiction of the vascular surgeon may expand over time to incorporate the interventional radiology element, which would allow them to undertake these procedures independently. As an emergent technology, the jurisdictions between these specialties are currently being constituted.

5.1. Background

The following section provides details of the background to the case study. A chronology has been developed, with reference to key publications and secondary materials, to provide context to the national and local reconfiguration processes.

5.1.1. National Level

Figure 7 presents the key influences that occurred at a national level. The majority of these influences were publications from external bodies. In the earlier years, these publications were focused on building a consensus within the profession regarding the need for service change. In the latter years, there is a stronger emphasis on the formal adoption of the recommendations and the consequent implementation of the changes.

Figure 7: Key Influences at National Level for Vascular Case Study
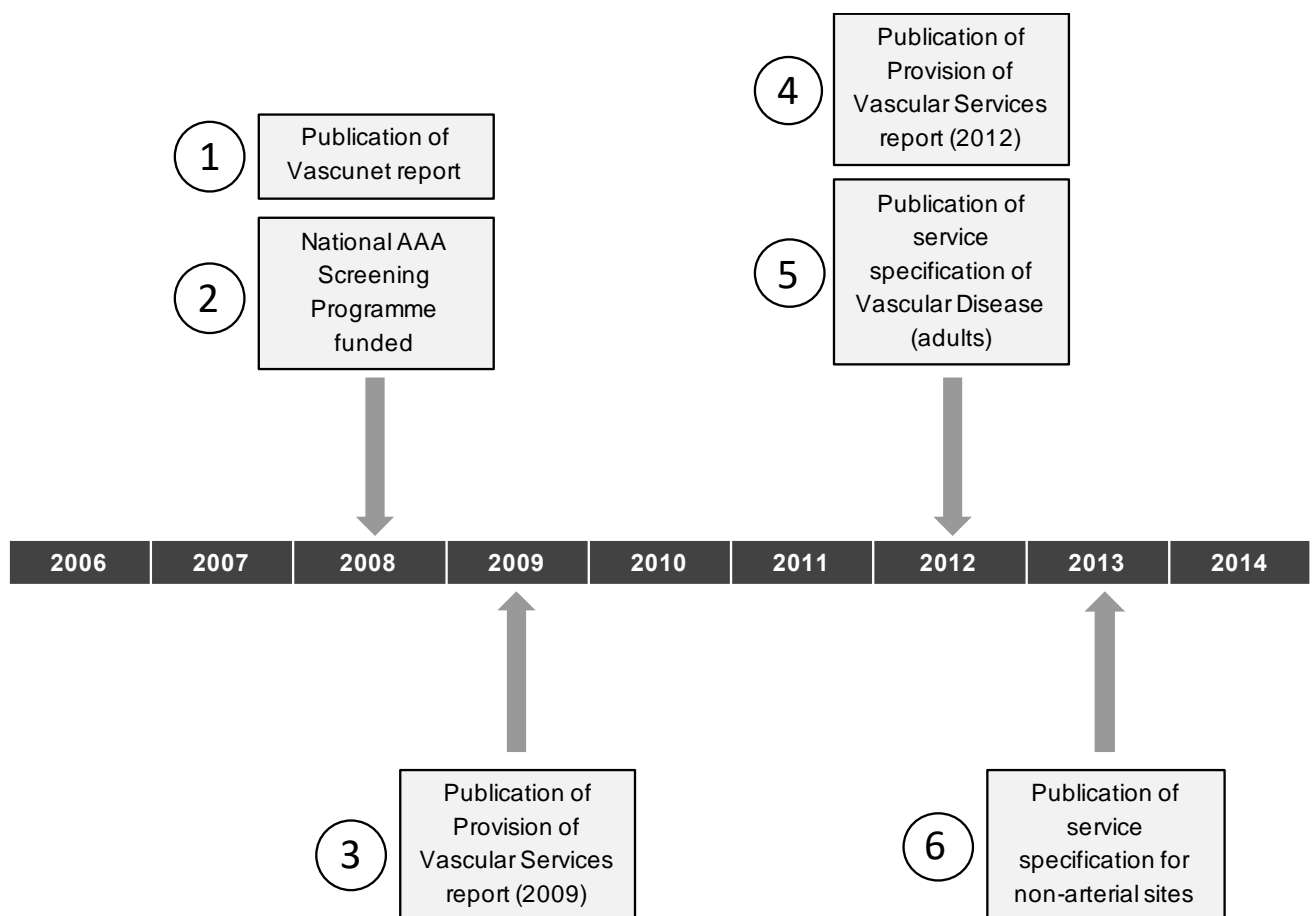
(1) The European Society of Vascular Surgery (2008) published its Vascunet report providing comparative surgical outcomes from ten countries. The UK compared poorly with the highest mortality rate in Western Europe following elective abdominal aortic aneurysm (AAA) surgery.

(2) The Department of Health launched the national NHS AAA screening programme in England. Local screening programmes were established, providing the template for vascular networks in future years.

(3) The Vascular Society of Great Britain and Ireland published the *Provision of Vascular Services* (2009), which recommended the formation of collaborative networks to provide vascular services.

(4) An updated *Provision of Vascular Services* (2012) was published. It noted the relationship between operators performing higher surgical volumes and improved clinical outcomes. It recommended the need to focus expertise in a smaller number of centres, based on a minimum size of population, to maintain adequate surgical volumes and operator competence. Patients should not be treated outside a fully centralised service, or formalised clinical network, with a designated single site for all major interventions providing a 24/7 service. Care should be provided by specialist centres supported by a multi-disciplinary vascular team and the appropriate facilities. This process of centralisation was anticipated to result in fifty fewer vascular centres. The capacity of the service to offer procedures like EVAR should be enhanced. The shortage of competent practitioners to undertake these procedures, especially outside normal working hours, was acknowledged.

(5) A draft service specification for vascular disease was developed by NHS specialised commissioners. A minimum population of 800,000 people was defined for a vascular centre. This threshold would result in the halving of vascular centres in the UK to roughly fifty-five to sixty centres. A centre should have six vascular surgeons and six interventional radiologists to provide a sustainable and comprehensive service. Two service models emerged, based

on the concept of a network of providers: centralising all vascular surgical services in a single centre, but continuing to provide outpatients and diagnostics in local hospitals; or, centralising arterial (major) surgery in a 'hub' hospital, and providing non-arterial (minor) surgery, outpatients and diagnostics in local 'spoke' hospitals. It was anticipated that the reconfiguration of vascular services would be undertaken over the following two to three years.

(6) A draft service specification was published for 'spoke' hospital sites. It stated that there was no single model of how vascular services should be provided at 'spoke' hospitals, but the level of support from the 'hub' hospital should ensure the maintenance of the quality of services on the 'spoke' hospital sites.

5.1.2.   Local Level

In parallel with the changes that occurred at a national level, there was a local reconfiguration of vascular services (see Figure 8). The local reconfiguration was a response to national commissioning intentions. However, it was also influenced by the impetus from the Vascular Society to reform.

Figure 8: Key Influences at Local Level for Vascular Case Study
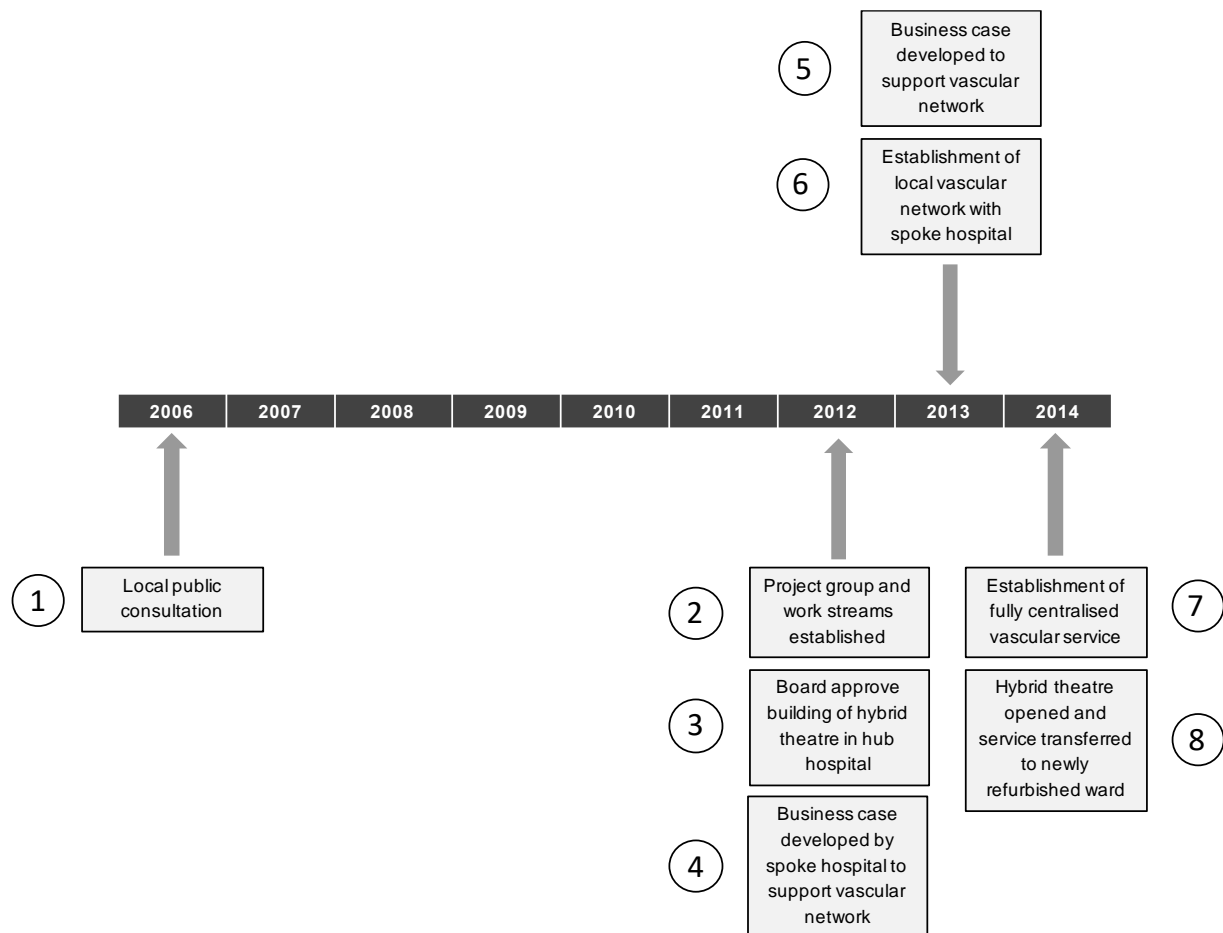
① In a prescient move, the NHS trust consulted publicly to reconfigure a number of clinical services, including vascular surgery.

② The trust board announced plans to centralise local services by the end of the year. A number of project groups were established to oversee planning for the

centralisation.

3 The trust board agreed to make an investment in a new dedicated 'hybrid' theatre facility on the hub hospital site. It was agreed that the vascular surgeons would withdraw from the general surgical on-call rota and commence a specialist vascular on-call rota.

4 The spoke hospital trust board were asked to approve the transfer of major surgery from the spoke to the hub hospital. The existing spoke hospital vascular surgeon would retain outpatient and minor surgery on the spoke hospital site, however, they would also contribute to the delivery of services at the hub as part of the network arrangements.

5 The trusts outlined a plan to develop a networked model of care with the hub hospital linked to the spoke hospital.

6 The trust developed a business case to support the local vascular network. The application to be designated as a vascular network had been successful. It noted that the existing spoke hospital vascular surgeon had decided to rescind his agreement to participate in the network. In response, the trust commenced discussions regarding a joint consultant appointment to work across both organisations.

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8 The vascular service was finally centralised to the hub hospital, with a new inpatient ward and hybrid theatre located on the hub hospital site. The former sister hospital team were transferred to the hub hospital.

The following sections will consider the presence of themes relating to professional status and their role within this process of organisational change.

5.2. Capability

The theme of capability has been expressed in four different ways: the practical capability of the vascular surgeons vis-à-vis their immediate peers, the former site-specific teams, the spoke surgeon and their wider peer group.

5.2.1. Immediate Peers

There is evidence that professional status has been based on the perceived capability of individual surgeons vis-à-vis their peers / colleagues. For instance, the following excerpt refers to the perceived weakness in terms of clinical practice of consultant colleagues:

> *[Some vascular surgeons] are weaker clinically. And that has been picked up on by [a surgeon who] walked into the theatre […] and went 'oh, my god, are you still only on this case because I've already done two.' […] There's a bit of […] testosterone […] I'm faster and better.*
>
> *(General Manager)*

The surgeon has undermined a consultant colleague, who was operating at the time, by drawing attention to their relative capability in terms of surgical speed. This public announcement would have been audible to entire surgical team. This statement may play a performative role in the construction of the surgeon's identity. This may be the equivalent of a silverback gorilla beating its chest; a demonstration of their dominance over a subordinate.

As the excerpt suggests, for some individuals, surgical speed is still used as a basis for their construction of professional status. This isn't simply about being more productive. Surgical speed is not only determined by the deftness of a surgeon's practical skills, but also their decision-making capacity. In other words, it has as much to do with their heads as their hands. A fast surgeon is well organised; they are able to make a quick determination of what they need to do; they have an economy of movement, and there is a logical flow from each surgical step to the next.

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5.2.2. Former Site-Specific Teams

The interview participants also made references, peppered with antipathy, to the relative practical skills of the two formerly independent vascular surgeon teams. The reconfiguration resulted in the need for the former sister hospital team to transfer into the jurisdiction of the former hub hospital team. The established norms and working practices of both teams have been disrupted and have had to be reconstructed. This can be demonstrated by the opprobrium heaped by the former sister hospital surgeons upon their new colleagues for their outmoded, inefficient ways of working. The following excerpt is from one of the former sister hospital surgeons who reflects on the working practices that have subsisted in the hub hospital:

One of us is in the hospital all week managing emergencies, that's me this week, and I have done a ward round every morning of all of the patients, I have emptied the ward out, I have cleared all the ward, all of the rubbish. […] I have sent home everybody who has come in for an investigation, everybody who has been waiting for stuff. […] All people who are day cases, the overnight stays […] I have sent everybody home.

(Vascular Surgeon 1)

The 'faster and better' complex, therefore, is not just reserved for the theatre environment, but for the full gamut of clinical practice including activities such as ward rounds. This isn't just an articulation of technical speed and competence in performing these activities. Rather, this is also an indirect expression of tolerance for risk, as earlier discharge of patients does rely on a judgement about the clinical desirability of withdrawing hospital-based care. For understandable reasons, the lowest thresholds for risk are typically evinced by junior doctors. The highest thresholds of risk are more likely to be displayed by doctors with greater confidence informed by their years of experience.

The references to clearing the ward of 'all of the rubbish' relates to perceived wasteful practices of the former hub hospital surgeons. Holding on to patients in hospital beds unnecessarily may be perceived as indicative of their lack of capability or of a self-aggrandisement that places their personal convenience above the needs of the

patients and the wider service. Interestingly, there may be completely different constructions of professional status as mediated through the use of hospital beds. Freidson (1988: 304), refers to the role that the medical profession plays as gatekeepers to special resources the most obvious of which are hospital beds. For the former sister hospital team, the efficient use of these beds is associated with their relative capability *vis-à-vis* their former hub hospital colleagues. However, for the former hub hospital surgeons the construction of their status may not be derived in the same way.

The 'rubbish' refers to patients that should not have been admitted to hospital or should not remain in hospital. The former hub hospital consultants are maligned for inappropriately admitting patients. For instance, the admission of a patient to hospital the day before their surgery, where this is not clinically necessary, may be related to the status of the operating surgeon. In some cases, this is an act designed to block a patient bed overnight, and to guarantee that the patient will be in a bed before the commencement of the surgeon's operating list in the morning.

The blocking of beds reduces the total number of beds available in the hospital – by effectively increasing the length of stay of planned admissions – and consequently may result in the cancellation of other patients' surgery because of a lack of identified bed post-operatively. Therefore, this can be seen as evidence of egoism and prioritising the convenience and whim of the surgeon above the wider needs of the organisation – or, indeed, their surgeon colleagues. However, the ability to bring a patient in the day before surgery could be a demonstration of the surgeon's power, unbending will and unrestrained practice.

There are parallels between the perceived wasteful practices of the former hub hospital consultants and the management of waiting lists. For some doctors, a huge waiting list may be indicative of a lack of competence in managing referrals or a low threshold for discharging patients back to the care of their GP – again, this is related to tolerance for risk. However, for other doctors, a huge waiting list could be a demonstration of their importance and the demand for their knowledge and practical capabilities.

If a patient has to wait a considerable time for their consultation, treatment or surgery, does this reflect poorly on the consultant concerned, or does this demonstrate the demand for their knowledge and skills? There is little research on the role of waiting lists in informing the professional status of clinicians. However, Hanning & Spångberg (2000) did consider the imposition of maximum waiting time standards in the Swedish healthcare system. These standards were regarded as a restriction on clinical freedom and consequently were perceived to have a detrimental impact of the status of medical professionals.

The disdain articulated about wasteful practices is not reserved exclusively for the vascular surgeons. Indeed, there are broader references to outmoded practices and differential thresholds for risk articulated by the former sister hospital team regarding the hub hospital. These sentiments have been articulated by not only medical staff, but by the wider multi-disciplinary team. The following excerpt is from a consultant nurse who has also been transferred from the sister to the hub hospital. Note that during the process of transition, a number of sister hospital clinicians chose to leave the organisation or withdraw from vascular services, rather than be transferred to the hub hospital site.

We now have lost experienced radiologists who were very good and were not risk averse and now we have radiologists who are very risk averse and so won't tackle more risky procedures and are quite nervous of doing anything that's outwith their comfort zone which seems to be quite low, quite narrow.

(Consultant Nurse)

The 'otherness' of the formerly independent clinical teams may contribute to their underlying perception of this divergent clinical practice. This points to the fact that different clinical cultures subsist within these separate organisations. Again, the differential thresholds for clinical risk are highlighted. In the hub hospital, the culture has been characterised as a nervousness or fear of stepping outside of their comfort zone.

The status of the sister hospital team, in their own eyes, is elevated as they have the confidence and self-assurance to tolerate a higher threshold of risk. You can imagine,

however, that this characterisation could be turned on its head by the hub hospital clinicians to describe the *modus operandi* of the sister hospital clinicians as being more cavalier. Both sets of hospital clinicians exhibit a homophilic relationship with similar beliefs, values and behaviours. It can be debated whether these clinical cultures are self-perpetuating in their selective recruitment of like individuals, or whether individuals gradually adopt the norms and values of their adoptive clinical team.

5.2.3.   Spoke Hospital Site Surgeon

This 'otherness' factor is even more pronounced in a significant number of reflections about the perceived woeful and incompetent clinical practices in the spoke hospital. These include reflections on the quality of the historic service offered by the spoke hospital to their communities. There does seem to be a bias in their reflections towards valuing the quality of services offered by specialist vascular surgeons as opposed to general surgeons that do 'a bit' of vascular surgery.

These excerpts suggest that the existence of an existential 'other' is important in defining a clinical team's own status position. This is consistent with a symbolic interactionist approach, which would dictate that a subject can only be fully understood, when it is considered in its interaction with other objects of analysis (see Blumer,1973). There may also be parallels with social identity theory (Tajfel, 1978) which states that an individual's identity and sense of belonging is determined by their group membership. In order to increase their self-image and status, individuals enhance the status of their own group by discriminating against those outside of the group. The world is categorised into social groups of 'them' and 'us'. The similarities within groups and differences between groups, and the negative characteristics of other groups tend to be exaggerated.

The strength of the conviction from the vascular surgeons, does suggest a power or status differential that permits them to make these sorts of unguarded statements. They are clearly not concerned about any act of censure or the risk of sullying relationships. They are certainly not as bold in their criticism of their immediate consultant colleagues and peers. This suggests that there is a lack of parity of esteem between the hub and spoke hospital teams. Interestingly, one of the more incendiary

statements made by one of the vascular surgeons, in discussions with the spoke hospital clinical team, was to refer to their organisation as a 'cottage hospital'. This was used as a pejorative term with its associations of the hospital being small, outmoded, provincial and rural.

[It was] third rate. […] We are seeing from [the spoke hospital] end stage disease […] The stuff that is coming up from [the spoke hospital] is of a county that has had no vascular provision.

(Vascular Surgeon 1)

[A tertiary hospital] just took their shit and no one asked any questions.

(Vascular Surgeon 2)

The spoke hospital surgeons were seen to have made grave errors in patient care which were regarded as wholly avoidable. This constituted a dereliction of their professionalism and duty. Therefore, it had a significant impact on their perceived professional status. Bosk (2003) undertook a seminal study that considered the way in which errors in surgery were acknowledged and treated by the profession. This research demonstrated that clinical mistakes were freely admitted and accepted as being inevitable and part of the risks associated with surgery. However, normative errors, in which a surgeon was considered to have failed in their accepted professional standards, and conscientious duty, were regarded as unacceptable.

Furthermore, the interviewees offered reflections for what they perceived to be the reasons behind the reticence of the former vascular / general surgeon in the spoke hospital to join the vascular network. The over-ridding factor expressed in the source material was lack of competence to perform major surgery. The following excerpts are from the director of strategy from the hub / sister hospital trust who attributes the reluctance to join the vascular network to a fear of being exposed as lacking competence – in other words, leaving a clinical environment where they are a big fish in a small pond.

[There] is fear about their own clinical competence and that being exposed. […] There are

some pretty smart operators in the team here, that if the conversations were going along the lines of 'oh, yes, you can come and operate with us, use our facilities', he's thinking 'oh, no, no, I'm quite happy over in my little theatre where I'm the top dog and that people have got nothing to compare me to, that's not quite what I've got in mind.' […] You can get away with things, […] in a small team. Who's going to say to you that's not current practice. […] It might be surgical techniques, it might be the length of time it takes you in theatre, like the tests you ordered before you make a decision […] there's a whole range of complex things that suddenly in a network, in a bigger team get exposed.

(Director of Strategy)

Some of the most influential sociological studies on the so-called frog-pond or fish-pond effect has been focussed on higher education (Davis, 1966; Marsh & Parker, 1984). The essential conclusion of these studies was that people are not satisfied by being in a high-status group if they are not afforded a high status within that group. Conversely, people are less dissatisfied about being in a lower status group if they are afforded a high-status within that group. It is the relative status of the individual to the wider group that is important.

There could be a personal risk for clinicians who have previously worked in smaller centres being drawn into clinical networks or practicing within larger centres – that the quality of their clinical practice may be exposed to their wider peers. There is a level of insulation when working in a smaller centre. This may well have been a significant factor in the late withdrawal of the spoke consultant from the vascular network. This may have indicated a fear of loss of status if their clinical practice was demonstrated to be inferior, outmoded or inadequate.

The response from the spoke hospital consultant can be seen as wholly rational in these circumstances. Better to be a middle of the road general surgeon than be exposed as a poor vascular surgeon. The idea of this insulating oneself against exposure, by eschewing working within larger teams, may reach its apotheosis in general practice, where there are still a good number of independent practitioners, particularly in rural areas.

Furthermore, the interview participants reflect on what they perceive as poor practice

that is still accepted in the spoke hospital. The hub hospital clinicians provide input into the care of inpatients and to the multi-disciplinary team meetings on the spoke site. This has created flashpoints in terms of clinical jurisdiction. The former general / vascular surgeon on the spoke site is still seen to be 'dabbling' in the care of vascular patients. It is difficult for the hub surgeons to police this practice, on a geographically distant hospital site, where they do not have a daily presence. This may suggest that the colonisation of the spoke hospital by the hub hospital clinical team has not necessarily raised their status as their authority in clinical matters continues to be challenged. The impotence of the hub hospital consultants in challenging the 'dabbling' of the spoke hospital consultants may undermine their professional status.

There may be an issue of reach for clinical teams beyond which it is difficult to maintain their status position. Furthermore, it is interesting that one of the major frustrations for the hub hospital consultants, when they first started to provide cover on the spoke hospital site, was that the spoke hospital clinical and management teams had withdrawn the support of the junior doctor team. The spoke hospital was also initially remiss in not providing desk space or office facilities for the hub hospital surgeons. This could be characterised as the spoke hospital symbolically denying the hub hospital surgeons the dignity, spoils and regalia of office.

The scornful comments about the practice of the spoke surgeons are not reserved to their competence in performing surgery, but also their judgement about when it is appropriate to intervene, and when it is better to manage patients' conditions more conservatively. Any surgery poses a potential risk of life-threatening complications and should be avoided where possible. The diagnostic capabilities of the hub surgeons, in this instance, are more important than their practical or technical capabilities. The following excerpts represent a fraction of the source material relating to the perceived deficiencies of the spoke hospital team's clinical practice:

You've got your old woodpecker finch pecking away and all of a sudden there's this fucking lesser spotted weasel toe woodpecker comes in and goes 'you might have evolved that, but look at this, this is how we're doing it here.' And they're going 'but, but… […], I peck a bit, I don't peck as well as you, I appreciate that' […] All of a sudden […] you've got [hub surgeons] going in and saying 'this isn't a MDT, it's an x-ray meeting,

you're treating x-rays, that's why you do 300 angios a year because half of them you don't need to do.'

<div align="right">(Vascular Surgeon 2)</div>

There's plenty of patients that say, 'for God's sake don't send me back.'

<div align="right">(Vascular Surgeon 2)</div>

A lot of the work you are doing locally you wouldn't have a leg to stand on, pardon the pun, if it all went tits up. If you're doing an angioplasty in a man who can walk three-hundred yards, he might have asked for it, and been desperate for it, and signed the consent form, but if most of your peers up and down the country wouldn't have done an angioplasty under those circumstances, […] You'll be struggling in court. And it will be an expensive mistake.

<div align="right">(Vascular Surgeon 2)</div>

The above excerpts make an appeal to patient perceptions about the quality of the spoke hospital services and their desire to be retained under the management of the hub hospital team. There may be a rhetorical element in appealing to the interests and opinions of patients. In some ways, the patient is positioned as the arbiter of which clinical team is better than the other clinical team. In other words, even the patients know that the spoke hospital team are not very good!

5.2.4.   Wider Peer Group

Finally, there are references to the capability of individual surgeons relative to their wider peer group. The outcomes of vascular surgery are published nationally at surgeon level for a number of indicators. Although this data is not presented as an absolute ranking, the surgeons' data is presented side-by-side for any given organisation. The rates of mortality following surgery may represent a particularly pronounced feature of vascular surgery compared to other medical specialties where clinical outcomes may be more indeterminate.

The national vascular registry basically tells you what your percentage death rate is over the last five years. […] The national mortality for the last five years is 1.9% […] and mine

is 0. […] Those are the figures that we're all chasing.

This outcome data is a very transparent way that surgeons are weighed and measured. This data is available to peruse by both surgeons and the wider public. The ability to boast that your mortality rate is 0% is used by Vascular Surgeon 3 as a proxy for their clinical capability and prowess relative to their peers. What better indicator for their capability can there be than their ability to save patients' lives and prevent any avoidable deaths. A vascular surgeon will understand their relative position to their peers based on this outcome data.

Because we kill a lot of people, we always get judged on death, and that's very old-fashioned, but that's the way it is.

(Vascular Surgeon 1)

The interview material also referred to the capability of surgeons to undertake EVAR. There are relatively few surgeons with the skills to perform EVAR procedures. The capability of these surgeons has been articulated in a number of different ways including how quickly a surgeon can reach a level of technical capability and competence compared to their peers:

[The Vascular Society] said, for a consultant surgeon, you have to have done fifteen open aneurysms. Can you imagine, […] to be a concert pianist you've got to play about 350 times. And this is life and death. […] I'd done 150 elective aortic surgeries, […] I'd done 70 EVARs, and I was well ahead of most of my peers. […] It's a competency-based thing, […] one person might need to do 400 of something to get good whereas another person might need to do 150.

(Vascular Surgeon 2)

We've got old school vascular surgeons in place, and I suppose I count myself in there because we didn't learn EVAR as a trainee and we still haven't learned EVAR.

(Vascular Surgeon 3)

Furthermore, the relative capability of these surgeons has also been couched in terms of how easily a surgeon can appropriate the skills of different clinical specialists. In so doing, this is an expression of jurisdictional creep. The excerpt below refers to the jurisdictional boundary in performing EVAR between vascular surgeons and interventional radiologists.

Some of the surgeons have gone, 'well you know I can do interventional radiology, it can't be that difficult, I can learn it in a morning.'

(Vascular Surgeon 1)

The surgeon's sentiment is that the interventional radiologist's contribution could be picked up and performed by the vascular surgeon. In other words, they are suggesting that the interventional radiology element is easy enough for the vascular surgeon to perform both functions at the same time. The surgeon is diminishing the value of the contribution from the interventional radiologist, whilst demonstrating their technical dexterity as well as how easily they can learn and master these skills.

*   *   *

In summary, the theme of capability was expressed with reference to 'others' including the vascular surgeons' immediate peers, colleagues in neighbouring hospitals and the profession at large. There were a number of reflections that concerned the role of status within processes of organisational change. These included the incompatibility of divergent constructions of professional status in the instance that the former hub hospital and former sister hospital surgeons were collocated on the same hospital site. This was mediated through the object of hospital beds. The former sister hospital consultants based their construction of status on the efficient use of beds. However, for the former hub hospital consultants the way they used the beds was an expression of their power within the organisation. These incompatible constructions of status resulted in the integration of their working practices being fraught with difficulty.

Secondly, there is evidence that organisational change poses a status threat because of the fish-pond effect. This was particularly apparent in the eleventh-hour withdrawal of the spoke hospital consultant from the network. This doctor effectively forfeited their

ability to perform major vascular surgery. However, they retrenched to other fields of practice where their competence could not be questioned. Similarly, new techniques like EVAR present a similar status threat to those established consultants for whom it is simply too late to retrain. They may similarly retreat to other fields of practice where their clinical authority remains dominant.

5.3. Specialisation

Vascular surgery has become increasingly specialised, and since 2013, has been recognised as a separate surgical specialty from general surgery. Until recently, most surgeons trained as generalists and then developed sub-specialist interests in upper or lower gastrointestinal, breast or vascular surgery. It is now possible for surgeons to train as pure vascular surgeons. This means that future surgeons will have different training opportunities and will develop different skill sets (e.g. EVAR) compared to their established consultant colleagues. This indicates the dynamic and shifting nature of expert knowledge and skills. The exclusivity of these skills will diminish in future years and become more routine. Similarly, the construction of status will also be reconstituted to reflect the changing complexion of the workforce and expert knowledge.

The following excerpt provides a reflection on how the status of the specialty has changed over time. As vascular services expanded, surgeons were able to gain greater control over their activities. The ability to be masters of their own fate has a significant role to play in their construction of professional status.

I spent about ten years of my life just being called […] when I was on-call and not on-call, and that became unacceptable. […] You had to have rotas, […] you had to have enough surgeons to be able to run the rotas, and that meant coalescing services, and building bigger units with more and more vascular surgeons.

(Vascular Surgeon 1)

The establishment of vascular networks could be seen as a continuation of the specialty's increasing specialisation. The vascular service initially developed the capacity to deliver services more comprehensively and sustainably. Subsequently, this has provided the headroom for them to develop more specialist activities, which is difficult to accomplish this whilst you are continually at the beck and call of the hospital. It has also permitted them to divest themselves from non-specialist activities. Until recently, vascular surgeons have had to supplement their vascular surgical activities with other general surgical procedures such as hernia operations. However, the increase in planned and emergency arterial admissions to the vascular hubs has

required a greater focus on complex vascular surgery.

You've got to marry up your on-call rota […] with the amount of elective work there is to do by the same people. […] We got round that historically by doing other bits and pieces. […] Now by centralising you can be pure vascular.

(Vascular Surgeon 2)

The former sister and hub hospital teams have responded differently to the opportunity to divest from general surgical procedures. The former sister hospital surgeons have given up virtually all of their routine general surgical activities and have gained a significant amount of pure vascular surgery. The former hub hospital surgeons have been a little more reluctant to lose all their routine general surgical work. This may be because procedures like hernia repair have quite a high value in private practice.

In this context, professional status has been constructed in different ways by the former sister and former hub hospital teams. For the former sister hospital team, status is elevated by the designation of being a specialist vascular hub. The corollary is an increase in vascular planned and emergency procedures, which requires a refocusing of their activities. The former hub hospital team have always valued straddling both camps by undertaking vascular surgery but also retaining a healthy proportion of general surgical work. Indeed, as a result of the reconfiguration, the former sister hospital surgeons' workload has become significantly busier with major cases.

The former hub hospital surgeons have the best of both worlds, having the recognition as being specialist, but maintaining a more balanced mix of activities. This is reflected by the fact that, unlike the former sister hospital surgeons, the individual surgeons do not refer to themselves as a 'consultant in vascular surgery', but rather a 'consultant general and vascular surgeon'. The former hub hospital surgeons acquiesced to the process of designation as a vascular network but did not pursue this agenda with any vigour. The relative status between being a 'general and vascular surgeon' or a pure 'consultant in vascular surgery' may be a difference in emphasis rather than kind.

Furthermore, one of the requirements of a vascular network is the provision of a specialist vascular on-call service. The development has required vascular surgeons

to be released from the general surgical on-call rota. In other words, they will only be called to provide an opinion on a patient that has a vascular complication. As a consequence of these changes, in most centres, gastrointestinal surgeons nearly exclusively staff the general surgical on-call rota. It is not unreasonable to assume that the establishment of a specialist rota would elevate the status of the surgeons working at the hub hospital. However, the structure of the network means that the on-call surgeon effectively now has to cover three hospital sites (i.e. the hub, sister and spoke hospitals). This means that the specialisation of the rota has to be balanced with an increasingly burdensome span of activities.

As discussed above, the emergence of EVAR has brought into sharp relief the blurring of jurisdictional boundaries between vascular surgery and interventional radiology. This is because the skill set to undertake both the interventional radiology and surgical elements associated with EVAR is not currently embodied in any one specialist. However, the boundaries between these specialties are gradually overlapping and surgeons are being trained in competencies to allow them to undertake procedures like EVAR independently without interventional radiologist support.

In ten years' time, there won't be two branches of treating the same people, there won't be interventional radiologists, there will be interventional vascular surgeons.

(Vascular Surgeon 1)

In terms of vascular intervention, there's now a lot of opinion that it will be subsumed by vascular surgery. Which doesn't leave much. […] We obviously lost all cardiac work.

(Interventional Radiologist)

There is a jostling between interventional radiology and vascular surgery for the control of the task of performing EVAR. This is consistent with Abbott's (1988) conception of shifting jurisdictional boundaries, and a continuous state of flux in which tasks are created and abolished and jurisdictions are reshaped. The loss of the jurisdiction associated with interventional vascular surgery mirrors the emergence of independent interventional cardiologists that undertake procedures like angioplasty. The cardiac

cath lab is a clinical jurisdiction that has been lost by radiologists to other medical specialists. The relative status of these different specialties may be a key determinant in leveraging resources, and maintaining, defending and expanding clinical jurisdiction over specialist activities.

*   *   *

In summary, the theme of specialisation was expressed in terms of the increasing specialisation of vascular surgery. This has led to an expansion of specialist activities and dropping general surgical activities. There were a number of reflections that concerned the role of status within processes of organisational change. Firstly, the increasing specialisation of vascular surgery has enabled vascular surgeons to gain greater control over their activities and be the masters of their own fate. However, there are divergent interpretations of the impact of the vascular network on professional status.

For the former hub hospital surgeons, they have maintained a dual identity of vascular and general surgeon. This is partly because this allows them to maintain outside interests. On the other hand, the former sister hospital surgeons have based their construction of professional status on the designation of being a vascular hub. However, the scope of the network, which requires more specialist provision to be spread much thinner, may diminish their professional status, or at the very least negate any status benefit associated with the vascular network.

The emergence of new techniques like EVAR poses a jurisdictional threat to interventional radiology. This is because of the scope for the vascular surgeon to embody both functions within their role. This extension of jurisdiction can be used to further extend specialisation and provides an opportunity to build professional status.

5.4. Technology

EVAR is a highly specialised form of surgery that is undertaken using a range of sophisticated technologies. The use of technology is an inherent feature of minimally invasive surgery. For instance, it may involve imaging and delivery systems to avoid the use of radical or highly invasive 'open' surgery. These technologies tend to be at the forefront of research and innovation and the tools and techniques are continuously being refined.

Figures 9 and 10 demonstrate the extent to which the 'open' AAA repair is qualitatively different from EVAR surgery. This is expressed both in terms of the trauma caused by the 'open' surgery to the patient's body, but also the nature of the tools that are used – solid metal objects such as retractors and clips compared with catheters and tiny stent devices. This does not mean that EVAR avoids any trauma to a patient's body, nor is it devoid of blood and guts. However, minimally invasive techniques do reduce trauma compared to an open procedure.

Expandable stent-graft device

Catheter
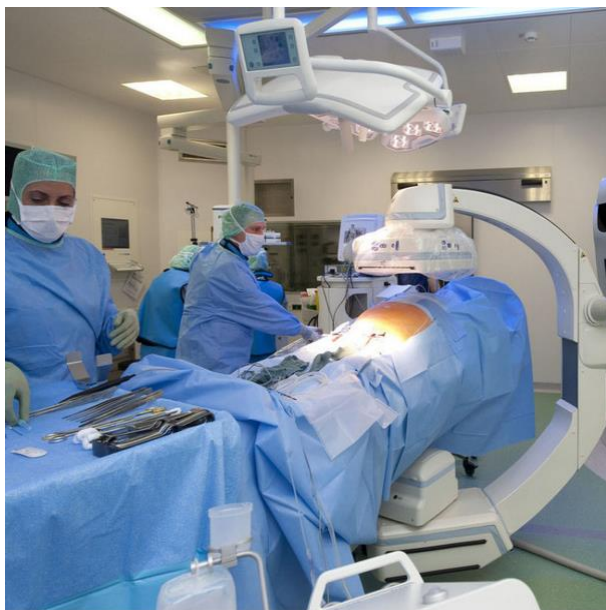
EVAR procedure in hybrid theatre

Fluoroscopic (X-ray) guidance

Laparotomy (bowel) surgical set
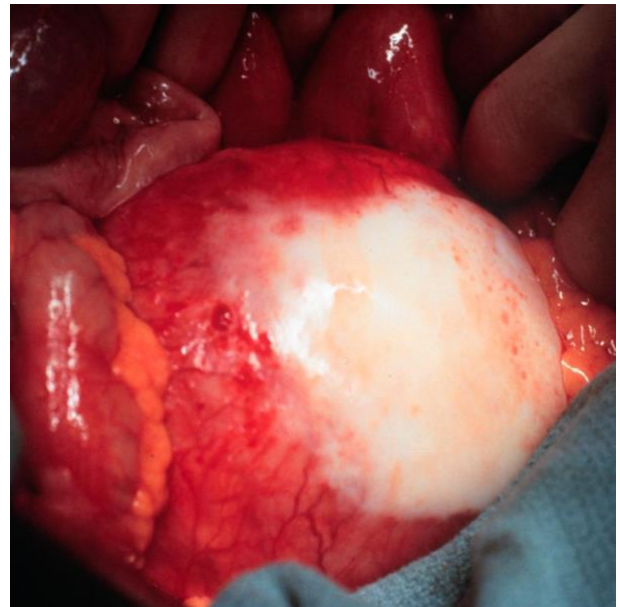
Aortic aneurysm
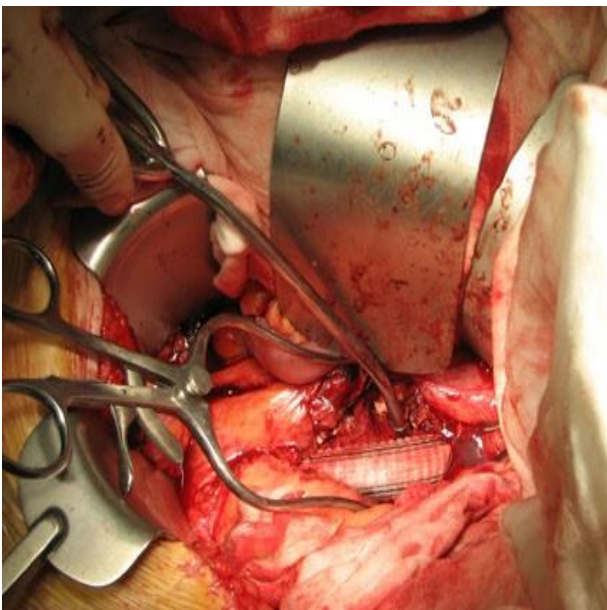
Open AAA Surgical Procedure

Surgical site

The use of technology may be used as a proxy for professional status, because it is reflective of the progressive nature of the surgeon's practice. Korica & Molloy (2010) explored how surgeons used new technology to inform their professional identity. For instance, new technology offers a way to maintain one's professional currency – as someone on the cutting edge and not 'yesterday's man'. It can also be used by junior professionals to establish their credentials and even challenge the established order. The use of EVAR is consistent with this analysis; it has occasioned insider / outsider dynamics and has influenced the ongoing negotiation of professional identity.

As an emergent technology, EVAR does face some sceptical voices from within the profession. For instance, because this is a minimally invasive form of surgery, there is an anticipated improvement in survival rates from EVAR compared with conventional 'open' surgery. However, some of the published data is equivocal and the efficacy of this technique is the subject of ongoing debate.

The outcomes after EVAR have improved over the years and therefore the evidence for doing it is a lot stronger. […] The proportion done by EVAR has risen. But then, even the real enthusiasts […] will admit […] they might have just been doing a few too many, stretching the limits of where we should be doing them […] and finding the problems. And therefore, needing to back off […] until such times we either do more advanced EVARs and the device has improved allowing us to do safer complex EVARs.

(Vascular Surgeon 3)

[After] ten years, there's an excess mortality in the EVAR patients over the open patients. […] We don't really understand that fully. The guys who like open surgery say, 'oh, it's because stents are shit.' The guys who like stent surgery say 'oh, it's because we did this study twelve years ago, […] it is not reflective of current practice'. And the truth is somewhere in between.

(Vascular Surgeon 2)

The excerpts above are interesting because it suggests that emergent technologies have an element of risk in their application, especially when there is a paucity of research demonstrating their relative efficacy. These minimally invasive procedures are not without their complications and dangers. For procedures like EVAR, there is

the risk that the stent device could 'travel' or 'leak'. Similarly, for cancer surgery, there is the risk that the completeness of resection of disease association with an 'open' procedure cannot be achieved using a laparoscopic technique which would have more limited visibility and access. In many circumstances, surrogate markers will be used to determine the efficacy of the minimally invasive procedures such as recovery time, rates of mortality or morbidity etc. Again, the theme of a tolerance for risk comes through strongly in the interview material.

The excerpts also suggest that the use of these technologies often stretches the boundaries of appropriateness in terms of patient suitability and application. This may be partly attributed to the vagaries of using new technologies and their resultant outcomes. However, this may also suggest that the utilisation of these technologies may sometimes override a consideration of their direct utility for the care of patients. This may be because a surgeon may be loath to miss an opportunity to use technology to elevate their professional standing. The mastery of new technologies presents them with an ever-greater technical challenge.

It is interesting that a former hub hospital vascular surgeon, who expressed the greatest level of scepticism towards this technology, attempted to establish their own EVAR service without reference to the most proficient surgeon in this technique, who at the time was based in the sister hospital.

[They] tried to start a parallel […] programme about three or four years ago, having referred a lot of their patients past us. […] They just booked in a case […] I found out that they were doing it because [...] the anaesthetist was moaning about it, because they'd booked the ITU to do this bloody EVAR next week. […] It all kicked off.

(Vascular Surgeon 2)

This passage indicates a clear reluctance on behalf of the surgeon concerned to refer the patient on to one of their colleagues. Instead, patients had, until recently, been referred to other centres in the region, rather than to their colleagues down the road. This indicates a level of competitiveness, antipathy or inter-personal rivalry. This may suggest that the use of these technologies have been threatening to the status of the

consultant surgeon involved.

There may be parallels that can be drawn between the introduction of EVAR and other technologies. For instance, Barley (1986) considered the introduction of CT scanners into the radiology departments of two hospitals, and how these new devices altered the organisational and occupational structure of radiological work. It is significant that this study considered 'technology' as a social rather than a physical object, and 'structure' as a process rather than an entity. Barley demonstrated that although this technology was introduced in comparable organisations, following the same process, the outcome were divergent forms of organisation.

In a similar way, the introduction of EVAR into the two hospitals has had different effects on organisational structure because of the actions of its respective members. The former sister hospital team approached the introduction of this technology in a more transparent and open way. Whereas, the former hub hospital team tried to sneak this development past their colleagues. The consequence was that members of the former sister hospital team developed their identity and practice around this technology. On the other hand, the former hub hospital surgeons, this technology failed to take hold.

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In summary, the theme of technology was expressed in terms of the emergence of minimally invasive surgical techniques like EVAR. There were a number of reflections that concerned the role of status within processes of organisational change. Technology was used as an expression of the superior and progressive nature of a surgeon's clinical practice. The use of emergent technology is presented as a high stakes gamble that may have positive or negative consequences for a doctor's professional status. In circumstances where a technology is being adopted without any evidence of its relative efficacy, and the appropriateness of patient selection is questionable, status is presented as an end in itself. In the desire to establish their own EVAR service, the hub surgeon demonstrated that they understood the utility of technology in the construction of professional status.

5.5.   Material Value

In discussing the theme of material, it is first necessary to provide a more thorough description about the differences between the hub and sister hospitals. Although these hospitals are located in adjacent towns, they diverge significantly in terms of character (see Table 9).

Table 9: Characteristics of the Hub & Sister Hospitals

Hub Hospital	Sister Hospital
- Smaller hospital - Regency brick - Wealthy and educated population - Little ethnic or cultural diversity	- Larger hospital - 1970s concrete - Socially disadvantaged population - Ethnically & culturally diverse - Greater proportion of chronic disease

There are a number of references to the different clinical cultures that subsist within each of these hospitals. This difference has its roots partly in the divergent characteristics of the towns where the hospitals are located. The hub hospital is characterized as a comfortable place to work where consultants can more effectively balance their NHS commitments with private practice. The sister hospital is larger, busier, and there is less private practice. The theme of material will be explored with reference to private practice and the earning potential of surgeons, the hybrid theatre, the leveraging of investment and the control of resources, and the social strata of patients and the characteristics of their disease.

5.5.1.   Private Practice

The earning potential of individuals has been couched in terms of private practice. In relative terms, vascular surgeons maintain a healthy, but in no respects the highest, level of private patient earnings. However, the following excerpt expresses considerable resentment towards higher earning specialties.

I drove in behind a gynaecologist […] who does a lot of fertility work […] driving a four-wheel drive Porsche. And I just thought […] I'll never be able to afford that vehicle. […] They're smiling, and they've got a Porsche, and I'm miserable and I've got a Honda Civic.

(Vascular Surgeon 2)

Although surgeons in both hospitals undertake private practice, the hub surgeons are identified as having a greater predilection for private earnings. The interviewees suggest that private practice can be related to resistance to change.

In [the hub hospital] you've got a lot more people who are about their private practice than in [the sister hospital where] you've got people who are […] not really that into the money.

(General Manager)

The […] thing that gets in the way is private practice […] because their private referrals tend to come from the geographical areas in which they work, so if you are bringing people together, and it wasn't on their site, there was the concern that 'oh, crikey, no […] I've lost contact with my referring clinicians for private practice.' […] Their concern is that they're less visible and […] present in those networks.

(Medical Director)

The vascular centralisation posed the risk of losing jurisdiction over private activities, by transferring surgeons out of their referring network, and of having to share jurisdiction and revenue with those surgeons transferring into a particular locality. This can explain reluctance to move one's NHS practice out of a certain locality, or to dilute the referral pathways from a locality by introducing colleagues that may compete for business. For consultant surgeons offering private practice, their status and standing

in the eyes of referring clinicians is very important. Their private income is partly dependent upon developing and maintaining positive relationships with these clinicians.

5.5.2. Hybrid Theatre

The leveraging of investment and resources and the control of high value equipment and facilities is an important theme. The most significant development was the building of a new multi-million-pound hybrid theatre to support the centralised hub hospital service. This hybrid theatre blended the design of an operating theatre with a radiology procedure room. Interestingly, this facility is varyingly referred to as a 'hybrid theatre' or an 'IR theatre', with 'IR' referring to interventional radiology. The interview participants' choice of reference was determined by whether they were persuaded to emphasise the leading role of one or the other specialty. The development of this facility has created a significant jurisdictional overlap.

It is important to note that the radiology team did not advocate the building of this hybrid theatre. It was a service development pursued doggedly by the vascular surgeons. Indeed, it has been described as one of the 'carrots' to encourage the former sister hospital surgeons to centralise services in the hub hospital. The investment in this facility can be regarded as an expression of the ability of the vascular surgeons to leverage a multi-million-pound investment over and above their radiologist colleagues.

This may indicate the relative status of the vascular surgeons compared to the interventional radiologist team. This could translate into their ability to influence senior managers and policy makers. Alternatively, this could be seen as a pragmatic judgement by the senior management about the relative risk to the organisation's reputation of disenfranchising a group of consultant surgeons. The decision to invest in this facility has been presented as a remarkable last-minute decision on behalf of the senior management team.

There was a cogent argument from radiology […] that a full-blown hybrid theatre added very little value. […] In terms of the greatest good for the population, not just vascular

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patients, a good interventional radiology facility based in radiology would deliver that and a lot more. That argument was won […] and then was reversed at the eleventh hour on the basis of […] slippery dealing by [surgeon]. He was very, very upset by that decision.

(Medical Director)

Furthermore, notwithstanding the fact that the hybrid theatre sessions are shared between the radiology and vascular surgery, the facility is a theatre within the surgical domain, rather than an interventional procedure room within the radiological domain. This is significant because the surgeons not only leveraged the investment for this facility, but also established control over the facility and wed it to the norms, routines and behaviours of an operating theatre.

A theatre is a surgeon's domain so [you] wear all sorts of green kit [and] everybody comes and watches you in a mask and admires you. If you were in radiology […] it wouldn't have been a theatre, but it would be the radiology domain. […] The fact that it's ended up under surgical jurisdiction means it's quite a difficult domain […] in terms of we're infiltrating into somebody else's world here.

(Medical Director)

Again, the theme of control of resources is central to the dialogue, in terms of both jurisdiction and the determination of the norms and behaviours that are permitted in this facility.

Finally, the hybrid theatre is regarded by the surgeons as a 'beacon' or 'figurehead' for the vascular service. This resource has an attractor quality and elevates the status of the vascular team. It confers added value upon the service, enhancing the competitive edge of the hub hospital in the recruitment of vascular surgeons and other allied clinical staff members. The following excerpt reflects upon the attendant benefits associated with the hybrid theatre.

A case was made for having a hybrid theatre so that we could move forward as a 21st century, […] pukka vascular unit. It's […] a beacon for us. […] It's going to be one of the more attractive things to be able to get staff to join us, certainly at consultant level but probably other tiers of staffing as well. […] Its futureproofed us for quite a while. […] It's a

shame we just haven't got three of them.

(Vascular Surgeon 3)

The above excerpt is interesting in that the utility of the hybrid theatre is as much related to creating a field of activity as servicing the needs of the population in the treatment of their disease.

5.5.3. Social Strata

There were references to the particular characteristics of vascular patients and the nature of their disease. This is not a specialty that deals directly with organs of symbolic value (i.e. heart, brain, eyes), but with a bodily system. Vascular surgery tends to treat a disproportionate number of patients from lower socio-economic backgrounds. The nature of vascular disease is associated with underlying poor lifestyle choices e.g. smoking, diabetes related to obesity.

People at the lower end of the social spectrum just don't look after themselves. […] The best vascular units are in conurbations, urban areas where there's a lot of vascular pathology. […] Vascular is dependent upon people who smoke and won't give up smoking.

(Vascular Surgeon 2)

The type of patients treated by vascular services tend to be poorer in terms of health and material wealth. These can be challenging patients to treat because of their multiple comorbidities and their often-unplanned presentation.

Obesity is the new smoking. But with obesity comes, […] lots of venous problems, lymphatic problems […] and you get […] diabetes and diabetic feet. […] It's difficult so it's badly managed. It's labour intensive. It doesn't come in during daylight hours necessarily. […] A lot of what vascular surgeons do isn't particularly nice because it is the patients who just can't help themselves.

(Vascular Surgeon 2)

The idea of working in a hospital that only deals with emergency patients was maligned

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by one of the interview participants. There are surgeons that only provide cover for on-call rotas and emergency lists. These usually called 'emergency surgeons'. Their status is very low as they tend to be roles filled by individuals that have not been able to attain a specialist consultant post. The following reflection was offered by one of the vascular surgeons about these roles:

Who wants to just do drunks and tramps in the middle of the night. Because essentially that's a lot of what you do, drunks, tramps, […] the bottom end of the poverty scale […] who don't say thank you.

(Vascular Surgeon 2)

This sentiment was also very pronounced in reflections regarding the locality surrounding the spoke hospital. This may account for the lack of appetite from the hub hospital consultants to extend the ambit of their control to this population. This population is significantly more deprived than the localities surrounding both the hub and sister hospitals. There may be little to be gained for the status of the hospital or individual surgeons by serving these communities.

It's just a high concentration of low social strata. […] And you see […] vascular pathology which is just an order of magnitude worse than patients we see here.

(Vascular Surgeon 2)

It should be noted that all specialties deal with patients from a range of socio-economic backgrounds and mundane or unpleasant end of the clinical spectrum. This this isn't an exclusive feature of vascular surgery.

With upper [gastro-intestinal] surgery you'll have the nutters who've got biliary colic […] people who moan and groan about pain. With colorectal you've got the people with itchy bums and haemorrhoids and […] you smell of shit half the time because you're dealing with […] bloody offal […] and bowels and things. With vascular […] you've got stinking diabetic toes with a whiff of gangrene and things […] And with urology you've got the bloody penis problems. […] You've got the bits of every specialty that you laugh at.

(Vascular Surgeon 2)

With respect to the vascular network, the important point to note is the preponderance of patients from lower socio-economic backgrounds. The presence of unpleasant pathology *per se* does not necessarily have a bearing on the construction of professional status.

* * *

In summary, the theme of material was expressed in terms of private practice, the leveraging of investment for, and control of the hybrid theatre, and the social strata of patients and the characteristics of their disease. There were a number of reflections that concerned the role of status within processes of organisational change. For instance, private practice was described as something that 'gets in the way' of organisational change. There may be a resistance relating to losing jurisdiction and revenue related to private practice, or a concern that changing the pattern of the associated referral network will lead to a sharing of revenues with other consultants.

The *volte face* associated with the building of the hybrid theatre indicates that the surgeons were able to leverage investment over and above their radiology colleagues. This suggests that vascular surgery has higher professional status because they have been able to draw this resource into the ambit of their control. The hybrid theatre is also presented as a 'figurehead' elevating the status of the entire vascular service and increasing its competitive edge over other hospitals. Finally, there is evidence that there is little status advantage in extending the jurisdiction of the vascular network to the spoke hospital locality because of the preponderance of lower-socioeconomic groups with chronic diseases. The logical extension would be that there may be an advantage of extending the reach of the service into more prosperous regions with more acute disease and a wealthier populace.

5.6.   Organisational Standing

The interview transcripts were replete with references to organisational standing of the vascular service. These references can be sub-divided into four groups. The volume / outcome drivers for change and the process of centralising vascular services at a national level, the centralisation of services between the hub and sister hospitals, and the incorporation of the spoke hospitals into the vascular network.

5.6.1.   Volume / Outcome

The most important driver related to the formation of vascular networks has been volume / outcome research that links the volume of surgery performed by an individual or organisation to the quality of the clinical outcomes. The logic being that small centres that undertook low volumes of specialist surgery were likely to produce poorer outcomes.

If you do a few big operations, […] you don't get very good results. If you coalesce those into big centres, the volume outcomes relationship says the more you do, the better you get.

(Vascular Surgeon 1)

Volume / outcome is a complex relationship which isn't just putting a group of vascular surgeons together, it's actually putting a group of vascular surgeons, a group of vascular nurses, having a ward, an ITU which is used to vascular services and […] stroke physicians, your renal physicians, your cardiologists, all on the same site. Team working […] produces good outcomes. So that's why figures have been placed as institutional figures, not as individual figures.

(Vascular Surgeon 2)

The requisite size of population to support a vascular centre was chosen because it is broadly equivalent to the critical mass required to support an aneurysm screening service and was also regarded as sufficient to maintain an appropriate volume of elective operating for a team of vascular surgeons to maintain competency. It also balanced the size of a vascular surgery on-call rota to support the more intense pattern

of working required in a vascular hub.

The Vascular Society suggested that that you needed 150,000 population per vascular surgeon […] to give them enough elective operating. […] So, you need the better part of 900,000 population to have a reasonable on-call rota so you're not too busy and enough elective work to do.

(Vascular Surgeon 2)

In a number of localities, where no single organisation had the requisite critical mass of population, it was necessary to form organisational networks. These networks were structured as hub and spoke services, with the acute and life-threatening major arterial work being undertaken at the hubs, and the lower acuity and more routine activity being carried out for at the spoke units.

The national vascular network perceives that population mass required to be in the region of 800,000, maybe a million. […] We had two choices really, we relinquish the service and hand it over to somebody else […] or we attempted to form a network that would allow us to get up to that population and to a critical mass. […] There seemed to be support internally […] for the concept of becoming a vascular hub […] and engaging with [the spoke hospital] took us to a population that's probably 800,000 or at least very close to it.

(Medical Director)

The corollary of the formation of the vascular network was an implicit recognition that in order to be fully competent to provide a range of specialist surgery, a vascular service needed to have a critical mass to enable the team of surgeons to sub-specialise within different fields of clinical practice. The focus on the volume of surgery undertaken in each centre, paired with the nationally reported clinical outcome data, resulted in a high level of scrutiny. It was no longer sufficient for an individual surgeon to simply avow the quality of their clinical practice.

There are particular skills […] which you really can't have everybody training, so […] you need a critical mass of people to have that range of expertise that demonstrates or represents a comprehensive service.

(Medical Director)

The argument that as long as you keep yourself up-to-date you'll be okay is diminishing. You have to be in a network that enables you to develop your skills across a certain critical mass. […] Whilst it looks like it's honing the skills of the individual operator, it's […] that these patients are being cared for in specialist centres with easy access to multiple disciplines where everybody knows what they're doing.

(Director of Strategy)

A number of the interview participants were quick to point to the initial success of the centralising process in improving surgical outcomes. Although the formation of the networks and the centralisation of services are still in their early stages, there has been a demonstrable improvement in mortality rates. The following excerpt expresses a sense of vindication that the centralisation process has improved clinical outcomes.

When we started the […] mortality rates in England and Wales […] were 7.5%, and last year, when the centralisation process was really only two thirds done, mortality rate is now 2.3%. […] Whoever says, […] 'I don't believe in centralisation, its bloody rubbish, I don't see why people […] should have to come all the way to [the hub] to have their aneurysms treated', the answer is because you get a two thirds reduction in mortality. […] The truth is the narrative is so good that it's unchallengeable.

(Vascular surgeon 1)

The focus on the volume / outcome relationship has had a significant impact on the construction of professional status. There has been an explicit consideration of the competency of individual surgeons and quality of care offered in different surgical centres. Until recently, it may have been anathema to question the status of individual surgeons.

5.6.2.   Centralisation

The centralisation of vascular services has been led by the vascular profession. It has provided core standards, which have been appropriated by policy makers and commissioning organisations. This has been a bottom-up change. That does not mean that there has been universal approval, but the centralisation would have been unlikely to get off the ground without promotion by the professional body. A number of parallels

can be drawn between the clinical leadership from the professional body leading changes to vascular services and the reconfiguration of cancer services. Ferlie *et al* (2012) considered the formation of managed cancer networks and the presence of clinical managerial hybrids. These hybrid roles straddling both clinical practice and management are also present in this case.

There has just been this rolling programme of centralising vascular now around England […] what's happening in [here] is happening all around the country, led by […] a London vascular review, which had teeth, […] and actually reduced the number of vascular centres from sixteen down to seven. […] They have lost another two since then.

(Vascular Surgeon 1)

The formation of vascular networks has necessitated a considerable amount of organisational upheaval across the nation. There have been different experiences around the country between those that already had the requisite critical mass to support a vascular service, those that met the challenge to form a vascular network, and those that have fiercely resisted, or are continuing to resist the change to their local vascular services.

Some places just say okay, let's do it. [Hospital A] is a big endovascular centre, it's got a hybrid theatre. [Hospital B] is a bigger centre with cardiac surgery, transplant surgery. […] They haven't had a very good endovascular unit, haven't got a hybrid theatre, so the work should go to [hospital B], but all the kit, hardware and expertise is in [hospital A]. [Hospital C] had […] a professor of vascular surgery who said vascular surgery is for numpties, it's for idiots, it doesn't work, you kill people, doesn't make them survive. […] So, they're about ten years behind the curve. But it's [a tertiary centre] it's got cardiac stuff, it's got transplant stuff. So, it's the natural pre-eminent institution, which should drag the service in. But then you've got [hospital D] who've got very dedicated keen surgeons who are […] in front of the curve. [Hospital C] can't appoint because it's a mess, everyone knows it's a mess, everyone knows that [hospital C] are behind the curve. […] The whole country is a bit of a mess.

(Vascular Surgeon 2)

[It] was obviously the guys in the bigger units driving it […] who knew the direction of travel

[…] and then the guys in the smaller units who didn't want to change their life and how they worked.

<div align="right">(Vascular Surgeon 2)</div>

There are places that have been very resistant […] The bloke stabbed me in the chest, 'YOU WILL BE THE DEATH OF THE DISTRICT HOSPITAL!' […] I have heard it loads of times before, […] they say, 'we are perfectly fine, our results are good, bugger off.' […] There are going to be hospitals that are big losers.

<div align="right">(Vascular Surgeon 1)</div>

These excerpts provide a number of reflections that relate to professional status. Firstly, there is a suggestion that they are some key components to be a vascular hub: to be a big endovascular (minimally invasive surgery) unit, to have a hybrid theatre, the right kit, and personnel with the right expertise to use it, including keen and suitably orientated surgeons. There is a suggestion that the vascular hub would complement other specialist services embedded within a tertiary centre such as cardiac surgery and transplant surgery. The loss of vascular services may represent the slipping of the crown of a tertiary centre, and incompatible with their dignity and status. Furthermore, there is a sentiment that these changes have been driven by those individuals and services in large units with sustainable services. These organisations are self-assured that they can meet the requirements defined by the profession in their core standards.

Smaller centres fear the loss of vascular services. They are often described as the thin end of the wedge. Vascular services have a range of linkages with other specialties. They specialty also has a greater focus on emergency activities and life-saving interventions. The loss of the service is not only regarded as a loss of status for the specialty and individual clinicians but may also destabilise other services and lead to an erosion of specialist services and a downgrading of the status of the entire organisation.

If you look at […] stroke […] in London, where they ended up with three or four centres, […] that model works quite well […] where you've got […] millions of population and sufficient demand. As you move out into the more rural parts of the country […] how can you have that viable mass within a large geographical area that's not that densely populated. […] If you look at our catchment population it may never be big enough. And

then it then becomes this stack of cards or dominoes. […] For […] specialist burns, specialist trauma […] people can see large regional centres work well for that. When you then get into stroke, when you get into vascular, you get into services that are a bit more traditionally [general hospital] services.

(Director of Operations)

The implications of the Keogh Report (2013) were foremost in the minds of a number of the interviewees. This review focussed on the emergency and urgent care system to help improve its safety and effectiveness. The review differentiated between 'emergency centres' and 'major emergency centres'. The latter would include specialist services for heart attack, stroke, major trauma, vascular surgery and critically ill children. The implications of the review were open to interpretation. However, there was a fear that this could again represent a loss for some local hospitals currently providing these specialist services. This may lower the status of these hospitals and make future recruitment and retention of high calibre staff more problematic.

If you are a really high-quality clinician coming out of training now, you have got a range of different organisations you can work in. You're more likely to gravitate to the specialist centre, the bigger hospital. In the old days, it used to be the teaching hospital. […] And then, if you didn't do that, then you went to a good [general hospital] in a nice part of the country. […] There could potentially be, in the longer-term, parts of the country which become not quite no-go areas […] that are staffed with […] doctors that […] wouldn't be good enough for a big teaching hospital and/or is staffed by high degrees of locums, temporary staffing, wholly overseas trained staffing. […] If you're […] a relatively small [general hospital] what type of people do you attract?

(Director of Operations)

The status of an organisation is partly informed by the quality of the doctors that it is able to attract. There may be a homophilic relationship that dictates that high calibre surgeons are attracted to work with like-surgeons in pre-eminent organisations, and less capable surgeons that are relegated to work within less viable organisations. The loss of vascular services will further undermine the quality and comprehensive nature of services offered in an organisation. This is a vicious cycle that contributes to the status drain of an organisation.

5.6.3. Hub & Sister Hospitals

The centralisation of vascular services has not only necessitated the development of vascular hubs on a regional level, but also led to the centralisation of services within organisations that have historically operated vascular services across multiple sites. In this particular case study, the organisation had previously provided vascular services on two hospital sites. The formation of the vascular network necessitated the centralisation of the vascular service to one of these sites. The trust board determined that the vascular service should be centralised in the hub hospital – the smaller of the two sites. The clinical teams from the sister hospital were transferred over to a new centralised facility in the hub hospital.

The decision to centralise the service in the hub hospital has been met with considerable consternation from the former sister hospital team. The frustration centred upon the choice of site being based on purely political expedience.

Wrong site. And it wasn't centralisation, it was polarisation. […] Trauma is coming here, stroke is coming here, renal is here, bleeding women from maternity problems were here […] and they put vascular on the other side of the county. […] anyone will tell you that was a fucking stupid thing to do.

(Vascular Surgeon 2)

Pretty much over sixty, seventy per cent of people in the room at the time said it was a bad idea to move it to [the hub hospital]. And I still […] believe it was the wrong decision. Because I don't see the sense of having a trauma unit separate from vascular. […] It was a political decision to maintain a hospital as being a viable hospital.

(Consultant Radiologist)

The [hub hospital] clinicians […] apparently thought that the hospital was going to be closed.

(Vascular Surgeon 2)

This trust board's decision was intended to assuage the anxiety of the local population and clinical teams in the hub hospital about the fear of a creeping loss of services from

the hub hospital to the sister hospital. The decision to centralise services in the hub hospital was, therefore, an attempt by the senior management to demonstrate that the site would not be relegated to the status of a cold hospital (i.e. no emergency services) nor that this would represent a first step towards the eventual closure of the hospital site.

The location of the centralised service in the hub hospital was an attempt to balance the footprint of services between both sites. In the context of wider service developments between the two sites, the centralisation to the hub hospital site was a pragmatic decision based on the available ward and theatre space.

We felt that the unit should be here and [they] felt it should be there. […] It was an entirely political decision to move it to this site. […] There was no overwhelming clinical imperative, it was more or less equally balanced and the services seemed to be dominantly moving towards [the sister hospital]. We had to [ensure] that there was a balance and that [the hub hospital] wasn't going to decline because there had been a promise that it would be kept as an acute, thriving acute hospital. And understandably and very sensibly the decision was made to keep the service here.

(Vascular Surgeon 3)

There was a well-known sense that [the sister hospital] was a bigger hospital and wanted to dominate by taking all the services. […] That was a sort of a well disclosed secret from even when I started, that [the sister hospital] was bigger and better. […] There was naturally going to be an awful lot of loss of face if that position was given up lightly.

(Vascular Surgeon 3)

The dissatisfaction of the former sister hospital consultants is partly animated by the fact that the hub hospital has seen the service on their site enhanced with new facilities supporting the centralised service including a multimillion-pound hybrid theatre and a refurbished ward facility. There is a sense that the sister hospital lost out on this investment. This may indicate a loss of status for the sister hospital and the vascular team formerly located on this site.

The interviewees also describe one of the greatest challenges to changing the

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operational model of the vascular service was a resistance to change *per se*. There is evidence of an inherent conservatism related to change in working pattern and organisational context.

They were quite happy with their status quo. If you asked any of them […] at some point do you need to centralise your vascular service they've had gone 'oh yeah, yeah.' […] They were actually both perfectly happy being two teams […] and it didn't really matter that they couldn't sit in the same room together. […] It was a battle and [the sister hospital] team lost, […] because they were resigned to the fact that they knew this was going to have to come one day and they could see that the [hub hospital] team were not going to budge.

(General Manager)

This reluctance to embrace change can be attributed to the teams in both hospitals and is expressed by the hub hospital surgeons' intransigence and refusal to consider changing sites, and the sister hospital surgeons' unhappiness with having to move sites for what they regarded as purely political reasons. It is interesting that there may be divergent conceptions of whether centralising the vascular service and developing a vascular hub confers an increase in status. The sister hospital team were more invested in the development of the vascular hub. Whereas their hub hospital counterparts were more willing to accept the *status quo*. The idea of becoming a hub did not have the same attractor quality for the respective surgical teams.

It would be an understatement to say that the interview excerpts express a level of personal antagonism between the consultant surgeons who previously worked on the different hospital sites. This is a very strong and consistent feature of the interview material. This antagonism was particularly centred upon the relationship between two senior consultants. This has been characterised as a 'battle' or a conflict between two 'alpha males'. This was a status conflict *par excellence*.

This has been going on for a very, very long time. The turf war if you like. I don't mind calling it that because it's generally acknowledged that that's what it was.

(Vascular Surgeon 3)

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You've got the two alpha males essentially completely opposed in their ideals and how things should work. […] So, you put six quite different personalities together with two alpha males and you've got a recipe for disaster.

<div align="right">

(General Manager)

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The centralisation of the service brought together two divergent and potentially incompatible ways of working. The status conflict that ensued related to the norms of accepted practice and behaviour that developed on each hospital site. The most ferocious battles were fought over the proper way to allocate junior medical staff, and the management of specialist nursing staff.

We're not really a centralisation, we're a kind of two units have been plonked on one site, but they haven't actually come together. […] There are clearly two different ways of working that happen at a senior clinician level. […] There's almost like a territorial approach. […] I see difficulty from a nursing specialist point of view because […] the nurses were managed predominantly by the consultant surgeons over on the [hub hospital] site. [Compared to] very much kind of working like a junior doctor type role [with] autonomy, taking on more responsibility and having […] an equal voice across the clinical team. […] That's quite stark that difference […] in that they're not given the autonomy or authority to make clinical decisions independently and influence patient pathways. […] It's very difficult because of the personalities that are involved. […] They don't want to […] have any more impact or take on anything in addition to what they currently have. […] And it is very much a cultural thing that's entrenched there. […] They seem to have an option as to what they do and don't do.

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(Nurse Consultant)

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The above except refers to the way in which the former hub hospital surgeons attempt to control resources, such as senior nursing roles, and defend their territory (see Currie *et al*, 2012). This is an expression of their status and relative power. Furthermore, the reference to the volition of the former hub hospital surgeons about whether they change their practice, suggests that there is no one, in either a clinical or managerial role, that can oblige them to change their practice. Again, this is an expression of their power and status position.

The reconciliation of these divergent practices can be characterised as a war of

attrition. The bringing together of two incompatible ways of working meant that the wider clinical team found themselves in the equivalent of 'one country, two systems' rule. This dispute was eventually resolved with each team compromising on some issues, whilst accepting the persistence of other differential practices in perpetuity, or at least until the retirement of the main antagonists.

5.6.4.   Spoke Hospital

In order to meet the requisite population to establish a vascular hub, the trust needed to collaborate with the spoke hospital. The spoke hospital effectively lost its status as a vascular centre, and the service was taken over by the clinical team working from the hub hospital.

[The spoke] felt that they had their hands tied behind their backs and they were shackled, and they had to hook up with somebody because their vascular service had effectively fallen apart. […] They almost had a single-handed vascular surgeon left who wasn't doing the full range of vascular surgery, wasn't having much contact with outside vascular surgeons. […] He was very isolated. […] They could see that service couldn't be maintained […] and […] couldn't stand up to scrutiny much longer. […] They knew that the writing was on the wall, they knew they were going to have to partner with somebody and then it was just a question of who.

(Vascular Surgeon 2)

This takeover of the spoke hospital vascular services by the hub hospital represents a departure from the original plan for the service. The original concept of the vascular network was as a partnership between the two trusts. However, an eleventh-hour decision to abrogate any responsibility for the vascular network, by the spoke vascular/general surgeon, resulted in a need for the hub hospital consultants to run the service on their behalf.

Our clinical team thought they were getting into a network and that they would be joined by colleagues from [the spoke hospital]. […] That position changed to one where the clinician who was claiming he was the vascular surgeon decided he wasn't a vascular surgeon overnight and was going to stop and […] go back to being a general surgeon. […] That left essentially an unsupported service.

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All of a sudden [the spoke's consultant surgeon] said, 'I don't want to do […] the emergency vascular surgery, but I'd like to keep doing some of the vascular surgery.' We said, 'yeah, this isn't really in the spirit of things. […] You can't be a half-arsed member of the service. And that's actually quite a cynical way of doing it.' […] We said 'no.' So he said 'right, I'm pulling out.' And then [the spoke hospital] pulled him, his team, the secretarial support, everything was suddenly gone. […] We are starting with no infrastructure. And that's a massively different commitment.

(Vascular Surgeon 3)

The interviewees provided an account of the hostility that the hub hospital clinical team received at spoke hospital site since their takeover of the service. The loss of status for the spoke hospital may be the underlying cause of this hostility. It should be noted that the hub consultants, who were once the peers of the spoke consultants, are now making decisions about the management of patients at the spoke hospital and taking jurisdiction over their facilities.

[The spoke hospital] hate us, we are roundly despised […] they think we raped them, and they go around saying so, 'we have been taken over, stolen, our practice and work has been stolen.' Actually, they were friendless, because they were so horrible, and completely isolated, and they didn't see it coming, […] if they had been really smart, they would have merged with [another hospital] ages ago.

(Vascular Surgeon 1)

It has been fairly hostile. […] There's […] a great deal of suspicion present. There's the feeling that they've been taken over, that they have no say in what happens, and that they've not been involved. […] There are a lot of tensions from [the spoke hospital] team because they like to do what they like to do and aren't terribly receptive to us giving an opinion. Or we may give an opinion, but they ignore it and do their own thing anyway.

(Nurse Consultant)

It is interesting that some of the reflections about the spoke hospital centre on the development of allied roles to the former vascular/general surgeon. These roles have

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been cast adrift by the vascular/general surgeon's withdrawal from participation in the vascular network. The development of these roles does not represent the general surgeons extending their influence and status. Rather, these are an expression of a formerly deficient vascular service.

The only two people who are left in [the spoke] who have any interest in vascular are people who have got nowhere else to go. So, the vascular nurse practitioner […] and […] the podiatric surgeon, whose job it is to manage diabetic feet. Well he has got nowhere else to go.

(Vascular Surgeon 1)

[The spoke is] a bit like the Galapagos islands. […] It's an oceanic island, […] its services evolved in the absence of a significant niche being occupied by vascular surgeons. […] So, the vascular nurses, radiologists and podiatrists evolved, taking much more responsible roles. That's part of the problems we've got.

(Vascular Surgeon 2)

The interviewees suggest that there is capital in working in a large organisation that is meeting the range of clinical standards, performing a range of complex surgeries, and delivering good outcomes for their patients. However, the obverse is that the status of the smaller centres, and by extension their clinical teams, will diminish as the number of services are centralised and networked with major centres.

There is a kudos for clinical teams of being in a big team […] that meets all the national standards. […] Whereas before, if you were a vascular surgeon, you could have gone to [the spoke hospital], there will be fewer choices. […] Without being part of a network […] they won't be able to do the specialist stuff. […] Ten years ago, people would have gone to one of the smaller hospitals with an aspiration of building up the service. […] It can't happen like that now.

(Director of Strategy)

We only have to look at the sort of pain that [hospital F] have gone through […] to realise just how demotivated and undervalued a hospital can start feeling if it loses specialist services. […] If we're going to make hospital networks work we're going to have to rapidly get to a point of saying everybody within that network is valued and is a critical component

of that network. […] The trouble with spoke and hub is somehow the hub feels like it's very important and the spokes feel they're at the end of a long stick.

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(Medical Director)

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The above excerpts make a number of interesting observations. Firstly, there is derision from the vascular surgeons about the quality of the surgeons and allied roles that developed in the spoke hospital. There is the sense that they were rank amateurs compared to the level of professionalism and expertise evinced by the hub hospital team. There is a suggestion that the development of roles like a nurse consultant are signifiers of the size and maturity of a clinical service. However, the allied roles that were developed in the spoke hospital originated in the context of a paucity of specialist provision and from necessity rather than by design.

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In summary, the theme of organisation was expressed in terms of volume / outcome drivers for the centralisation of vascular services, the process of centralising services at a national level, the centralisation of services between the hub and sister hospital sites, and the incorporation of the spoke hospital within the vascular network. There were a number of reflections that concerned the role of status within processes of organisational change. The drive to centralise vascular services has been led by the vascular professional body. This has been a bottom-up change process.

However, the impact on those doctors at the sharp end of this change process is no less painful. There has been a ferocious resistance to losing services at a local level. The loss of these services is seen as the thin end of the wedge. There is a suggestion that doctors working in the larger centres, that already meet the core standards, as defined by the vascular professional body, have steered this process of change. They have done so from a position of security and self-assurance. Change is actively embraced when it is safe to do so.

There is evidence of divergent conceptions of professional status between the hub and sister hospital teams. This has led them to respond to change in different ways. The former hub hospital team have dug their heels in and resisted any change in their

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established routines and working practices. They were happy with the *status quo.* They feared that the loss of vascular services at the hub hospital may presage the further diminution of services or even the closure of the site.

On the other hand, the importance of being designated as a vascular centre by the former sister hospital team has meant that they have pursued this end even if it has meant the indignity of moving site, a disruption to their working practices and the breaking of clinical linkages between services. The integration of the incompatible ways of working of the hub and sister hospital teams on the hub hospital site has underlined the fact even though the change started at a macro level, the consequences are felt most acutely at the micro-level of day-to-day interactions.

The slash and burn response of the spoke hospital to the loss of jurisdiction over vascular services is indicative of a lack of enfranchisement; they have no investment in the future of the service, and have nothing to lose in abrogating responsibility, displaying outright hostility toward the hub hospital and withholding even a modicum of support. Change has happened to, rather than with, the spoke hospital.

5.7.   Autonomy

The theme of autonomy is associated with the ability of the former hub hospital team to maintain control of their jurisdiction. The transfer of the former sister hospital team to the hub hospital site was a product of the resistance of the former hub hospital team to any change to their established routines and working practices. Despite the integration of the two teams on one site, the former hub hospital team have managed to maintain their standing and have even enhanced the quality of their services on the hub hospital site with the building of the hybrid theatre and new ward facilities.

Two teams have come together, and for one team everything has changed, and for the other […] nothing has changed at all.

(Nurse Consultant)

The consultants […] that came over […] they've gone through the stages of change, […] they've mourned, they've been angry, […] now they're resigned. […] But they're the ones

that actually had to make the biggest change, they had to move site, leave their office, leave the wards, leave all the people that they worked with and built up all the relationships with and go to what effectively is somebody else's patch.

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(General Manager)

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A number of reflections have been offered regarding the behaviour of the former hub hospital team. These centre on an unwillingness to change and a level of satisfaction with their well-ordered routines. However, there are also specific references to control centred on one individual surgeon. Interestingly, there is some frustration expressed by clinicians and managers about this surgeon's behaviour. This is partly centred on the fact that the individual is seen to exhibit a level of discretion about whether or not there is any change to their working practices i.e. in the face of pressure from peers or the hospital management team.

There's a dominant individual, who is very much a control freak. […] People don't run, don't make independent decisions on anything that's even remotely contentious because he'll be cross. […] He's without a shadow of a doubt their alpha male. […] He didn't want things to change, he wanted his life to remain the same. […] He's a bully, he's a control freak and he can be very aggressive. […] I know that the team around him are all a little bit scared of him and so they just find it easier to go with what he wants.

<div align="right">

(General Manager)

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The theme of control is articulated very clearly; no decisions to be made without reference to the dominant individual. There is a fear from staff about not referring to this individual. The individual concerned considers it appropriate that they be consulted in all matters related to the service. Their own construction of status means that they require due deference to be shown to them.

It is interesting that following the centralisation, the former hub hospital surgeons have retained their office space, whereas the former sister hospital team have had to hot desk for many months in a shared office space until alternative accommodation could be identified. This can be seen as an indirect expression of how unwelcome the team were on the hub hospital site. The ability to defend and retain the offices of the former hub hospital surgeons was an expression of their power and intransigence in the face

of an agenda that was not their own. The scrabbling around for the crumbs of office space may also be a demonstration of the loss of status of the former sister hospital team.

Siebert *et al* (2018) provide some interesting reflections on the association between organisational spaces and professional status. They considered the impact of how the workspace was designed and the availability of social spaces, including offices and other facilities. They demonstrated that the loss of these social spaces led to feelings of deprofessionalisation. This was because of emplacement: the loss of these facilities represented an application of coercive power both in and through spatial arrangements, and isolation: the physical alienation in the workspace leading to disconnection and a perceived loss of power.

* * *

In summary, the theme of autonomy was expressed in terms of control exerted by the former hub hospital consultants to maintain their established routines and working practices. There were a number of reflections that concerned the role of status within processes of organisational change. These centred on the role of a dominant individual and their ability to derail processes of change. This indicates the centrality of that individual consultants can have in determining the outcome of change. As a result of their intransigence, the centralisation of vascular services has occurred, but any aspects of the change that may have had an adverse impact on their working lives have been nullified.

The interplay between the contributory theme of organisation and the mitigating theme of autonomy can be observed. The centralisation of the service had the goal of establishing a larger, more sustainable service. This warranted the transfer of the surgeons on to one site and the appropriation of the smaller spoke hospital into the vascular network.

The centralisation of the service was a threat to the former hub hospital surgeons. As a small team, there were accepted norms and practices that were shared and maintained on this site. The transfer of the surgeons on to the sister hospital site, as

part of a larger team, would have diminished their control and autonomy. However, the agreement to transfer the centralised service to the hub hospital has reinforced their control. This is because they have prevented any significant change to their working lives and have maintained their working practices in parallel to the imported practices from the sister hospital site.

The ability to prevent substantive change to their working practices was a demonstration of their power. Their construction of professional status vis-à-vis the former sister hospital consultants will also take succour from the disruption caused to their working lives and the fact that they are run ragged fulfilling the demands of the vascular network arrangements.

Chapter Six

Cardiology Case Study

6. Chapter Six: Cardiology Case Study

'Existential Threat'

The following case study relates to the extension of services in a general hospital for Primary Percutaneous Coronary Intervention (PPCI) which is a treatment for patients suffering from heart attack. The hospital had an existing, working-hours-only, PPCI service. However, there was a national drive to reduce the number of centres offering PPCI and to centralise services to a smaller number of 24/7 centres. In order to extend the working hours of the hospital's PPCI service to meet these new standards, substantial investment was required. There was a question about whether the hospital could afford to extend these services. This is a story about fear of an existential threat to the future viability of a clinical service.

The proposed extension of the PPCI service reignited a debate about the configuration of cardiac services across two general hospital sites – hereafter referred to as the 'east hospital' and the 'west hospital'. The most controversial issue being the location and control of resources including the cardiac cath labs. Both sites had established cardiac services, however, although the smaller of the two sites, the two cath labs were located in the east hospital (see Table 10).

Table 10: Characteristics of the East & West Hospitals

East Hospital	West Hospital
- Smaller hospital - 20 cardiac beds - 3 consultant cardiologists - 2 cath labs	- Larger hospital - 40 cardiac beds - 5 consultant cardiologists

The extension of the PPCI service risked becoming a pyrrhic victory – the reduction in the overall number of hospitals offering PPCI services markedly increased the workload in these centres. This had a profound impact on the working conditions of the consultant cardiologists as they needed to increase their support to these unpredictable, emergency services.

6.1. Background

6.1.1. National Level

The following section provides details of the background to the case study. A chronology has been developed, with reference to key publications and secondary materials, to provide context to the national and local reconfiguration processes. Figure 11 presents a chronology of the key influences at a national level.

Figure 11: Key Influences at National Level for Cardiology Case Study
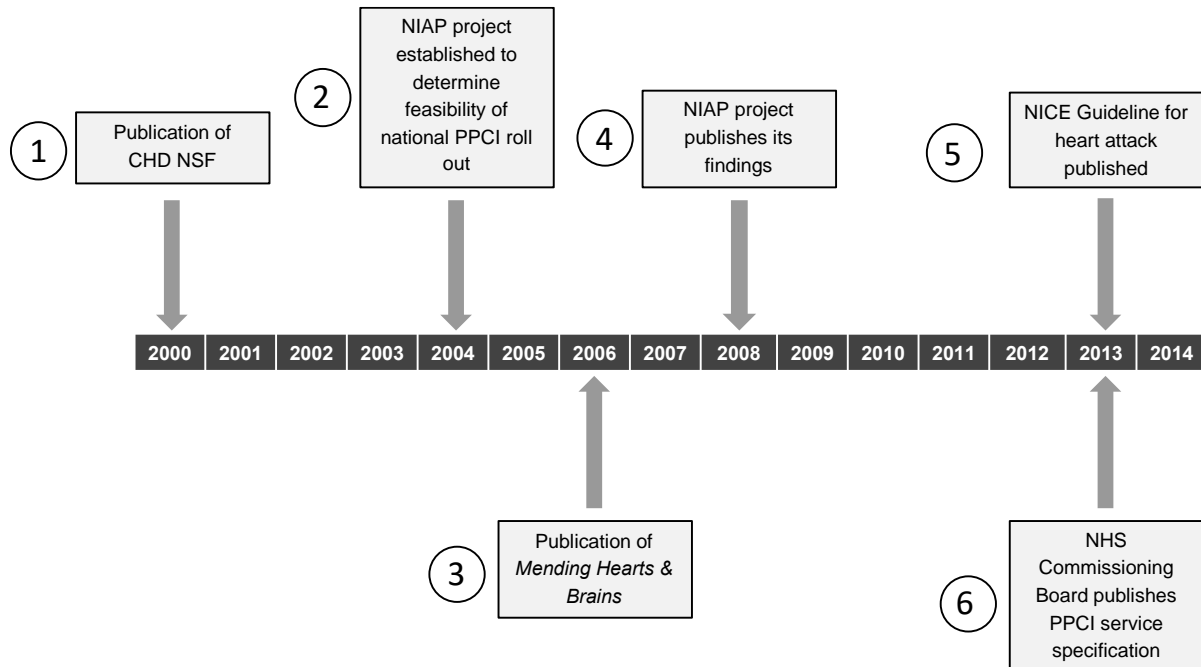
① The *Coronary Heart Disease National Service Framework* (2000) was a rallying call to improve community and hospital-based services. The UK was reported

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to have under-invested in CHD services. The treatment rates for heart attack were poor and waiting times for diagnosis and treatment were relatively long compared to other counties. It was recognised that there was a need to expand capacity with new surgeons, cardiologists and other skilled staff. It stated that coronary artery bypass graft (CABG) surgery and PCI should be offered. PCI should only be carried out in an organisation with pre-arranged surgical cover i.e. to respond in the event of serious complications. The implication was that PCI services should be focussed in tertiary hospitals.

(2) Some regions of the UK, particularly London, were offering 24/7 PPCI services. In other areas, services were patchy. Doubts were expressed about whether it would be possible to establish local services across the nation (NHS Improvement, 2012: 6). The National Infarct Angioplasty Project (NIAP) was established to undertake a feasibility study concerning the roll out of services.

(3) *Mending Hearts and Brains* (2006: 1-2) stated that PPCI services should be delivered in centres of excellence, by specialists, with the appropriate facilities, on a 24/7 basis.

(4) The NIAP (2008: 4-5) published the outcome of its feasibility study. It concluded that the roll out was feasible, over the next three years, but may be logistically challenging in some parts of the country. PPCI should be provided in specialist centres, offering 24/7 services, with sufficient volumes of cases to maintain and develop the skills of operators. Working-hours-only services were deemed 'unsatisfactory'.

The development of PPCI services was partly dependent upon pre-existing infrastructure, clinical practices and local geography. As a consequence, PPCI services developed in different ways. The general trend was a significant increase in the number of patients receiving PPCI in the event of a heart attack.

(5) The National Institute for Health and Care Excellence (2013), published its guideline for the management of heart attack. It recommended the timely delivery of PPCI as the preferred treatment for heart attack.

The NHS Commissioning Board (2013) issued a service specification for PPCI services. It stated unequivocally that PPCI services must be provided 24/7.

There continued to be a considerable mixed economy of services across the country. Sixty centres were reported to offer 24/7 services. Eighty-one centres offered working-hours-only services. In addition, a small number of hospitals offered 'hybrid' services, with organisations collaborating to provide out-of-hours services, for a region.

There was considerable debate at a national level about the minimum volumes of cases required to maintain clinical expertise, and whether further centralisation was justifiable. The recommendation of the Joint Working Group on PCI of the British Cardiovascular Intervention Society and the British Cardiac Society was that outcomes were better in centres preforming at least 400 procedures per annum. In 2013, 22% of PCI centres performed fewer than 400 cases per annum (NAPCI, 2014a: 13).

6.1.2.   Local Level

In parallel with the changes that occurred at a national level, there was a local drive to extend PPCI services. Figure 12 presents a chronology of the key events that occurred at a local level.

Figure 12: Key Influences at Local Level for Cardiology Case Study
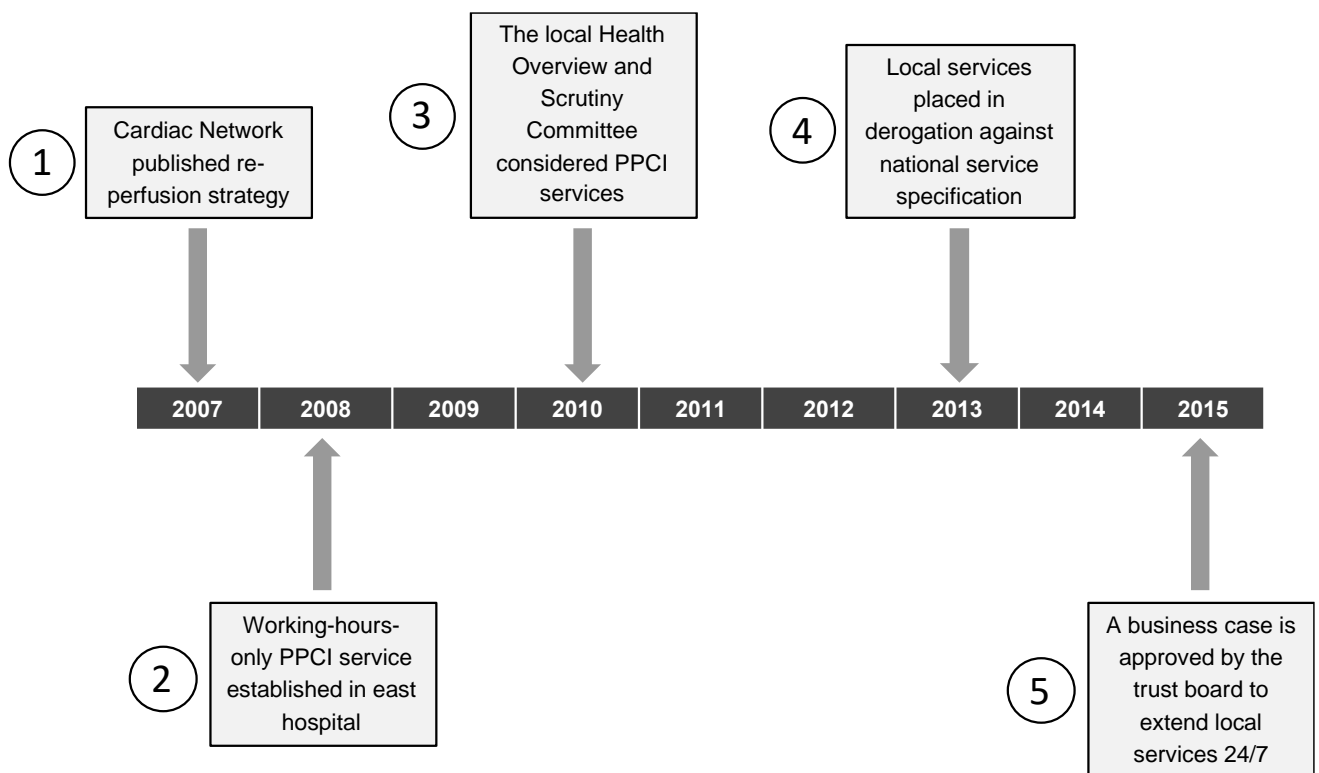
(1) The development of local PPCI services was coordinated by the cardiac network. The tertiary hospital in the region had already established 24/7 services. The focus of the cardiac network was to support the network-wide extension of PPCI services.

(2) A working-hours-only PPCI service was established in the east hospital. Out-of-hours patients were taken to the region's tertiary hospital.

③ The local overview and scrutiny committee considered the cardiac network's plans to extend PPCI services. The immediate plan was to establish working-hours-only (9am-5pm) services in the region, with a phased extension to 7am-7pm on weekdays. Between 2010 and 2015, at a local hospital level, there was little progress in extending beyond the working hours PPCI service. This can be attributed to several factors including:

- A lack of agreement between the east and west hospital consultant teams about the best strategy for the service.

- The absence of an external imperative to extend the service and a lack of appetite from hospital management to invest in a potentially loss-making service.

④ The trust was placed in derogation against the national PPCI service specification. A review was commenced of limited hours and hybrid services. The anticipation was that at the conclusion of this review, any services that failed to meet the threshold of providing a 24/7 service, would no longer be commissioned to provide any PPCI services. At the trust level, this resulted in discussions beginning in earnest about the need to extend the PPCI service.

⑤ A business case was submitted to the trust board to extend the PPCI service. In order to extend the working hours of the existing service, the business case sought investment in additional consultant cardiologists, cath lab and ward staff. It was noted that this service was a loss leader and that further investment in the PPCI service would translate into a significant financial loss. The costs of extending the service were set against the risk that losing PPCI (emergency) services could represent the thin end of the wedge with losing all PCI (planned) procedures. The business case was approved.

The following sections will consider the presence of the eleven identified themes relating to professional status and their association with organisational change related to the extension of PPCI services.

6.2. Capability

The theme of capability referred to the 'surgical' nature of the cardiologist's practice. They also refer to 'surgical' behaviours and characteristics, including assertiveness and competitiveness. Cardiologists are described by a number of the interview participants as occupying the intersection between physician and surgeon. As such, the cardiologist is described as exhibiting the most desirable characteristics of both professional groups. The following excerpts provide a description of these dual characteristics of physician and surgeon:

Cardiologists are the most like surgeons out of the physician group. […] The interventional nature of the work they do. It's very like working in a theatre. […] I am not sure they do see themselves as physicians. […] Some of them see themselves as neither physician or surgeon.

(Divisional Director)

It's more […] intellectually interesting than the surgical doctoring. […] It's a bit like Sherlock Holmes. Surgery […] was very much, got a lump, hack it out, sort of thing. […] With physicians, […] you made a diagnosis, you treated the patient, and you followed them up. […] You got to know your patients better.

(Consultant Cardiologist 5)

It's a semi-surgical speciality […] you get the […] excitement of working in a catheter lab, a hot environment, deal with acutely sick people, and you also get the environment of looking after them subsequently in a cold environment […] you get it all.

(Consultant Cardiologist 5)

The above excerpts suggest that the value of the specialty is derived from marrying its practical surgical skills with the intellectual challenge of medicine. It is interesting that this is not simply a case of drawing parallels between cardiologist and surgeon, cath lab and theatre. The reflections are more nuanced. They indicate the way in which physicians construct their status vis-à-vis surgeons. For instance, the implication of the above would be that the practice of surgeons lacks the sophistication of physicians – they simply 'hack out' a lump. The surgeon does not sustain a long-term, meaningful

relationship with the patient – the patient is just referred on once the surgery has been completed. However, importantly, just like surgeons, and owing to the interventional nature of their practice, the cardiologist has an enhanced curative capacity compared with other medical specialists.

The interview participants also suggested that cardiology sub-specialties occupy the intersection between surgeon and physician to a different degree. The sub-specialty that exhibited the greatest similarity to surgical practice was interventional cardiology. These practitioners perform interventional procedures such as elective PCI (i.e. planned) and PPCI (i.e. emergency). The following excerpts describe the relative competitive nature of training to be an interventional cardiologist, and the practical challenge of performing interventional procedures

It is very competitive. Even within cardiology, interventional Cardiology is even more competitive. […] It attracts some of the best and brightest talent.

(Consultant Cardiologist 2)

It's been seen like the brain surgery of neurology.

(Consultant Cardiologist 3)

There will be some people who really want to do intervention, and if they have enough insight they'll quickly realise if they don't have the skills required. The ones that don't have insight are filtered out pretty quickly.

(Consultant Cardiologist 1)

The following excerpt goes a step further to describe how the training process to become an interventional cardiologist can itself be highly selective. This is because the need to gain exposure to the cath lab can lead to a more onerous and demanding working pattern.

Interventionalists have a certain set of characteristics […] they tend to be people who make […] clinical decisions in a more definitive way than perhaps some of their other colleagues. […] It's something that's borne out of the way in which they approach cardiac emergencies.

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[…] The training programmes for interventional cardiology involve early starts and late finishes […] because you want operating experience, and it's the same for surgeons. […] All the other activity that you are meant to do, like looking after patients, do your paperwork, admin, is spread out to the other ends of the day, outside operating hours. So, you tend to work longer and you're very much goal driven. […] The non-interventional cardiologists, their working patterns are different. They don't have the same pressures to gain the hand skills. […] They put in their hours, but […] the way they organise their lives are different […] and that translates into how they behave and perform as consultants as well.

(Consultant Cardiologist 1)

These excerpts suggest that the decision to sub-specialise in interventional cardiology is not simply a choice, but also a question of practical capability and willingness to accept the need to work longer hours than their non-interventional colleagues. However, the fact that this is described as a competitive process would suggest that this sub-specialty remains attractive despite these considerations. It is the subject of debate as to whether the sub-specialty attracts individuals with the confidence of conviction to act in a definitive way, or whether this is the product of training and the acute, emergency nature of their practice.

It is clear that the specialty constructs its status with reference to the surgical nature of its practice. It is an interventional specialty that has a high curative capacity. Entry to the specialty is highly competitive and selective. However, the intersection between surgery and medicine is not described as relegating the cardiologist to the status of a pseudo-surgeon. It is not the case that the cardiologist is described as the first among the physicians but second fiddle to the surgeons. Rather, the occupation of the intersection between medicine and surgery provides the specialty with the best of both worlds. It derives the status value from the surgical characteristics of the specialty but uses the characteristics of medicine to address what would otherwise be regarded as deficiencies in surgical practice.

*   *   *

In summary, the theme of capability was expressed in terms of the surgical characteristics of interventional cardiologists. These consultants perform PCI and PPCI. These doctors were described as inhabiting the intersection between physician and surgeon. Their professional status is derived from the fact that they have the best of both worlds: the excitement of surgical practice, but with the continuity of patient care offered by medicine.

6.3. Specialisation

The theme of specialisation relates to the emergence of the sub-specialty of interventional cardiology. Given that most general hospitals only started performing PCI around the millennium, the expansion in the number of interventional cardiologists and the PCI services that they support has been dramatic. Indeed, in the context of the local hospital, the interventional cardiologists now represent the greater proportion of the workforce.

The expansion of PCI services has resulted in the net loss from other surgical specialties, including a reduction of the status or 'glamour' of cardiac surgery, because it has appropriated the ability to effectively cure patients.

We've taken on PCI, so cardiac surgery has declined big time. […] The glamour that traditionally surgeons carried, because they could solve people's problems, has been taken away, and has come to […] procedural medical specialties.

(Consultant Cardiologist 2)

Despite the expansion of PCI services, the demand for interventional cardiologists is described as slowing. The number of interventional cardiologists is partly limited by the number of cases available for each consultant to maintain their competence. Therefore, the number of interventional cardiologists is in some ways limited to the prevalence of disease in the wider population.

The number of openings now for interventional cardiologists is so much smaller and the rate of increase of consultant appointments in interventions has gone right down, in fact it may even be slightly negative on last year's national audit. […] We're reaching a plateau.

(Consultant Cardiologist 3)

Fewer doctors are also choosing to train in intervention because of the intensity of PPCI services. Compared to intervention, other areas of specialisation are much more attractive.

It used to be considered the pinnacle […] by far the most competitive area. […] It has changed a lot now […] because of the antisocial issue. People who are doing primary PCI all seem very miserable. […] They don't like having to get up in the middle of the night, they feel too old for it.

<div align="right">(Consultant Cardiologist 4)</div>

It's not as popular as it was. […] There's a lot of pressure on interventionists. […] Some of them are sinking. […] People do not look forward to doing one in five or six on-call rotas when they're in their fifties

<div align="right">(Consultant Cardiologist 5)</div>

You would think that [tertiary hospital] would be devastated that we are going 24/7. They are laughing, they can't wait […] because it is killing them. […] They can't cope […] They don't leave […] they just stay there, have some coffee until the next one comes in. So, it is constant, relentless.

<div align="right">(Consultant Cardiologist 2)</div>

The following excerpt describes a diversification of cardiology activity. This may represent a dilution of its relative status. It also describes the demand for imaging sub-specialists over and above interventional cardiologists. This demand is linked to the growing importance of cardiac imaging within medicine. The result has been an increase in the competition for imaging training places and an increase in the esteem and status of this sub-specialty.

The esteem has shifted […] imaging work has expanded. […] The demand for imaging cardiologists, the people who specialise in echo, MRI and CT, has really gone up very high indeed over the last few years, because these modalities have become more and more important to our practice. […] When the demand grows then more and more trainees want to do it. That's why the competition is hard. […] If it's more competitive it will be regarded in a more prestigious light.

<div align="right">(Consultant Cardiologist 1)</div>

The interview participants, therefore, provide some interesting reflections on the association between specialisation and professional status. The increasing sub-specialisation within cardiology is reflective of the degree of functional differentiation

within the specialty. However, sub-specialisation doesn't necessarily reflect an increase in status. The emergence and relative fortunes of sub-specialties is dynamic, and subject to continuous flux.

*   *   *

In summary, the theme of specialisation was expressed in terms of the emergence of the sub-specialty of interventional cardiology. Procedural medical sub-specialties, like interventional cardiology and endoscopy, has resulted in a net loss of glamour from surgical specialties. The obverse being that these specialties have increased in status. However, there is some evidence that the growth in number of interventional cardiologists is plateauing. This is partly attributable to the sub-specialty being less desirable, owing to the unpredictable demands of PPCI services, and the emergence of new fields of practice like cardiac imaging.

6.4. Technology

One of the defining features of interventional cardiology is the ability to offer curative treatment. The treatments provided require sophisticated technology to be able to reach the arteries feeding a patient's beating heart. These technologies allow the interventional cardiologist to give curative treatment to patients, providing 'instant gratification' back to the operator.

Why interventional cardiology? […] The fact that we can change people's outcomes quite dramatically. […] Intervention is at the forefront in cardiology. […] The instant gratification […] that you could make somebody who's sick, and desperate, and about to die, and being very well in a matter of two hours, just because of what you've done for them.

(Consultant Cardiologist 2)

Before the introduction of PCI, the treatment for heart attack was thrombolysis (clot busting drugs). The use of PCI has raised the status of the specialty because it has shifted from administering a non-specific drug therapy to a highly technical interventional procedure. The tools of the trade for the administration of thrombolysis were an ECG trace and a needle and drug vial (see Figure 13). These tools are crude and lack technological sophistication.

Figure 13: Tools of the Trade for Cardiac Thrombolysis
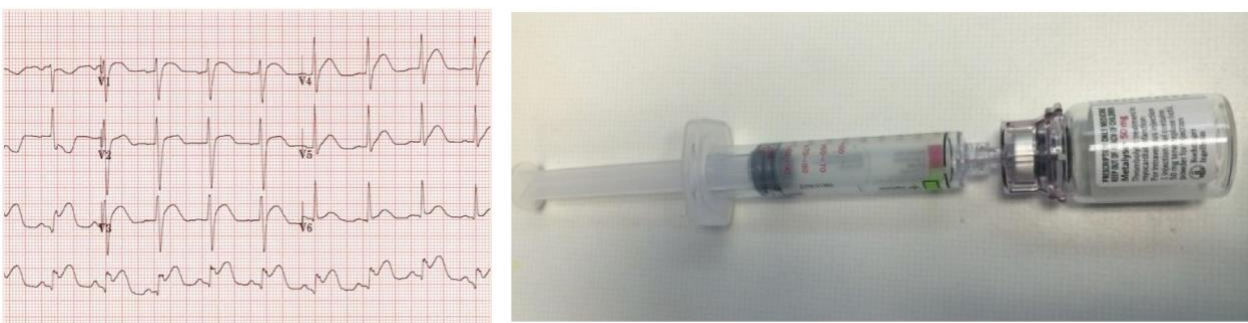
The administration of PPCI, on the other hand, requires a completely different approach including the use of large complex technology to enable the visualisation of

the anatomy of the heart and the coronary arteries. The so-called c-arm is a large x-ray device that is positioned around the patient (see Figure 14).

Figure 14: Tools of the Trade for PPCI
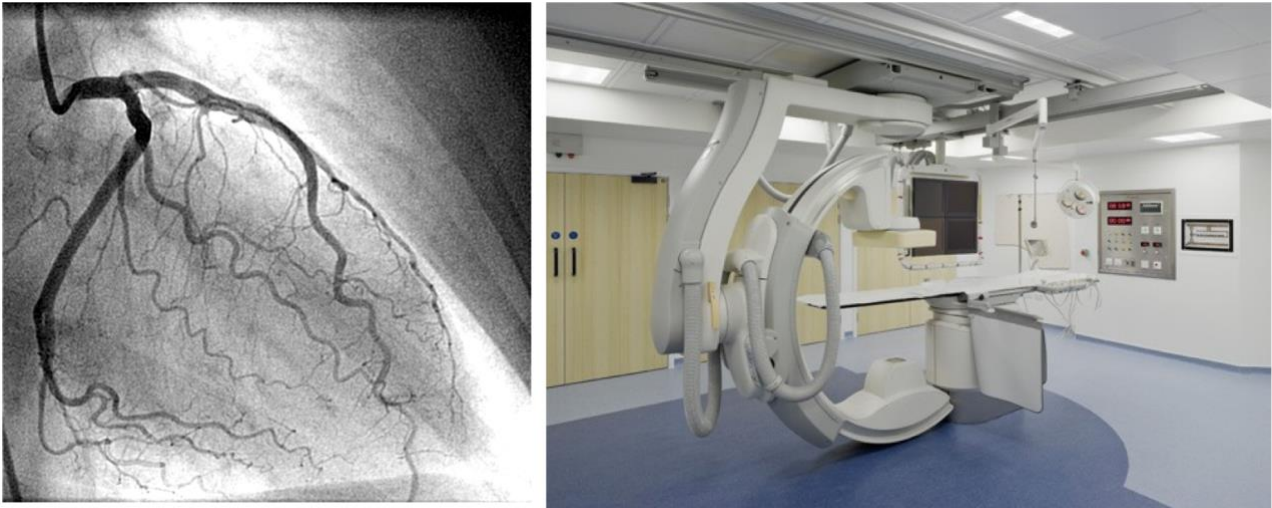
The introduction of the enabling technologies to support PCI services happened at different rates throughout the country. The participants offered reflections on the speed of adoption of new technology and treatments relative to other organisations. They suggest that the adoption of technology offers a level of kudos for individuals and organisations. The following excerpts provide a useful comparison between the perceived sluggish adoption of new technology in the local hospital and the dynamism of one of the London cardiac centres.

The move towards [PPCI] locally [...] was about 2005. [...] There will be places in London [...] doing angioplasty since about 1994. And the expansion to district general hospitals [...] occurred around 1999/2000. [...] We were a little late here. [...] A lot of things have happened here late.

(Consultant Cardiologist 1)

The first [PPCI] service in London was effectively driven through by the lead consultant of the London chest, [...] his approach has always been to embrace change and to always look at the next thing on the horizon, and to have a unit that is constantly evolving.

There is a palpable sense of frustration in the first excerpt about the late introduction of PPCI services in their local hospital. The second excerpt suggests that PPCI services were established in London because of the vision of a particular consultant. Note the reference to 'driven through'. This is suggesting that there has to be a push for change otherwise the investment in these sophisticated technologies will not happen or will happen too late.

*   *   *

In summary, the theme of technology was expressed in terms of the characteristics of PPCI treatment, and the technical sophistication of PPCI compared to its precursor non-specific drug therapies. The speed of adoption of new technologies is noted to be variable. There is a risk to the status of an organisation, and by extension the doctors that work within, if it does not invest in the latest technologies.

6.5.   Material Value

The theme of material was observed in relation to two subjects associated with the organisational change in question: the location of the cardiac cath labs, and the investment in staffing resources required to support the extension of PPCI services.

6.5.1.   Cath Labs

The issue of the location of the cath labs was a long-standing concern of the west hospital consultant cardiologists. When the cath lab service was originally established, the two hospitals were part of separate organisations. A cath lab service was originally built in the 1990s at the east hospital. As the service expanded, a second cath lab was also built on this site.

The following excerpt was provided by an east hospital consultant when questioned about why the service coalesced in the east rather than the west hospital. There is a sense that this has been a competition for resources between the two consultant cardiologist teams.

I was a bigger Rottweiler. […] I fought harder for it.

(Consultant Cardiologist 5)

This configuration of services has been a considerable source of frustration for the west hospital consultant cardiologists. The west site is larger and has a greater number of emergency admissions for cardiology services. However, there is no cath lab facility on this site. This necessitates the transfer by ambulance of inpatients between the sites on a frequent basis. Therefore, the service that the west hospital consultants can offer their patients is suboptimal. There may be an association between the status of the west hospital team and their ability to deliver the best outcome for their patients, and their perceived impotence in changing the configuration of the cath labs.

If you have […] eighty percent of your patients with a cardiac diagnosis coming through one hospital, and your cath lab is at the other, it's no surprise that on any given day there

will be [...] seven or eight patients who are still awaiting their procedure at one end, whereas the other end, where it's quieter, and where the cath labs are, those patients get processed much more quickly. So, you're constantly disadvantaging those patients.

<div align="right">

(Consultant Cardiologist 1)

</div>

There is a clear difference of opinion between the two consultant teams about whether cath labs should be established on both sites or should be transferred from the east to the west hospital site. For instance, the following reflection is offered by the divisional director for the lack of consensus between the consultant cardiologists:

There is a practical issue here around the consolidation of the cath labs. They should, in a very 'no-brainer, let's not discuss it' way, be on the [west hospital] site. [...] But the problem is that the consultants as a group don't agree. [...] Some [...] will say, 'well [...] if we can't afford it, why are we even discussing it?' [...] The other side of the coin is [...] we should plan at some point over the next couple of years to actively move the cath labs. [...] The problem we've got is that [the east hospital consultant cardiologists] say that they're supportive, but then they put lots of obstacles in the way from a logistics perspective. [...] You'd see at least one of them would retire if we moved the cath labs.

<div align="right">

(Divisional Director)

</div>

The above excerpt provides a number of interesting reflections. The hospital management is sympathetic to the perspective of the west hospital consultant team. This is attributable to the high demand being experienced on this site, the inefficiency created by the need to transfer patients between sites and the consequent increase in hospital length of stay. There are 'obstacles' being put in the way of changing the configuration of the service by the east hospital consultants – the cost of any reconfiguration, logistical challenges, and the possible threat of a consultant to retire if the labs are moved. Similar appeals to logistical challenges to the contrary are offered by the west hospital consultants. The following two reflections are offered by west hospital consultants:

I don't buy into [...] the idea that it would be sensible to have invasive labs on two sites, because dividing the expertise, dividing all the support structure, makes no sense to me

at all. […] It was the wrong decision because [the west hospital] was much busier. […] It wouldn't have been a decision that anyone would have made strategically in terms of trying to plan the cath labs for the whole country, they would have put them here.

<div align="right">

(Consultant Cardiologist 4)

</div>

Publicly there's a consensus that we ought to be on one site. Some of my colleagues will go as far as to say that it ought to be at the [west] hospital site. Some of them will say publicly they don't believe it needs to be at the [west] hospital site. I strongly believe that that isn't the case. […] Consolidation of services goes a long way. […] What maintains the status quo is […] personal ambition, it's nothing to do with the greater good, because if you look at it objectively […] they can't justify it on the grounds of what's best for patients.

<div align="right">

(Consultant Cardiologist 1)

</div>

The crude data that we have demonstrates that if you have a heart attack at the emergency end, if you compare it to the patients that come instead through the cath lab hospital, your mortality is […] four times greater. […] It is terrifying, and it makes you really think, why should you persist having this model when the impact on patients' lives is very easy to measure?

<div align="right">

(Consultant Cardiologist 1)

</div>

The lack of appetite to change the configuration of the cath labs is attributed to a lack of political will. It is also claimed that it was convenient for the east hospital consultants, the majority of whom live close to this site. It is clear that there is a value attached to the cath labs. The appropriation of these facilities offers an opportunity for the west hospital consultants to readdress a historical imbalance, and to raise the status of their service. For the east hospital consultants, the loss of the cath labs would represent a substantial diminishment of the status of their service.

The cath labs are also used to help construct the identity of the consultant cardiologists. There is a risk of losing jurisdiction or access to the cath labs. The consultant team is comprised of interventional cardiologists and non-interventional cardiologists. Of the non-interventional cardiologists, one is only trained to undertake

diagnostic angiography. They are one of the longest-standing and established consultants.

Some of the non-interventionalists still do diagnostic angios, because to keep their skill levels up. However, at least one of them probably doesn't do enough to justify a list every week and with two more interventionalists being appointed we need that cath lab list. So, that's causing tension at the moment. […] They just don't want to drop it. […] They would see it as being de-skilled. […] It's the status.

<div align="right">

(Divisional Director)

</div>

Although the individual's general clinical skills are held in high regard, their cath lab skills are outmoded. There has been a stubborn resistance from the consultant to having their operating list reallocated to an interventionist colleague. The implication may be that their list is being given to someone newer or better. The loss of access to the cath lab and the risk of deskilling may also be associated with the loss of private practice.

6.5.2. Staffing Resources

The other issue related to material resources relates to staffing resources required to staff the 24/7 PPCI on-call rota. Interestingly, the following excerpts describe different facets of status. The first excerpt describes a willingness to commence a 24/7 PPCI rota with four consultants. The prize of establishing a 24/7 PPCI service being traded off against the impact on the individual's work intensity. Both excerpts reflect a desire to swell the total number of interventionists to eight consultants. This represents a doubling of the headcount prior to the investment outlined in the business case.

There's been a will to do [PPCI] amongst the clinicians for a long time. Indeed, they were even prepared to start, at risk, with four interventionists. […] Ideally, you'd like eight, to make it a sensible rota, but they could cope with six for the time being.

<div align="right">

(Consultant Cardiologist 5)

</div>

Our view was that you couldn't run primary PCI 24/7 given that we had to cover two sites […], we had the other commitments, both on the wards and also in the lab, […] and we

couldn't do it unless we had twelve cardiologists. […] Because the moment these guys do primary PCI 24/7, the amount of time they've got to do anything else is so short that nothing else works. […] We're undermanned.

<div align="right">(Consultant Cardiologist 4)</div>

Finally, there were some very interesting reflections offered about the business case. There were divergent reflections offered by one of the consultant cardiologists and the chief executive officer. The consultant characterised the trust as giving the consultant cardiologists a blank cheque, within reason. However, the chief executive officer describes an attempt by the consultants to conflate the investment with a broader agenda, and of exhibiting 'childish' behaviour to get the level of investment that they wanted.

We've gone through the motions. […] We've created a business case, and within reason, we could have put down anything we wanted, and it probably would have been approved.

<div align="right">(Consultant Cardiologist 1)</div>

The issue is not to allow people to form a bigger agenda, to try and say, 'we need this, this and this.' […] There are a wider set of issues […] that need solving, but this is one part of it, we can get on and do that, it is not contingent on these other things. Some people are trying to make it contingent, and I'm determined they won't. […] You have to […] focus on what's right for patients, and don't get distracted by, at times, childish behaviour going on. […] Some of the individual consultant behaviours, […] they drive you bananas, and you go 'why are you doing that?'

<div align="right">(Chief Executive Officer)</div>

The divergence in these interpretations may be a question of emphasis. There was broad support at trust board level to support the extension of the PPCI service. Given that this development will contribute to a financial net loss for the organisation. There is little appetite from the trust management to hoover up other elements. However, the consultant team do have considerable leverage as the service is seen as one of the jewels in the trust's crown. The loss of local services would have a deleterious impact on the status of the consultants, the service and the wider trust.

*   *   *

In summary, the theme of material was expressed in terms of the location of the cath labs, and the leveraging of investment in staffing to support the extension of the PPCI service. There were a number of reflections that concerned the role of status within processes of organisational change. For instance, the cath lab is intimately associated with the identity of consultants. They are also acutely aware of the importance of their access to this resource being linked to their status and that of the wider service. The reluctance of the non-interventional cardiologist, to forfeit access to the cath lab, is indicative of the risk of a critical loss of status. The cath lab has become the bread and butter of most consultant cardiologists, and the loss of access to this resource would set in sharp relief this deficiency in their skill set.

Furthermore, the willingness of the interventional cardiologist to extend the PPCI rota without the requisite number of consultants suggests that different determinants of status may be traded off against one another. The status gain for extending the PPCI service versus the increase in antisocial working and the higher intensity of working pattern.

6.6. Organisational Standing & Autonomy

There are two sets of reflections related to the themes of organisational standing and autonomy. Firstly, the impact of losing PPCI services on the consultants working within general hospitals, and, secondly, the consequence of extending PPCI services on tertiary centres on those same consultants.

6.6.1. General Hospital

The interview participants expressed very real fear that, in the event of being unable to extend to a 24/7 PPCI service, there would be the loss of the entire gamut of elective interventional cardiology procedures. Therefore, the loss of PPCI services represented the thin end of the wedge.

> *There's a burning platform […] the current favourite jargon. […] Armageddon. […] The specialised commissioners have said, you can't do [PCI] unless you are doing [PPCI], and you can't do primary [PPCI], unless you are doing it 24/7. So, unless you […] set yourselves up to offer this 24/7, we will take away the [PPCI] that you do already and give it to [other hospitals] and […] you won't be permitted to do elective [PCI] either.*
>
> *(Clinical Director)*

> *Unless you are able to do it 24/7, you are vulnerable, because […] there is a move back to having bigger centres. […] If you lose intervention, […] what you hold on to doesn't […] make economic sense. So, you pretty well lose everything if you lose intervention.*
>
> *(Consultant Cardiologist 4)*

> *They see it very much as their professional capability and capacity will be eroded if we don't do it.*
>
> *(Divisional Director)*

> *If you are not one of those centres, then you devolve yourself.*
>
> *(Consultant Cardiologist 1)*

These excerpts represent just a sample of the risks articulated by the interview participants of failing to extend the PPCI services. The consequence of losing PPCI services could be an inability to recruit and retain interventional cardiologists.

The consultants would do it tomorrow because they're not stupid. I don't think anyone feels like calling NHS England's bluff. I suspect that it wouldn't be possible to send all the [PPCI] somewhere else at the drop of a hat, but if you're talking about your whole career, you wouldn't want to gamble, you'd want to make sure you were doing 24/7 [PPCI].

(Clinical Director)

All over the country people are moving. Even in a place like this, where you wouldn't expect people to be looking at other jobs. […] And certainly, if we lose interventions, all of the guys who do intervention will definitely choose to move.

(Consultant Cardiologist 4)

If NHS England follows through with this service specification […] then inevitably some units will stop doing [PPCI], and as a corollary […] they will stop […] doing any [PCI], and if that happens, then those […] interventional colleagues working in those centres will inevitably be looking for posts elsewhere.

(Consultant Cardiologist 3)

With the proposed changes to PPCI services at a national level, the interview participants described the PPCI services across the country as in a state of flux.

6.6.2. Tertiary Centre

Reflections were offered on the impact of extending PPCI services on the regional tertiary centre. These reflections were a lot more varied. Firstly, one of the interview participants described how general hospital settings have been attractive to interventional cardiologists. This is attributable to the fact that the focus of the 24/7 PPCI activity in the larger tertiary centres has crowded out the opportunity for exposure to elective PCI. In this regard, the extension of 24/7 PPCI services in general hospitals will result in an equalisation of these pressures. This may represent a double-edged

sword – the status gain of being accredited as a 24/7 PPCI service offset against the increase in work intensity and risk of crowding out of elective PCI activity.

The problem with surgical centres, as PCI has devolved in last ten-odd years, is that elective work has almost disappeared from surgical centres. […] People are on the rotas, and because those rotas have to be manned in a meaningful way, so that people don't kill themselves, so there are one in eight or one in ten or whatever. But what that means is that you dilute the amount of procedural exposure that people get to your specialties. So, giving an example, the UK average for annual PCI numbers is about 120. […] I did 300 last year. That's because there's just four of us and it's a small place and that was an attraction. If I'd stayed in [a tertiary hospital] I wouldn't have been able to do half as many PCIs as I am doing here.

(Consultant Cardiologist 2)

The general hospital interventionists also view their relative lack of support compared with the tertiary centres, working as part of a smaller team with less back-up, as a badge of pride. The relative demands and responsibility placed on these individuals is much greater, compared with their counterparts working in well-resourced tertiary centres.

The work ethic is very different. So, the surgical centres have a bigger critical mass of people and the variety of talent that you have available is very different. So, you could have at any one given point in time, four interventional cardiologists operating at the same time in a cath lab. Where we don't have that luxury here. And it has some disadvantages, because there are times you want them to be there, because you're just on your own and you don't have a friend or a colleague to hold your hand or ask for help. […] You probably need to be much better at what you do for being in a district general, surviving and providing a safe service, because you are just on your own.

(Consultant Cardiologist 2)

These reflections are interesting given that in the early days of performing PPCI, there was an expectation that it should only be performed where there is an available cardiac surgery team in support. The implication was to restrict practice to only the tertiary centres. As the use of PPCI extended to general hospitals, the cardiac support was often offered as part of network arrangements with neighbouring tertiary hospitals. In

the present day, there is no longer the expectation that there is on-site cardiac surgery support. This represents a tremendous shift as the technique has been refined and become safer and part of routine practice.

It wasn't really very much done in district general hospitals because [...] there was this thought, 'oh blimey, you've got to have a surgeon nearby if all goes pear-shaped' [...] but we all felt this is nonsense, and we were prepared to take that risk. [...] It was just a question of having the courage to do it, and once it was started it was inevitable.

(Consultant Cardiologist 5)

The transfer of PPCI activity from the tertiary hospitals to the general hospitals offers the opportunity to develop and expand the use of new specialist technologies. One of the most important of these new technologies is Transcatheter Aortic Value Implantation (TAVI). As the cardiac surgeons have lost jurisdiction over the 24/7 PPCI activity, they have created a new field of practice.

TAVI is going to be a big game changer for surgical centres. [...] What you will find is that those labs which are in [tertiary hospitals] being used for elective PCI will now get used for TAVI, so they won't be able to do the TAVI and the elective PCI. [...] They will get overwhelmed [...] so it will be perfectly reasonable for them to say, 'right, you guys have been doing 1,000 cases, can you do another 500 for us.'

(Consultant Cardiology 2)

This shifting of clinical jurisdictions provides the cardiac surgeons with the headspace to develop new techniques such as TAVI. This reflects a recurrent pattern of emergent technologies (such as PPCI) being established in tertiary centres, routinised into practice, and then pushed down to general hospitals.

* * *

In summary, the theme of organisational standing as relevant to status was expressed in terms of the impact of losing PPCI services on the general hospital, and the consequences of extending the PPCI service for the tertiary centre. The impetus for change was stimulated by the palpable fear that the loss of PPCI services would be

like a deck of cards and would have a detrimental impact on the status of the service and the consultants working within the service. The theme of autonomy was expressed with reference to the relative lack of support of general hospital cardiologists compared with their colleagues working in the well-resourced tertiary centres.

The interplay between the contributory theme of organisation and the mitigating theme of autonomy can be observed. For instance, the relative size and sustainability of the general hospital meant that there was a risk to the status of this organisation. By association, the standing of the general hospital cardiologists was also under threat. However, by drawing on the mitigating theme of autonomy in their construction of professional status, the cardiologists turned this deficiency into a virtue. The lack of resources at the general hospital site meant that they simply had to cope with what happened, and be better at what they did, because there was no one coming to help them in a crisis. This became a badge of pride and served to maintain their construction of professional status despite the limited service offered in comparison to the tertiary centre.

Chapter Seven

Respiratory Case Study

7. Chapter Seven: Respiratory Case Study

'Control Freakery'

The following case study relates to the formation of an integrated respiratory team, which was composed of nurses and physiotherapists. This integration brought together a 'community-based team' that worked closely with GPs, and a 'hospital-based team' that worked under the aegis of the respiratory consultants. These services have evolved independently, establishing their own working practices, leading to considerable duplication and overlapping of clinical jurisdictions. It is conceivable that patients could be under the care of hospital-based and community-based teams at the same time. This led to episodes of miscoordination, confusion and frustration.

The function of a community-based team was to work alongside GPs to manage long-term conditions including chronic obstructive pulmonary disorder (COPD), asthma and bronchiectasis. COPD is a lung disease that is characterised by a chronic obstruction of lung airflow which impairs normal breathing. They would regularly check patients' medications, their use of oxygen therapies, provide rehabilitation and offer advice, education and support.

The hospital-based team support outpatient clinics and provide input to the care of inpatients. The team also provided an early facilitated discharge service. This means that the patient is supported by the team in their place of residence. These patients would otherwise stay in hospital for a few more days. During the time that patients are being supported by the hospital-based team, they remain under the care and jurisdiction of the respiratory consultants. When the patient is medically fit, they are discharged back to the care of their GP and the community team. GPs were not able to access the services of the hospital-based team directly. They were accessible only via a referral to the respiratory consultants.

The integration of these teams was designed to produce a more joined up and effective service. This required the bringing together of two organisational cultures, with a revised management structure and reporting lines. The process raised pertinent

questions about the jurisdiction and leadership of the new service, and its relationship to general practice and the respiratory consultant team. This is a story of control freakery and a resistance to ceding jurisdiction.

7.1. Background

The following section provides details of the background to the case study. A chronology has been developed, with reference to key publications and secondary materials, to provide context to the reconfiguration processes (see Figure 15).

Figure 15: Key Influences for Respiratory Case Study
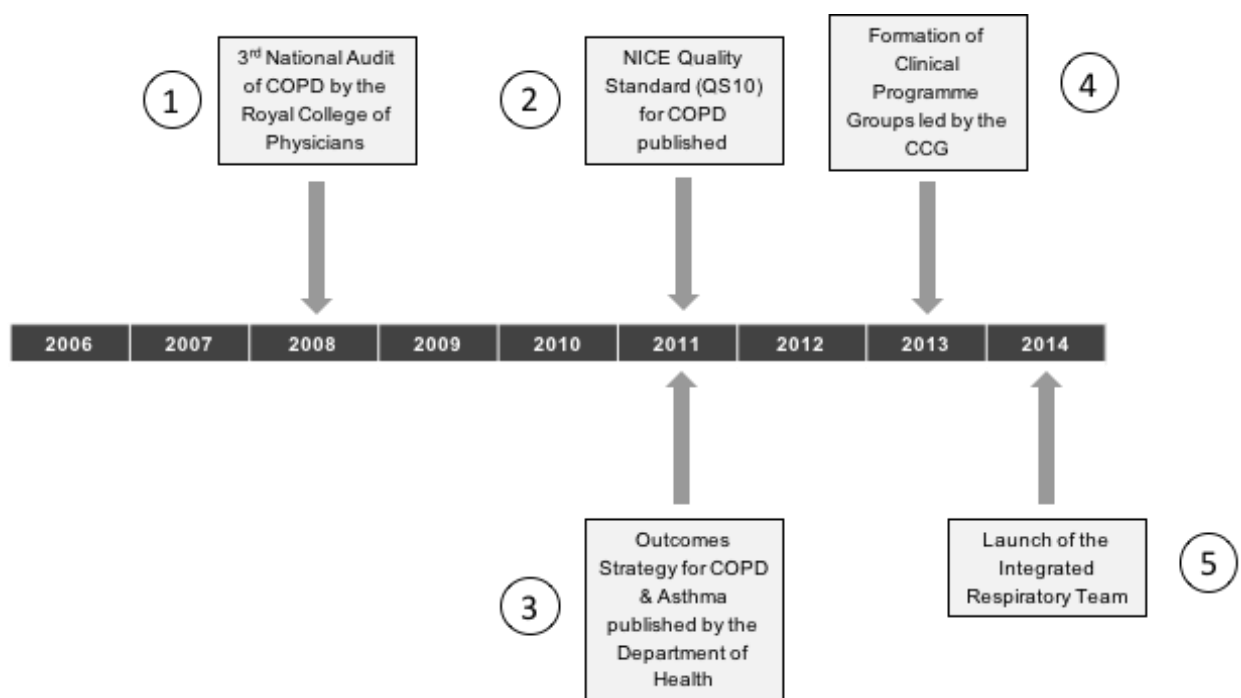
(1) The Third National Audit of COPD was published, stating that COPD was the second most common cause of emergency admission to hospital, and one of the costliest inpatient conditions. Patients should receive the right type of services and treatment, which would lead to a reduction in the need for hospital admission, a reduction in the length of stay, improvements to clinical outcomes and patients' quality of life.

② NICE published its Quality Standard for COPD. The document defines quality standards and the types of interventions that would deliver improvements to care.

③ An Outcomes Strategy for COPD & Asthma was published, encouraging the exploration of models of early supported discharge and the development of proactive, integrated and comprehensive care.

④ The local Clinical Commissioning Group (CCG) established a project group focused on the management of COPD. The group was led by a GP clinical commissioner and included other representatives from the clinical and management teams. The group developed a programme of work including a plan to integrate the community-based and hospital-based respiratory teams.

The impetus to integrate these services came from two individuals: a respiratory consultant and clinical lead for the hospital service, and a GP clinical commissioner and chair of the group. These individuals will hereafter be referred to a 'respiratory consultant 1' and 'GP commissioner 1' respectively. With the leadership of these two individuals, the project group developed a service specification for a new integrated service with a single management structure. The level of resistance to changing the current configuration of services was not underestimated. Figure 16 is derived from a presentation produced by GP Commissioner 1 characterising the probable response to the proposed changes.

There was considerable debate about which organisation should host and who should lead the new integrated service. It was determined that the community trust should run the service.

(5) The newly constituted integrated respiratory team was launched with the former members of the community and hospital teams working together within a unified service.

The following sections will consider the presence of themes relating to professional status and their role within this process of organisational change.

7.2.   Organisational Standing

The theme of organisational standing was referred to in relation to the sustainability of the current configuration of services. In hospital settings, there was an acknowledgement that the pattern of rising demand for services is unsustainable. This is driven by demographic changes including the pressure of a rising elderly population that have increasingly complex needs. Respiratory consultant 1, who led the case for change, referred to the rising tide of demand as a key rationale for needing a different way of working and utilising the available resources in the best way possible:

With an ageing population, with increased demand […] and a finite amount resources, we are going to have to do things better, smarter in order to be able to still keep standing. […] We want to be able to provide all of these good services […], but the demand is going to go up […], and if we're all rushed off our feet, delivering services, which could be delivered elsewhere, we won't be able to do a lot of the stuff that we would like to be doing in secondary care. […] It's simple, there's a demographic, and that's going to happen.

(Respiratory Consultant 1)

The above excerpt is interesting for a number of reasons. It outlines how this increase in demand is detracting from activities that could enhance the status of the consultants. For instance, the ability to 'do a lot of the stuff that we would like to be doing in secondary care', may refer to undertaking more specialist activities, making improvements to the quality of services or introducing new technologies. Furthermore, the rate of demand for hospital services has an impact on work-life balance and the desirability of undertaking a consultant role. The following excerpt provides a further reflection from this consultant:

Our referral rates are going up, we are busy as ever, so it's not like we feel like we are clinging on desperately to our workload. […] All of us feel overworked. […] When I was working here, […] twenty years ago as a junior doctor, […] many of these patients would be coming back every three or six months. Now, that doesn't happen, but then, with an ageing population with all the demographic changes, […] we are busy enough as it is. In fact, our consultant numbers have expanded hugely and despite that we are still just as busy, if not more busy, than we were.

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This excerpt refers to overwork and the busyness of the consultant team. The work rate is described as high despite recent investment. However, there is also a reference to having to change the pattern of patient review because of the increasing demand for services. In other words, the consultant team have almost had to self-ration the care that they can offer. This may be sub-optimal, but in a utilitarian sense may ensure that as many patients as possible are able to access their expertise. The necessity to self-ration may contribute to a diminishment of the professional status of the consultant. This is because they are not able to determine the pattern of treatment based on their professional standards or judgement, but this is being driven by expedience.

The following excerpt provides a similar reflection on the impact of rising demand but from the perspective of a GP. Similar themes are described including rising workload, the attendant impact on work-life balance, and the rationing of the type of care or service that a professional is able to offer. It is interesting that these reflections do not centre upon a demand for more resources *per se*. Rather, these excerpts suggest that there is a recognition of the incompatibility between the expectations of the public, rising demand, and the capacity of the service to respond.

The workload for general practice isn't sustainable. […] There are fifteen percent of GP jobs unfilled. […] Finding […] people prepared to do a full-time commitment is proving to be quite a challenge. […] GPs are struggling to find young GPs who want to be partners. They want to be salaried GPs, because they want an improvement in their work-life balance from the way that it has traditionally been. And actually, the direction of travel from the government does not suggest that GP work-life balance is going to improve. […] It's going to get worse. […] General practice is having to look at what it must do and what it hasn't got time to do.

(Head of Community Services)

Again, this excerpt may suggest a diminishment of the status of a GP for a number of reasons. Primarily, this relates to an impact on work-life balance and their ability to recruit and retain GP partners (i.e. a GP that shares the ownership of the practice and,

therefore, its profits and losses, rather than a GP that simply draws a salary from the NHS). The potential rewards are greater for a GP partner, but the pressure of running a business creates stresses and strains that are not present for salaried GPs. Moreover, the excerpt provides a recognition that the GP has to be self-limiting in the services that they can offer within the available capacity and time. This limitation is inconsistent with a professional's ability to project high status.

In response to this growing tide of demand and the pressure that it is placing on hospital and GP services, respiratory consultant 1 offers a vision for NHS services to work in a more collaborative and integrated manner. This vision is focussed on reducing demand for services over the longer term. The following two excerpts provide an account of this perspective:

A lot of the obstacles to […] the objectives we are trying to achieve in secondary care, can't be achieved in secondary care, and need to be achieved in a community setting. […] I was interested in how can we develop the services which are going to help with the secondary care issues, […] reducing admissions or making sure the services are available out there in the community so that patients don't come in. […] The expertise is in secondary care, but the solutions are in primary and in community care.

(Respiratory Consultant 1)

The question was how to develop this team. […] There seemed to be some duplication of community-based services […] and it seemed a very inefficient way of delivering a service across a wider health community. […] The simplest way of delivering that would be us to say we will take respiratory specialist services across secondary and community-based care and run it as one team.

(Respiratory Consultant 1)

There are two implicit references to professional status in the above excerpts. Firstly, a reference to the locus of expertise being centred within the acute hospital and the consultant team. The solution presented here is not about the in-reach of general practice into secondary care, but an outreach or extension of the consultants' expertise into the community. Secondly, there is an assumption that the best way to deliver an integrated service would be to combine the teams and for them to be run by the

hospital-based consultant team (i.e. 'we will take…'). Both of these references reflect an acute hospital bias. The integration of the teams may have provided an opportunity to increase the professional status of the consultant team by increasing the scope of *their* service.

The perspective of respiratory consultant 1 is described as being 'fairly unique'. This is attributed to some years working in the developing world and having to think of creative ways to provide services on a shoestring. This has provided respiratory consultant 1 with a 'more public health interest'. This is qualitatively different to the perspective of most respiratory consultants that are 'more hard-nosed, specialty science driven.' Respiratory consultant 1 laments the lack of interest or engagement with the proposed integration of services from their consultant colleagues:

Most of my colleagues were not interested. […] It was recognised as important mainly by the already existing community team and by the commissioners. […] Their view [was] to try and reduce hospital spend and things like that. […] The driving force for me was mainly a quality issue. […] I felt that we could do more with the same amount if we could integrate, rather than having two teams, two organisational structures. Try and find a model whereby people employed from two organisations could effectively be part of one team.

(Respiratory Consultant 1)

The lack of engagement from the other consultants may indicate that there was no perceived opportunity to increase status through the extension of the involvement with non-specialist, low technology, community-based services. This is despite general agreement with the principle that services should be more integrated and that there should be less duplication of effort. Indeed, there was also a lack of engagement by general practice demonstrated by the lack of representation at the project group being led by the clinical commissioning group. This may indicate a lack of prowess for respiratory medicine compared with other specialties. The following excerpt describes the relative appetite from general practice to contribute to the respiratory clinical programme group compared to cardiovascular disease clinical programme group.

I attend the clinical commissioning groups for respiratory, cardiac, and diabetes. […] However, the respiratory programme group cannot attract a GP to support that group. […] We held our first clinical commissioning group for cardiovascular disease a few months ago and there were […] six or seven GPs. […] They were out in force.

(Head of Community Services)

Given the prevalence of respiratory disease, and the breadth and variety of presentation, this is surprising. The status of GPs may be elevated by association with certain hospital specialists. Alternatively, there may be a concern from GPs about the scope to make an impact on the configuration of respiratory services, because of the perceived intransigence of key individuals leading these services. By happenstance, GP commissioner 1, had an interest in respiratory medicine and provided clinical leadership for this programme. The importance of the trust and shared vision developed between respiratory consultant 1 and GP commissioner 1 cannot be underestimated.

* * *

In summary, the theme of organisational standing with regards to status was expressed in terms of the sustainability of services, in the context of an ever-rising demand for services. There were a number of reflections that concerned the role of status within processes of organisational change. The case for change was presented, by respiratory consultant 1, as a burning platform. Their perspective was described as 'unique', because they reasoned that the only way to effect meaningful change, was to collaborate with general practice and community services. The lukewarm reaction from the other respiratory consultants suggests that their own perspectives were entrenched; this sort of collaborative working doesn't come naturally to these consultants and working with community partners, as equals, requires a levelling of their perceived status differences. The lack of engagement from general practitioners in the project group, may indicate an awareness of the aversion to change of the consultant team.

7.3. Autonomy

The theme of autonomy was expressed in terms of control. The participants discussed control of any change to their services. They couched their control in terms of governance and demonstrated as a lack of confidence in using services outside of their direct control. Table 11 summarises the way in which this theme has been described in the interview material:

Table 11: Description of Autonomy

Control of…	Articulated as…	Manifested as…
…any proposed changes to the service that would potentially adversely affect them and a desire to adopt a principal role in determining the shape of services.	…a risk to 'governance', 'accountability' or personal / professional 'liability'.	…a lack of confidence in utilising community services and clinical staff that are otherwise alien to their normal practice.

The following analysis is structured according to the presentation described in the table above: control, governance and confidence.

7.3.1.   Control

The individuals leading the integration of the services were aware of the necessity to involve members of the consultant team. This engagement was described as either helping to garner support behind the initiative, or to prevent any outright resistance. The following three excerpts provide an example of these sentiments.

The success or failure will hang on the clinical credence of the consultants. […] If it wasn't supported by the senior consultants, […] I don't think it would be happening.

(Head of Community Services)

If you said, 'we are just going to build up the community team and give them jurisdictional rights to come in and provide respiratory assisted discharge', the problem with that would be buy in from […] colleagues. So, that was a big reason why […] they had to be involved.

(Respiratory Consultant 1)

Consultants are important drivers of change but also obstacles for change. […] 'We don't want have to do this work out in the community, but we would like to have a veto.' […] Rather than, 'this is ours, we are in charge of it', […] people now feel 'oh well, this is the way things are going', they can see that there are certain benefits, but 'we want to keep our veto.'

(Respiratory Consultant 1)

The reference to retaining a 'veto' is an interesting reflection. Indeed, the consultant body was characterised as ranging from disinterested to completely against the proposed changes. The theme of control is relevant because the change has an impact on the consultants concerned. Any changes proposed that do not have an impact on them seems to be met with a degree of ambivalence.

Some [consultants] are really bought in, some are 'if it doesn't really impact on me, I'll just go with it', and then others […] have just outright been difficult.

(Team Leader)

I didn't perhaps make it centre stage and emphasise its importance as much as I should do because I just knew that people were either likely to be disinterested or against it, and I just pushed it on […] giving them some information, saying it was happening but not encouraging too much debate.

(Respiratory Consultant 1)

More has happened around consultants than with them. […] It just doesn't light their fires, they don't really engage with it.

A number of different explanations have been offered for the apparent lack of interest or engagement in the change process. Firstly, the commissioning manager attributes this behaviour to a fear of change *per se*. The consequences of a change may be unforeseen and have the potential to affect an individual's status. Therefore, the individual seeks to control the situation in order to minimise any risk to themselves:

If you take people out of their comfort zone, there is going to be some degree of anxiety, reticence, depending on the individual. […] A lot of it is down to people historically working in a certain way. So, when you actually introduce something that is quite new there is a degree of threat around that. […] 'How will this affect my practice, how will it affect my role, my standing with my colleagues etc?'

(Commissioning Manager)

A number of the interview participants referred to 'threat' or 'fear' of change. This characteristic may be more apparent in individuals that have attained a high status i.e. they may have more to lose. This resistance may not be so pronounced for lower status colleagues (e.g. physiotherapists or nurses).

The theme of control is also associated with the expectation that a particular individual or team would have a principal role in leading a service, or that there would be due deference to them in the design and running of the service. The following two excepts are from respiratory consultants. Firstly, respiratory consultant 2's comments relate to the launch of the home oxygen service, which is now provided by the integrated team.

The optimum model would be one of us leads it. […] I'm quite happy to do it. […] You could argue that if there was a GP with a special interest in oxygen out there, then that GP could […] be the medical lead. They still might have to come to us occasionally for advice, but that would be a bit more standalone.

(Respiratory Consultant 2)

The second reflection is from respiratory consultant 1 about their involvement with the project group. Again, there is a reference to the centrality of this consultant leading the new service:

Egotistically thinking that maybe I would lead such a service. […] I presented that idea, and one or two GPs said that's never going to work […] because of the dynamic between the community-based services and the hospital-based services. The [commissioners] would have been very resistant to the idea of us delivering community-based services […] that [they] very much wanted to remain independent from this hospital.

(Respiratory Consultant 1)

This sense of centrality to the leadership of the service is taken a step further in the following excerpt from the same consultant. It is interesting that respiratory consultant 1 describes the centrality of their involvement as being highjacked by the commissioners to add weight to the launch of the new service. The public and patients are described as being particularly susceptible to the allure of a consultant-led service. Furthermore, respiratory consultant 1 describes themselves as a 'talisman'. This would suggest that the status of the consultant can raise the standing of an entire service simply by association:

We have sold the […] respiratory team as something, which is integrated, perhaps more than it is, and media pictures will often put me in the centre. […] I don't know if it was done deliberately, but it kind of gives the impression that it's led by a consultant. […] Me being the centre, with the nurses and the physios around me, gives them a reassurance that this is a service which has full buy-in [even] if it doesn't particularly. […] I am sort of a public […] talisman.

(Respiratory Consultant 1)

Judging by the press photographs which publicised the launch of the new integrated service, it is difficult to disagree with their description. Figure 17 has been obscured and the consultant has been highlighted. The other team members – physiotherapists, nurses and administrators – are arrayed around the central figure of the consultant:
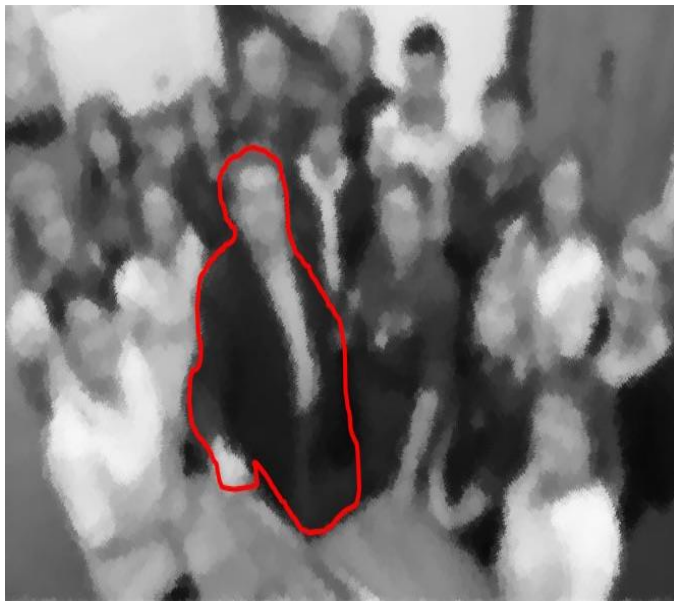
Finally, the theme of control is also evinced by the interaction of consultants with patients. The following excerpt is from a GP Commissioner who criticises a hospital consultant for their failure to fully consider the patients' perspective. The implication may be to suggest that GPs are better at considering patients' needs and less inclined to elevate their own importance. The integrated team's purpose is described as better fulfilling the needs of patients in the community. This is in comparison to the consultants' expectation that patients will inconvenience themselves to travel to a hospital-based outpatient appointment. It is important to note that the hospital is the locus of their control:

We all get siloed, even in primary care, but certainly in acute [they think] that patients like to come to hospital. Well, actually they don't. […] That's very powerful when the patient said 'no, I don't because it takes me four hours to park and pay and walk and see you for ten minutes and then come back and then I'm exhausted for ten days'. And poor old, [respiratory consultant], was mortified, wasn't he, his face fell at that. But actually, what people wanted is care closer to home. And people want to come to the surgery if they want to, but if they can't […] we've got this [community] service out there.

(GP Commissioner 1)

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The consultant's paternalistic attitude is juxtaposed against the GP's patient-centred viewpoint. The GP's construction of professional status owes a great deal to their image as being a patient advocate; a professional that has a holistic approach and isn't blinded by their own self-importance.

7.3.2. Governance

The interview material contains a significant number of references to 'governance'. This was used as a rhetorical device by doctors to mask a resistance to change, to manipulate the degree of uncertainty implied by the change, and to attempt to exert control over the process (Suddaby & Greenwood, 2005). 'Governance' in this sense refers to a risk or liability of some kind:

There is what is stated as an objection, and there may be other things which may be not stated. […] The stated concern is personal liability, who takes responsibility, who makes decisions, and the other thing, maybe, 'ooh, this is an attack on my prestige, as a consultant', but that would be less likely to be voiced. […] Oh governance, yeh it's kind of something that rolls off the tongue very easily. […] Who is accountable for these patients, what are the governance arrangements?

(Respiratory Consultant 1)

Currie *et al* (2012) discusses how doctors present themselves as 'arbiters of risk'. The following excerpt expands upon the consultant's sense of control and accountability for anything that happens to their patients. This accountability is seen as incompatible with a service being delivered at arm's length in the community. In order for the consultants to be comfortable with this service, it needs to be within the locus of their control. The idea of shared accountability is anathema to the consultants concerned:

The doctors probably were the most resistant both at the general practice level, and at the secondary care level. […] The big problem is one of control. […] The big key thing which gets wheeled out […] is accountability. So, the traditional […] medical model is that, I have a patient, decisions are made in my name. […] We call them […] 'my patient'. You don't hear nurses talking about 'my patient'. […] The consultant says, 'they are my patient because their name is at the head of the bed' and everything that goes wrong, they are ultimately responsible for. […] What we are talking about here with […] community teams,

shared-care, […] accountability in the traditional sense [...] no longer really works. We are taking joint accountability really, and doctors have trouble with that. […] One of my [consultant] colleagues [said] 'well if I say the person goes home with that team, I am taking accountability for that decision which means I therefore must have control over that team, because if I don't control them how can I have accountability for it'.

<div align="right">

(Respiratory Consultant 1)

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There is a clear sense that control, accountability and status of a consultant are interlinked. In order to exert control, the doctor needs to be able to draw upon some kind of power or authority. In order to be accountable, there has to be a sense in which the individual is entrusted to be the custodian of something or somebody; to be completely responsible for their care. The professional status of an individual rests upon these precepts. An erosion of their power, authority or accountability is detrimental to the projection of their status.

The below excerpt describes the formation of multi-disciplinary meetings (MDTs) as a strategy to address the perceived risk to the accountability of the individual. The MDT is used to help review the treatment plans and care of individual patients with the guidance and support of the respiratory consultants. The MDT allows the consultant to maintain a level of control over the care of patients being cared for by the community team. The *quid pro quo* is that the community team are afforded a level of professional support from the consultant team that had previously been reserved only for the hospital-based team. However, there is an interesting reference to the fact that accountability is a very personal issue for the consultants. It is not described as acceptable for one consultant to decide about the care of another consultant's patient. Again, there is a sense of control and ownership of individual patients:

It could be about risk aversion, it could be just individual control. […] We have talked about ways of addressing the […] accountability, governance, responsibility; these are all interlinked, so we have talked about MDTs, as possibly being a way to try and address governance issues. They still don't appease some people because if one of my colleagues doesn't go to an MDT […] and then maybe someone else is going to be making decisions on their behalf […] that then becomes difficult.

<div align="right">

(Respiratory Consultant 1)

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It is interesting that even within a team of consultants who have attained posts within the same organisational context, there is reluctance to make decisions about the care of one another's patients. This reflects a high degree of individualism. However, it may also reflect the doctors' view that no one will be able to provide better care to the patients than themselves.

7.3.3. Confidence

Finally, the absence of control by the consultants manifests itself as an aversion to the use of a service or team. A service beyond their control has an otherness – its quality cannot be determined or assured, whereas the team that work directly with or to the consultant team can afford greater confidence. The following excerpt refers pejoratively to the immediate hospital-based team as 'minions', to whom the consultants 'gave them their jobs', and as such are an extension of their practice:

A lot of it is about personality, control. […] Individuals do play an important part because there's mistrust within individuals who seem to have an affiliation […] with a different group, they are 'other'. […] We have got our respiratory specialist nurses […] there's no otherness about them, they are part of us, we gave them their jobs, […] they run their clinics next to us, they do what we say, they are our minions. […] I'm obviously exaggerating. […] In a sense, […] we use them to deliver services for our patients. […] They are an extension of our practice. […] If they're delivering care out in the community making independent decisions, working to pathways, liaising with GPs, they are their own bosses really.

(Respiratory Consultant 1)

Regardless of the extent to which it was a little tongue-in-cheek, the relative status of the consultants is rent large in the above excerpt. The main issue is one of confidence. In order to overcome resistance or aversion, the consultant team must have confidence in the community team. The following excerpt is interesting because the confidence in the team leader is derived from the fact that they were trained by the hospital consultants. There is no 'otherness' and they have been quality assured. This may have a good deal to do with interpersonal relationships. However, this may also

indicate another facet of professional status – the ability to pick and choose or anoint the team leader. It is not uncommon for consultants to be involved with the interview process for service leads as the most senior clinicians:

Some of that is confidence in the competence of the service. […] Where oxygen is concerned although this consultant has had some concerns […] it hasn't gone out of hand because […] the person who was appointed to the [team leader] post was trained by this hospital and by those consultants.

(Head of Community Services)

The theme of confidence is also closely associated with the act of delegation. The consultants must have confidence in the system, processes, services or individuals in order to make use of them. Consultants retain a high level of discretion about whether or not to refer to these services. If they do not want to use them, they will unlikely do so. Consultants regard themselves as the arbiters of what constitutes a quality service. If there is a concern that it is suboptimal, then they will find an alternative, or retain the patient within the ambit of their control. The following excerpt is from a GP commissioner and describes how difficult it can be for doctors to accede control:

They've got to have confidence that the system they are discharging that patient to. […] I wouldn't want to release my patients. […] Delegation is one of the hardest things to do in life. […] The comfortable thing is to hang on to them, and keep an eye on them, and check that everything is okay with them. So, you've got to have a really high degree of trust in the system if people are going to relinquish control and delegate efficiently and effectively.

(GP Commissioner 2)

On the other hand, the act of letting go or delegating does offer the scope to increase the professional status. This is because the headroom created by delegating effectively to the community team may offer them the chance to develop other specialist services. In the following excerpt GP commissioner 1 refers to an unmet need of patients requiring specialist input. The act of delegation may, therefore, offer opportunities to increase professional status.

There is a genuine fear among consultants that they're going to lose their jobs, that the workload won't be there. And my answer to them is yes, it might be absolutely right […] but actually we need your skills. […] You're going to still hold that base for the acute, the sick, that they'll need their specialists but there is still sort of cohorts of severe patients that we need their input too.

(GP Commissioner 1)

The fear of losing one's job because of a wholesale shift of the management of patients into the community might sound fanciful, but this was articulated by a number of participants as a genuine concern. In this context, the response to processes of change would be to dig one's heels in, because the doctors feel vulnerable.

* * *

In summary, the theme of autonomy was expressed in terms of control. This was articulated as a risk to governance and manifested itself in a lack of confidence in using the community services beyond the consultant's direct control. There were a number of reflections that concerned the role of professional status within processes of organisational change. There is a duality in the comments about the consultants' response to change. On the one hand, there is an acknowledgement that the engagement of consultants was essential to effect meaningful organisational change. However, there is also a clearly expressed apprehension that they were likely to be obstructive. The respiratory consultants were described as fearing change *per se*. There is evidence that high-status professionals resist change because they simply have more to lose.

The important distinction is the extent to which the change will affect the working lives of the respiratory consultants. If the change is peripheral to their clinical practice, then their response will be ambivalence, whereas, if the change affects them directly, there may be marked resistance. Their resistance to change is couched in terms of 'governance'. The lack of an explicit challenge to the change process may suggest a reluctance to display weakness or vulnerability by acknowledging that they are threatened by, or are not in the driving seat, of change.

The respiratory consultants managed this risk posed by the change by retaining veto rights. If it looked like it was going to cross a line, they could reel the process back in. Their resistance is also likely to soften, if they can retain some levers of control. For instance, extending their influence through MDTs, or establishing reporting lines. These levers help them to overcome the otherness of the community team, their lack of confidence in their service, and their unwillingness to delegate the responsibility for the care of their patients.

There was some evidence that the change posed an opportunity for the respiratory consultants to build their professional status. This may relate to their public service ethos in working collaboratively with other parties for the greater good, or simply as a pragmatic way of creating some headspace to develop specialist services. In the circumstances that the consultants are positively disposed to the change process, they play a principal role, even playing a talismanic effect, warranting and enabling the change to happen.

The interplay between the contributory theme of organisation and the mitigating theme of autonomy can be observed. For instance, the increasing level of demand on the hospital service posed a risk to the sustainability of the service and, therefore, the professional status of the respiratory consultants. The service was described as being overwhelmed and the demands were likely to continue to exceed supply. This risked the diminishment of the status of the entire service.

However, the integration of the community- and hospital-based teams provided the opportunity to more effectively manage this demand. In the absence of the mitigating theme of autonomy, this change would represent a net loss of jurisdiction for the respiratory consultants, and therefore, could potentially lower their professional status. On the other hand, the presence of the mitigating theme of autonomy meant that the consultants were able to extend their control over the integrated service through MDTs and line reporting, thus maintaining their professional status.

Chapter Eight

Analysis & Findings – Organisational Change

8. Chapter Eight: Analysis & Findings – Organisational Change

This chapter will consider the role of professional status within processes of organisational change by undertaking a cross-case analysis of the three case studies. This chapter builds upon the theoretical model outlined in Chapter Four which identifies eleven themes that doctors use as reference points in their construction of professional status. The chapter will consider the following in relation to the three case studies:

- The presence of themes related to professional status; where there are similarities and differences in the observed phenomena.

- The role of professional status in relation to organisational change; how professional status influences how doctors respond to change.

The cross-case analysis will be presented according to the principles outlined in Chapter Three, in both narrative and tabular form, using comparative tables to aid analysis, and to identify patterns and connections between the data (Miles and Huberman, 1994).

8.1. Relative Presence

Table 12 presents the relative presence of the contributory and mitigating themes in each case study. The assessment of the relative presence has been based on data derived from NVivo coding, indicating the number of references, and the within-case analyses presented in Chapter Five, Six and Seven. The relative presence is categorised as Strong (S), Moderate (M) or Weak (W).

Theme	Vascular	Cardiology	Respiratory
Capability	S	S	M
Specialisation	S	S	M
Emergency	M	M	M
Technology	S	S	W
Material Value	S	S	M
Organisational Standing	S	S	S
Breadth	M	M	M
Lifestyle	M	M	M
Craft	M	M	W
Ethos	M	M	M
Autonomy	S	M	S

A number of observations can be made about the relative presence of the themes in the case studies.

- These cases underline the analysis in Chapter Four concerning the extent to which the themes are interrelated. This analysis suggested that the themes seldom act in isolation and there is considerable interplay between them. Taking account of all three cases, all eleven themes are represented in the transcript data.

- There is a much stronger presence of the contributory themes (i.e. the first six themes in the table above), compared to the mitigating themes (i.e. the bottom

five). Again, this is consistent with the theoretical model presented in Chapter Four, which conceives of contributory themes being used in the construction of professional status, and the mitigating themes only becoming operative in the instance that there is an excessive presence of the corresponding contributory themes.

- There is a strong presence of the contributory theme of organisation, and the mitigating theme of autonomy. This was anticipated and is attributable to the purposive sampling of case studies to focus on organisational change.

- The relative absence of references to the contributory theme of emergency was surprising. All three cases had some reference to emergency or acute services. In particular, the vascular case study related to the centralisation of major surgery, such as abdominal aortic aneurysm repair, which often presents as an emergency case with a high mortality rate. Similarly, the cardiology case study relates to PPCI services which are an emergency treatment for heart attack. It is, therefore, curious that the interview participants did not make greater reference to this theme in their construction of their professional status.

- There also seems to be more commonality in terms of relative presence of themes between the vascular and cardiology cases. These case studies were both focussed on the services provided in a general hospital, whereas the respiratory case focussed primarily on the relationship with community services. This may suggest that the construction of professional status will be partly determined by organisational context. For instance, there will unlikely be a strong reliance on the theme of technology for general practice because of the relative lack of technology in their clinical practice. Furthermore, general practice simply doesn't have the resources of material value that are at a doctor's disposal in a hospital setting. This may explain the perceived lower status of general practice – it has less proximity to emergency services, technology and resources of material value.

- The mitigating theme of 'autonomy' is less pronounced in the cardiology case study. This may relate to the ability to control the requisite resources. In the respiratory case study, the consultants were able to extend their control through informal means such as MDTs and line reporting. In the vascular case study,

considerable resources had already been allocated as a 'carrot' to facilitate the centralisation of the service. In the cardiology case study, the ability of the cardiologists to extend the PPCI service, and ensure a sustainable service, required substantial investment, and was dependent on the support of the trust board. The relative impotence of the cardiologists in these circumstances may explain the more moderate presence of the theme of 'autonomy'.

8.2. Comparative Analysis of Case Studies

Table 13 provides a summary of comparative analysis of the presence of each theme in the three case studies and the common patterns that can be identified in relation to processes of organisational change.

Table 13: Comparative Analysis of Presence of Themes

Theme	Vascular	Cardiology	Respiratory	**Common Patterns**
Capability	Capability of surgeons is defined vis-à-vis immediate peers, neighbouring hospital teams and peers at a national level Spoke surgeon fearful of being exposed as being less competent; this led to the eleventh-hour withdrawal from the vascular network; fish-pond effect	Competitive nature of training as an interventional cardiologist Practical challenge of performing interventional procedures	Locus of expertise presented as respiratory consultants working in the hospital	In all three cases, the capability of a doctor is defined with reference to others. It is a relational construct. This may be in relation to their peers, their neighbours, their peers at a national level, other specialties etc.
Specialisation	Vascular surgery has become increasingly specialised The formation of vascular network has necessitated the dropping of general surgical activities The scope of the network has spread the consultants much thinner	Expansion of procedural medical specialties like cardiology represent a net loss of jurisdiction for surgical specialties; reduction in the glamour of cardiac surgery because of the curative nature of interventional cardiology	Increase in demand has detracted from opportunities to enhance specialist activities	The vascular and cardiology case studies describe a process of increasing specialisation and shifting jurisdictions. For instance, between surgical and procedural medical specialties, or between the services offered in tertiary centres compared to general hospitals.

	Former hub surgeons have retained dual identity as general / vascular surgeons EVAR services are at the jurisdictional boundary between vascular surgery and interventional radiology	Declining numbers of interventional cardiologists as new jurisdictions are being created in the sub-specialty of cardiac imaging		On the other hand, the respiratory case study described a diminishment of specialisation because the burden of demand is excluding opportunities to develop specialised practices. In all three cases, this is presented as a dynamic process as the fortunes of these specialties waxes and wanes.
Emergency	Vascular surgery attracts a particular type that can cope with 'not desperately fun' emergency-based workload Vascular surgeons are judged 'on death' with the publication of surgeon-level mortality rates	Relative importance and status of emergency service for heart attack; willingness of consultants to commence a 24/7 service in advance of any substantive investment in the service	The focus of the integration of services was on improving the management of COPD which accounts for a high proportion of emergency admissions	Both the vascular and cardiology cases studies refer to the challenge of managing emergency workloads – it is described as a matter of mission for both specialties The respiratory case is dissimilar as the focus is on preventative management of patients to prevent them becoming emergency admissions

Technology	EVAR is a minimally invasive technique and its use demonstrates the progressive nature of clinical practice There are inherent risks associated with emergent technologies; their adoption can be a gamble Rivalry of vascular team trying to set up independent EVAR service; demonstrating awareness of kudos of the technology	Sophisticated technology, providing curative treatment. PPCI is a minimally invasive technique that is more specific and targeted than its precursor drug therapies In past decades, there has been a variable rate of adoption of enabling technologies to perform PPCI	Not applicable – neither the community or hospital teams use sophisticated technologies	Both the vascular and cardiology cases are associated with minimally invasive procedures. There is competitive element to technology adoption – animated by the desire to be progressive or the fear of being outmoded; there is kudos in adopting new technologies. There is no reference to technology in the respiratory case
Material Value	Earning potential associated with private practice; reluctance to lose general surgical activity as it is lucrative private income; centralisation of services poses risk to private patient referral network	There is a jurisdictional conflict to control the cath labs; there is a kudos attached to controlling this resource The current configuration is considered sub-optimal for the care of patients in	Control of staffing resources associated with the hospital-based team; the consultants' 'minions' owe their position to the favour of the consultant body	All three cases provide examples of the ability to vie for control of jurisdiction of coveted resources. The vascular and cardiology cases refer to the ability of the

	and maintenance of revenues Hybrid theatre investment was leveraged by surgeons over radiologists and has become a surgical domain; it represents a figurehead to enhance the competitive edge of the service; it was a 'carrot' to convince the surgeons to support the centralisation of services Vascular surgery associated with lower socioeconomic groups and poor lifestyle; the spoke locality has a particularly high incidence of poorly managed disease Extension of jurisdiction over spoke hospital service; impact of rescindment of supporting roles and resources	the west hospital; there was a reported lack of political will to change the configuration of the cath labs The loss of access to the cath lab presents a crisis of identify for some consultants; the forfeiting of access to the cath labs may represent a critical loss of status for individual consultants The cardiologists are able to leverage significant investment in the PPCI service; the trust board approved the business case even though it was loss-making		consultants to leverage substantial investment in services. The vascular and cardiology cases refer to the importance of material resources in shaping the identity of consultants i.e. cath lab and theatre

Organisational Standing	Volume / outcome drivers used to justify centralisation of services; the required size of the service to be sustainable and have critical mass was defined at organisational level; this has necessitated the formation of a networked service	Fear that losing PPCI services may represent the thin end of the wedge and presage the loss of other planned services	Lack of sustainability for existing service that is overwhelmed with increasing demand	All three cases are related to the sustainability of services at an organisational level. In the vascular and cardiology cases, the loss of services is described as the thin end of the wedge; the loss of high-profile services risks having a catalytic effect on the sustainability of other services.
	Fierce resistance to centralisation from some hospitals; loss of vascular services seen as the 'thin end of the wedge' and the downgrading of the status of the consultant body within the organisation	Ambiguity over whether the service would achieve 24/7 status impacted on ability to recruit and retain consultants	Acknowledgment that the demand can only be managed through working collaboratively across hospital and community-based services	
		Double edged sword of achieving 24/7 status is the benefit associated with providing a viable and sustainable service weighed against an increase in workload intensity		All three cases present a picture of shifting jurisdictions. This resulted in a level of ambiguity about organisational status.
	Centralisation led by the vascular professional body; bottom-up change			
		Routinisation of PPCI leading to service being pushed down to general hospitals for cardiac surgeons in tertiary centres to establish new jurisdictions over procedures like TAVI		Both the vascular and cardiology cases provide examples of consultants accepting compromises to their working lives in order to pursue the goal of organisational sustainability.
	The standards defining the shape of vascular services regarded as having been authored by the large centres; they have a level of self-			

	assurance and security in that they already meet the requirements Political motivation behind the centralisation of services on the hub hospital site; as a product of the centralisation, investment was made in the services on this site Centralisation on the hub hospital site brought together two incompatible ways of working Kudos from working in a large organisation, meeting the required standards; formation of vascular network pursued despite all of the practical challenges			
Breadth	The former hub hospital surgeons resisted losing the general surgical aspects of their workload	Holism of medical aspects of care provided to their patients; getting to know their patients	Respiratory consultants criticised for a doctor-centric attitude and a lack of appreciation for the patient; the paternalism of	The vascular and the cardiology cases refer to the desire retain a breadth to their clinical practice. On the other hand, the respiratory case refers to

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			the consultant versus the holism of the GP	perceived lack of breath and holism in the respiratory consultants' clinical practice.
Lifestyle	The requirement to cover the on-call for three hospital sites as part of network arrangements is particularly onerous; there is an increasingly burdensome span of activities	PPCI services increasing antisocial working; declining attractiveness of interventional cardiology as a sub-specialty	Difficulty recruiting GPs; an increasing number are salaried GPs as they don't want the stress and responsibility of running a practice Overwork and busyness of consultant team	In all three cases, there is a consistent theme about onerous activities and unmanaged demand having a detractive impact on lifestyle.
Craft	Efficacy of EVAR compared to conventional 'open' surgery questioned by some vascular surgeons Additional technical challenge for surgeons presented with minimally invasive techniques	Appeal to the surgical aspects of cardiology in their construction of professional status; the specialty inhabits the intersection between medicine and surgery; it has the best of both worlds	Not applicable – there were no references to the theme of craft. This is related to the lack of presence of technology in the case study.	The vascular and cardiac cases refer to a traditional surgical role.
Ethos	Pushing the boundary of the appropriate use of EVAR; desire to acquire	Appeal to best interests of patients, and the quality of care that can be offered at	Perspective of respiratory consultant described as 'unique' and 'public health'	In all three cases, there are appeals made to the

	technology may subordinate what is in the best interests of patients	the west hospital, to inform location of cath labs	orientated; strong advocate for collaboration, transcending organisational silos, and working together for the greater good	needs, or best interests of patients.
Autonomy	There is an effort to maintain locus of control in the context of merging services and jurisdictions; conservativism and resistance to change; invested in the *status quo* Merging of organisational cultures resulting in battles fought over day-to-day working practices Centrality of individual consultants that can arrest change processes; conflict between individual surgeons	The relative lack of support, compared to the well-resourced tertiary centres, is held up as a badge of pride for the consultants; they have to be better able to act on their own	Lack of confidence in community team, which has an 'otherness'; unwillingness to delegate responsibility for patient care Extension of control by consultant team through MDTs and line reporting 'Governance', 'accountability', and 'liability' used as rhetorical devices to mask a resistance to change Respiratory consultants to retain veto over any change that may affect their practice Respiratory consultants are highly individualistic	All three cases refer to the control of a jurisdiction. The vascular and respiratory cases refer to a resistance to change *per se*. There is a desire to maintain the *status quo* and to veto any change. In the vascular and respiratory cases, the centrality of the consultant is paramount and has a deterministic effect on the process of change.

| | | | and unwilling to decide about the care of their colleagues' patients

Centrality of respiratory consultants within change process; consultant has a 'talismanic' effect | |
|---|---|---|---|---|

There are a number of observations that can be made from this comparative analysis of the case studies.

- There are many examples of status being defined with reference to others. As previously stated, this is a relational construct. Depending on the particular process of organisational change, the other may be defined at a macro-level (e.g. between occupational groups, or organisations), or at a micro-level (e.g. between peers or colleagues). The case studies indicate that these perceived differences become more pronounced during processes of organisational change (Ramirez *et al*, 2015) Otherness is emphasised because processes of organisational change are frequently battles for jurisdiction and control of resources (Stringfellow & Thompson, 2014). In these circumstances, the ability to find a common purpose and project a unified front becomes an invaluable asset.

- The construction of professional status is highly dynamic. It is dependent on the shifting of jurisdictions between organisations, specialties, and between individual doctors. In some cases, these shifts signal the death knoll for certain practices (e.g. cardiac thrombolysis or perhaps 'open' abdominal aortic aneurysm surgery), the emergence of new jurisdictions (e.g. minimally invasive techniques such as PPCI), the merging of jurisdictions (e.g. the integration of the respiratory hospital and community teams), the loss of jurisdiction (e.g. the cessation of major vascular surgery at the spoke hospital), and jurisdictional disputes (e.g. the emergence of EVAR at the intersection between vascular surgery and radiology).

- The 'fear' of losing jurisdiction and relinquishing status has a formative impact on the response to change. For some doctors, it meant a resistance to organisational change *per se* (e.g. the respiratory consultants blocking of change that directly affected their practice). For others, it meant the pursuit of organisational sustainability irrespective of the personal cost (e.g. the impact of the vascular network on the former sister hospital team or the willingness of the interventional cardiologists to implement a 24/7 PPCI service in advance of any investment in the service). In this context, the ability to extend control of a jurisdiction has a symbolic and practical importance. It is also intimately associated with the identity of doctors.

The observations derived from the cross-case analysis help to further develop the theoretical model to account for the role of status within processes of organisational change (see Figure 18).

Figure 18: Theoretical Model for Organisational Change

Role
- Organisational context of role determines characteristics
- Characteristics of role informs status construction

Change may modify role

Status Construct
- Status is socially constructed
- Interpreted in relation to 11 themes
- Balancing contributory and mitigating themes
- Orientation toward status gain and aversion to loss of status
- Tendency to lionise own traits

Status Construct informs response to change

Organisational Change
- Opportunities and threats to professional status
- Change is a dynamic process resulting in shifting jurisdictions

Change may transform others

Others
- Status constructed in relation to 'others'
-

The model presents a **Status Construct** which represents the doctors construction of professional status. This model recognises that status is socially constructed and perceived by individuals (Pearce, 2011). This construction of status is associated with the theoretical model for the construction of professional status outlined in Chapter 4. Professional status is interpreted with reference to eleven themes – six contributory themes and five mitigating themes. In the instance that there is an excessive presence of a contributory theme, a doctor may refer to a mitigating theme in order to maintain their construction of professional status. It is important to note that the themes are to a certain extent interrelated. The status construct is also premised on the idea that actors have a desire to pursue status (Lin, 1999; Thye, 2000), and have an aversion to the loss of status (Van Dijk & Van Dick, 2009; Scheepers & Ellmers, 2004). The status construct is also informed by actors' tendency to lionise their own traits (Tajfel, 1978; Turner, 1987).

A doctor's status construct is informed by their **Role**. A doctor's role will be associated with a particular organisational context where they work. For instance, a general practitioner will work in a GP surgery, whereas an orthopaedic surgeon will work in a hospital. The organisational context where they work will determine the characteristics of their role. For instance, the roles of different types of doctors working in different organisational contexts will have completely different characteristics such as the nature of their interaction with patients, their use of technology, the amount they can earn etc. Therefore, doctors will draw upon different characteristics particular to their role and organisational context where they work in their construction of professional status.

Professional status is also defined in relation to **Others**. These may be their immediate peers, teams in a neighbouring hospital or the profession at large. With reference to relational sociology, this conception acknowledges that actors are inseparable from their transactional contexts within which they are embedded. These relationships are dynamic in nature and an ongoing process (Emirbayer, 1997).

A doctor's status construct shapes their response to **Organisational Change**. This change may present opportunities or threats to the status of a given doctor. The nature and extent of this threat will be dependent on the basis for their particular status

construction. For instance, if the organisational change resulted in a loss of jurisdiction over a particular service (say, the leadership of a senior nursing team), but the doctor's status construct was not related to this service (they may be ambivalent about the loss of the service), then the organisational change would present no threat to their status. For a different actor, their position as a figurehead of the service may have a deleterious effect on their status construct.

Change is conceived of as a dynamic process that may result in the shifting of jurisdictions between individuals, specialties and organisations. How a doctor responds to change owes a great deal to their construction of professional status, and little to the relative prestige or standing of specialties in an objective sense. As a consequence of the organisational change, there may be a change to the role of the doctor. For instance, their service may move to another site. This may require a reconstruction of the professional status of the doctor. Their referral network may have been interrupted, they may have fewer resources at their disposal etc. In these instances, the doctor may draw upon a different characteristic of their role to maintain their construction of professional status.

On the other hand, the organisational change may result in the transformation of others. The clinical team in another hospital may have started to compete over the delivery of highly specialist surgery. This may also pose a threat to a doctor's construction of professional status. This may have been based on being the only surgeon in a region to offer a particular type of procedure. They may maintain their construction of professional status by establishing a new and exclusive field of clinical practice. In these circumstances, the doctor's status will be reconstructed.

* * *

In summary, a cross-case analysis has been undertaken which has considered the relative presence of themes across the three case studies. Similarities and differences in the observed phenomena have been highlighted. A comparative analysis has also been undertaken of the role of professional status within these cases of organisational change. A number of observations were derived from this comparative analysis. These

have been used to inform a theoretical model to account for the role of professional status within processes of organisational change.

Chapter Nine

Discussion & Conclusion

9. Chapter Nine: Discussion & Conclusion

This chapter will consider each of the research questions that were outlined at the beginning of this thesis. Based on the findings of this research, I will address each of these research questions and explain how these results relate to the literature. Then I will reflect upon how these results fit with the expectations of the research study. Finally, I will conclude the thesis by summarising the principal implications of this research for practice, the significance of these findings, potential limitations or weaknesses of the study, and subject areas for future research.

9.1. Construction of Professional Status

How Does the Medical Profession Construct Professional Status?

This thesis conceives of status as being socially constructed and having a subjective quality rather than being an objective structural reality. It has provided a theoretical model for how the medical profession constructs professional status with reference to eleven themes. These themes are divided into two categories. Six of these themes (Capability, Specialisation, Emergency, Technology, Material Value and Organisational Standing) are 'contributory themes' which contribute toward a doctor's construction of professional status.

For instance, a doctor may construct their professional status with reference to the contributory theme of Emergency. They may derive their notion of status from working in an environment in which they engage in life and death situations, and value the immediacy and excitement of emergency and acute practice. Alternatively, a doctor may construct their professional status with reference to the contributory theme of Material Value. They may derive their notion of status from how much they earn, or the value of their equipment and other resources.

In addition to the six contributory themes, there are five 'mitigating' themes (Breadth, Lifestyle, Craft, Ethos and Autonomy). These five mitigating themes are paired with the corresponding contributory themes. For instance, the contributory theme of Organisational Standing is paired with the corresponding mitigating theme of

Autonomy, and the contributory theme of Technology is paired with the mitigating theme of Craft. All but one of these contributory themes are paired with a corresponding mitigating theme. One contributory theme, Capability, is not paired with any mitigating theme.

In the event that there is an excessive presence of a contributory theme, there is a risk that the veridicality of a doctor's status construction becomes unsustainable. For instance, if a doctor's construction of status is based on the contributory theme of Emergency, an excessive presence may be associated with an increasingly onerous or unpredictable working pattern. Similarly, if a doctor's construction is based on the contributory theme of Material Value, they may be seen to be exhibiting mercenary behaviour in their clinical practice.

In these circumstances, the presence of the corresponding mitigating theme can help to maintain a construction of professional status. In the case of an excessive presence of the contributory theme of Emergency, the corresponding mitigating theme of Lifestyle would allow a doctor to maintain their construction of professional status. This is because the presence of Lifestyle is associated with active choices to pursue other interests such as family etc. The theoretical model conceives of social actors engaging in a continuous process of constructing and reconstructing their professional status with references to these themes.

The theoretical model, and the themes that it presents, were derived through an iterative process of theorisation, from the interview data. However, the case studies also provided an opportunity to observe the presence of these themes within processes of organisational change. The relative presence of the themes in the case studies has been considered. This demonstrated that the themes were interrelated and that there was considerable interplay between them. The relative lack of references to the theme of Emergency was considered curious, in particular given that two of the case studies considered services associated with emergency patients.

These findings represent a new perspective on professional status and organisational change. In reviewing the existing literature relating to our understanding of how the

medical profession constructs professional status, a number of gaps and weaknesses were identified. The two gaps identified in the literature relate to:

(i)   the lack of appreciation for the subjective quality of status in the study of the professions;

(ii)   the inadequate account of the extent to which status is constructed, contested and dynamic, particularly in relation to studies that have attempted to rank specialties by status or prestige;

I will now address each of these gaps in turn and will explain how the theoretical model summarised above contributes to enhancing our understanding of social phenomena related to professional status.

Firstly, I argue that the study of the professions has neglected the subjective quality of status. The departure point for this thesis is the contention that professional status is constructed (Pearce, 2011) and that structural accounts, which conceive of status as an objective characteristic, fail to account for the role of social actors interpreting and making sense of social phenomena (Denzin & Lincoln, 2018). In general, the majority of the accounts that emphasise the subjective quality of status have been developed by social psychologists (e.g. Secord and Backman, 1974).

In the study of professional groups, theorists have tended to conceptualise status as an objective and structural reality. This is because these studies have mostly concerned themselves with understanding how the professions, as macro-level actors, interact with other occupational groups, other professions and state institutions (Havighurst & King, 1983; Light & Levine, 1988; Light 2000; Abbott, 1988). These accounts have tended to emphasise the homogeneity and stability of the professions (Sanders & Harrison, 2008).

It is arguable that accounts of the status relationships between organisations, occupations or professions lend themselves to studies using a structural perspective. However, the observable characteristics that distinguish organisations, occupations or professions are less visible when the unit of analysis is shifted to the status relations

between segments within a profession. This subject requires a much more nuanced interpretation of status relations as these segments cannot simply be reduced to their observable characteristics such as power and wealth. For instance, the distinction between the status of a dermatologist and rheumatologist would not be apparent to the uninitiated observer.

However, a constructivist approach may uncover completely different constructions of professional status – their status may be derived from their interaction with community practitioners or the reassurance and care they offer their patients. These characteristics may inform a completely different response to processes or organisational change. For instance, they may conceive of opportunities and threats in divergent ways. In emphasising the considerable heterogeneity of the medical profession, the thesis is a step towards addressing the paucity of research related to intra-professional status (Abbott, 1981; Drazin, 1990) and enhancing our understanding of how different actors may respond to change.

Secondly, I contend that studies which represent status in terms of a linear ranking (e.g. Shortell, 1974; Matteson & Smith, 1977; Rosoff & Leone, 1991; Creed, Searle & Rogers, 2010; Album & Westin, 2008) fail to represent the extent to which status is constructed, contested and dynamic. The prestige ranking studies are too descriptive and do little to further our understanding of how the status constructs of individual actors can be used for explanatory purposes and as a guide to future behaviour. It is arguable that the ranking of the relative prestige of a specialty tells us more about the actors undertaking the ranking than the perspective and motivation of doctors working in those specialties.

I have demonstrated that these traditional hierarchical models, which rank the prestige or status of specialties, with brain and heart surgeons at the top, and GPs and psychiatrists languishing at the bottom, is at best misleading, and at worst unhelpful. Indeed, this thesis has given voice to the accounts of informants that turn this conventional conception of status as an orderly hierarchy on its head. It has shifted the analysis from questions about which specialty has the highest status, to how doctors in each specialty construct their own conception of status, drawing upon the characteristics that best suit their role.

It should be acknowledged that there have been attempts in the literature to capture the dynamism of intra-professional relationships. For instance, Abbott's (1988) conception of shifting jurisdictions and the jostling of actors for status. This conception does recognise that status has a dynamic quality. However, it errs by reducing down the relationship between actors to the control of tasks and jurisdiction. It fails to account for the diversity of professions with respect to differing perspectives, identities and constructions of professional practice (Light, 1984).

This matters because status may be derived from characteristics that have little relevance to the control of tasks. For instance, it may be related to the intrinsic reward that a doctor derives from their practice. The theoretical model presented in this thesis can account both for the dynamism of status construction, and how actors can construct potentially divergent conceptions of professional status.

9.2. Professional Status Within Organisational Change

What is the Role of Professional Status Within Processes of Organisational Change?

This thesis has demonstrated that a doctor's construction of professional status will inform their response to organisational change. For instance, the Respiratory case study has demonstrated divergent conceptions of professional status within the same consultant team. This meant that only one consultant embraced the integration of the community and hospital teams, whereas their colleagues remained disinterested. This is because the one consultant constructed their status based on their public health orientation, whereas the other consultants derived their status from the specialised nature of their hospital roles.

This thesis has offered a theoretical model which conceives of a doctor's construction of professional status as being influenced by their role, and in relation to 'others'. Processes of organisational change present opportunities and threats for a doctor's professional status. In the Cardiology case study, the need to extend the PPCI service to 24/7 presented an existential threat to their service. The status constructions of the cardiologists were based on their specialised activities which meant that they were very resistant to change, and hence they placed considerable pressure on the trust board to extend the working hours of the service. Furthermore, in the Vascular case study the centralisation of vascular services was simultaneously interpreted as both an opportunity and a threat, dependent upon the status constructions of the individual vascular surgeons.

A process of organisational change may modify the role of a doctor, and in so doing their construction of professional status may need to be reconstructed on a different basis. For instance, the loss of jurisdiction over EVAR by the consultant radiologist was described as an opportunity for them to develop other fields of specialist practice. Hence, their status construction was maintained despite the loss of control over this technology. Similarly, a process of organisational change may transform the 'others'. This may also result in the need for the doctor to reconstruct their professional status. For instance, in the Vascular case study, the centralisation of the vascular service

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transformed the position of the spoke hospital surgeon from being regarded as a peer to being perceived as a deficient practitioner.

In reviewing the existing literature relating to our understanding of the role of professional status within processes or organisational change, the following gaps and weaknesses were identified. This section will address each of these gaps in turn and will explain how the theoretical model summarised above contributes to enhancing our understanding of social phenomena related to organisational change. The two gaps identified in the literature relate to:

(i)   The lack of appreciation within the organisational change literature of the role of opportunities and threats to professional status as explaining acceptance or resistance to change;

(ii)   the lack of a developed understanding of how doctors construct and reconstruct their professional status in response to organisational change with reference to their role and in relation to others.

Firstly, I have shown that opportunities and threats to professional status are a key and under-explained element within organisational change literature, explaining acceptance or resistance to change. I have demonstrated how opportunities and threats to professional status are present in a range of studies related to organisational change. These studies included threats and opportunities to professional status and role identity (Reay *et al*, 2017; Kellogg, 2011), the differential response from actors based on their social position (Battilana, 2011; Compagni, Mele & Ravasi, 2015; Lockett *et al*, 2014), and jurisdictional boundaries between professional groups (Currie *et al*, 2012; Zetka, 2001). The theoretical model that I have developed takes account of the role of opportunities and threats in moderating the response of doctors to change.

There is a well-developed account of the orientation of actors towards status gain and their aversion to status loss within the social psychology literature (Scheepers & Ellemers, 2005; Pettit, Yong & Spataro, 2009). There have been some attempts to apply this psychology-based research that links organisational change to the framing

and interpretation of issues as either opportunities for gain or threats of loss in management and organisational theory (Kennedy & Fiss, 2009; Van Dijk & Van Dick, 2009; George et al, 2006). However, these studies have tended to concern themselves with how opportunities or threats make change more or less likely, or how change could be more effectively managed.

These approaches miss an understanding of how the perception of what constitutes an opportunity or a threat, and their response to change, is informed by a doctor's construction of professional status. For instance, in the Vascular case study, there were divergent conceptions of the centralisation of vascular services. For the former hub hospital surgeons, the change presented a threat to their established referral pathways, whereas, for the former sister hospital surgeons, the change offered the potential to increase their specialisation.

There is a benefit to developing a more thoroughgoing understanding of how opportunities and threats influence the construction of status, and consequently how this informs an actor's response to organisational change. This is because it provides change leaders with an understanding about the potential response to an organisational change. In the context, resistance to change will be understood at a deeper level compared to what may be reported or couched in terms such as 'governance' or 'risk'. In providing a theoretical model to account for the role of professional status within organisational change, I have contributed to a better understanding of the cognitive underpinning of actors' responses to organisational change. In so doing, this model develops our understanding of the links between micro-level interpretation of opportunities and threats with macro-level change processes.

Secondly, I argue that there is an insufficiently developed understanding in the literature of how doctors construct and re-construct their professional status in response to organisational change. The organisation studies literature has under-represented the extent to which the construction of status is both self-referential and relational. This is important because it enhances our understanding of the extent to which status is a dynamic concept, and how status constructs can be both ephemeral and highly adaptive.

There are a number of theoretical approaches that have emphasised the importance of social identity and the way that it is defined with reference to others (Cuddy, Fiske & Glick, 2008; Tajfel, 1978; Turner, 1987). The theoretical model presented in this thesis, shares some characteristics with one such approach, Expectation States Theory (Berger, Conner and Fisek, 1974). For instance, it supports the idea that status relations emerge as a consequence of actors comparing and defining themselves in relation to one another, in order to act towards a collective task (e.g. the delivery of healthcare). Similarly, the idea that actors are differentiated into social categories, which are invested with different status value about their worthiness and competence, is sympathetic to the model I have presented.

However, the theoretical model I have presented differs from this theory in important ways. The most significant departure from Expectation Status Theory is that it conceives of actors having a shared appreciation of the status value of certain characteristics and therefore the social groups that they are attributed to. The implication being that if a social group had characteristics that were collectively understood as having low value, then this social group would recognise that other groups are better than their own (Ridgeway, 2001).

This phenomenon isn't borne out in my data, as there is a clear tendency for the informants to lionise traits that play to the strengths of their particular specialty. I contend that the theoretical model I have offered can better account for the diversity of actors within professional groups and how they construct status in divergent ways. This is important because there is an increasing diversity within the profession which means that change processes may become increasingly contested and the outcomes more unpredictable.

These results fit broadly with the expectations of the research study. However, the strength of the presence of the theme of Organisational Standing throughout the case studies was unexpected. In addition, the extent to which this theme is interrelated with other themes was also unexpected. This may suggest that Organisational Standing is the most important theme in relation to the construction of professional status as other themes are shaped by this context.

9.3. Conclusion

The principal finding of this research study is to reconceptualise the nature of status within professional groups. This thesis offers a theoretical model which conceives of status as being constructed by professionals and having a subjective quality, rather than being an objective and structural reality. The findings of this thesis can better account for the diversity of professions, and how intra-professional status is constructed. Owing to the diverse roles and perspectives of the medical profession, status is conceived to be contested and dynamic.

The thesis has offered a theoretical model that can account for the role of professional status within processes of organisational change. A doctor's construction of professional status informs their response to organisational change. Doctors construct their professional status with reference to the characteristics of their role, and in relation to 'others'. Processes of organisational change present opportunities and threats to professional status and can modify the characteristics of a doctors role and transform the relative position of 'others'. This thesis conceives of opportunities and threats to professional status as explaining acceptance or resistance to change.

The theoretical contribution of this thesis is to the status and organisational change literature by linking the micro-level processes of sense making by doctors with macro-level processes of organisational change. This has been achieved by enhancing understanding of how doctors construct and reconstruct their professional status in response to organisational change with reference to their role identity and in relation to others. This thesis has contributed to addressing weaknesses in the current literature. One of the ways this has been achieved has been by importing some of the cognitive models developed in the field of social psychology to explain the cognitive underpinning associated with responses to organisational change.

The implications of this research for practice is to provide a more nuanced interpretation of the role of professional status within process of organisational change. Those leading change processes within healthcare should be sensitive to the diverse ways that doctors construct their professional status. In so doing, the response to change can be anticipated and strategies developed to lessen the extent to which

change can be perceived as a risk or enhance the extent to which change is perceived as an opportunity to develop their professional status.

9.3.1. Potential Limitations & Weakness of the Study

There are three potential limitations and weaknesses in this study. Firstly, the range of informants may have been too limited. As outlined in Chapter Three, purposive sampling was used to identify informants in a strategic way, so that those sampled are relevant to the research questions that are being posed (Bryman, 2012). A total of forty interviews were conducted, including thirty-one consultants or general practitioners. In collecting the research data, steps were taken to ensure its trustworthiness (Lincoln & Guba, 1985).

However, it is arguable that the study had some notable omissions including paediatrics and psychiatry. The reason for omitting these specialties was one of practicality, and that, as a researcher, I did not have any prior acquaintance with anyone working within these specialties. In the case of psychiatry, this specialty has been traditionally regarded as having low professional status (Merton, Bloom & Rogoff, 1956; Holmes *et al*, 2008). Given that psychiatrists are distinguished from other doctors by the characteristics of their role, and the organisational context where they work (i.e. a psychiatric hospital), the inclusion of this specialty could have provided an opportunity to further extend and develop the theoretical framework.

There is also a risk that these omissions may challenge the confirmability of this study as being representative of the medical profession, rather than the majority of the segments therein. In other words, to ensure that the study doesn't just reflect my interests and preferences as a researcher in terms of choice of informants. The question of how to faithfully capture the diversity of the roles within the medical profession was a key consideration in designing this study. However, it would have ideally stretched to these other segments of the profession to accommodate the particular characteristics of their roles, and how they shape social relations.

Secondly, the location of the three case studies within the same organisational locus may also be problematic. The choice of case studies was based on purposive sampling, and partly determined by what processes of organisational change were contemporaneous with the research study. For practical purposes, the research data was collected from the same regional locality. There is a risk that the findings of this

study may reflect the peculiarities of the particular organisational context. For instance, the organisational locus may have emphasised certain themes that may not be present in other localities, or indeed, there may have been themes missing that would have been present had the data collection spanned different contexts.

Finally, although attempts were made to choose case studies that considered the process of change across organisational contexts, there is a danger than the three case studies presented in this thesis, may have given voice to a hospital-centric view of these social relations. This may mean our understanding of the process of organisational change may be skewed towards viewing the hospital, and hospital-based doctors as the key informants, and therefore, be lacking in its account of the behaviour of community-based actors. Arguably, the decision to focus on case studies originating in a hospital setting is defensible in that this is also where there is the greatest role differentiation, which is essential to understand the dynamics of intra-professional status.

9.3.2. Opportunities for Future Research

There may be opportunities for future research by exploring the transferability of this research study to other professional groups. For instance, there are parallels between the intra-professional status of medical specialties and the various legal specialisms e.g. criminal law, contract law, family law, employment law etc. In their study of the Scottish legal system, Ozturk, Amis & Greenwood (2016) state that 'we found significant intra-professional differences across the legal field.' They considered the case of an organisational change that would result in the closure of the status gap between advocates (barristers) and solicitors. They stated that 'members of different groups defined their opposition by positively distinguishing themselves from other segments of the legal profession.' Advocates responded by 'differentiating themselves from solicitors and emphasising their distinctiveness, in function and status.'

The characteristics of the medical profession that I have observed in this thesis – the presence of distinct segments within the profession; dynamic and shifting jurisdictions between groups; the construction of professional status in relation to other groups – are clearly present in this study. Furthermore, there may be further parallels between

the legal and medical professions and their organisational structure. For instance, the magic circle law firms – the five most prestigious in the UK – may be analogous to tertiary centres or teaching hospitals where the field of practice is also much narrower, entry is notoriously competitive, and the working hours culture can be extremely long.

In extending the theoretical models outlined in this thesis to other professional groups, it may be possible to observe some overlap in the themes used by different professional groups to construct their professional status. These themes may owe much to the inherent characteristics of professional groups. By considering other professional groups, such as lawyers, architects or academics, it may be possible to construct a theoretical model that can account for the way that status is constructed in a range of organisational contexts. This would contribute to a better understanding of how a range of professional groups, and indeed, the segments within them, construct and reconstruct their professional status in response to organisational change.

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Appendices

11. Appendices

11.1. Extended Data Structure with Exemplar Narratives

Exemplar Narratives	First-Order Concepts	Second-Order Themes	Aggregate Codes
'All doctors are not the same; some are brighter than others.'	Differential academic capabilities	Capacity to perform	Capability
'When I look at who works in our teaching hospitals […] I wouldn't let them cut my dog up let alone me.'	Differential practical capabilities		
'There is without a question a pecking order. And it's based on […] how difficult it is to get into that field.'	Competition for specialist training / jobs	Attributes to succeed	
'Some are a lot more dynamic than others. […] Physicians are generally slow-paced compared with surgeons.'	Driven, dynamic character types		
'Intensive care has always been a hard graft and a lot of people are put off it. It's either your bag or it isn't.'	Motivated and hardworking character types	Application to progress	
'It's quite easy to become a subspecialist in cardiology and forget, or not do, a lot of the ordinary, general cardiology anymore.'	Specialised nature of knowledge and practice	Pursuing specialisation	Specialisation
'There is the old adage that the GPs know [...] less and less about more and more until they know nothing about everything.'	Disparagement of generalist roles	Eschewing generalism	
'I wanted to work in a [general hospital], does that mean you are better than these [...] specialists who are sitting in an	Breadth of knowledge and practice	Promoting breadth	Breadth

ivory tower, who haven't seen [...] a normal patient for years?'			
'In a tertiary centre, a lot of the work would have already been pre-selected as being up your alley by somebody else as it were.'	Strength as diagnostician		
'I don't want to be an interventional cardiologist because the thought of spending all day whamming needles in people, a trained monkey could do that!'	Devaluing contribution from specialists	Demoting specialisation	
'Some of it […] is old fashioned, […] I'm a vascular surgeon […] Superman, I save lives.'	Balancing Life and death	Life and death	Emergency
'When you see the patient improving in front of your eyes and you can help somebody. [...] It's nice when you see you can close a wound.'	Immediacy of intervention		
'Emergency doctors are more focused, and the attention span probably is short-lived. [...] When I did medical specialty for six months and I had to go to the wards to see the same patients every day […] I found it a bit boring.'	Emergency and acute practice	Emergency and acute	
'Being in a tertiary centre working my butt off and being up through the night for the extra kudos.'	Nature of the job affect desirability of lifestyle	Work-life balance	Lifestyle
'You will find that GPs, [...] like being on holiday a lot, spending time with the children.'	Desired lifestyle informs organisation / specialty		
'Dermatology, what's out there, a few ointments, […] it's not very	Technical sophistication	Commodity to acquire	Technology

technical.'			
'People said, 'Listen to this murmur', I heard nothing. […] 'Look at this extraordinary rash', the patient was just a massive blob. […] I looked down in this microscope, there was this cornea and in massive detail there was this ulcer, exquisite view.'	Clarity of clinical intervention / outcome	Tool to wield	
'Each procedure I do is recorded, I can be tracked down, […] if you treat a chest infection, with antibiotic A or B it might work it might not work.'	Focus and precision of intervention		
'The surgical intervention hasn't been accepted as the gold standard, we've moved on from that through lasers, […] things like cryotherapy, radio frequency ablation, […] the speciality has tried, thinking how could we make this less invasive, how can we make this better for patients.'	Interventional approach		
'You come in with a stroke, you get a blood thinner, it might work. […] Whereas with the heart [...] you come into the lab you have your artery opened up.'	Invasiveness of intervention		
'[Surgery] just feels a bit more active. [Medicine] is too much thinking all the time.'	Active versus passive orientation	Shaper of practice	
'You come in with a heart attack, you go straight to the lab, that's the artery, […] you open it up, you've cured it, so it's instant gratification for you as an operator.'	Curative nature of treatment / intervention		
'The increased demand […] has meant that we've had to	Progressive nature of clinical practice		

industrialise our processes. […] We're the best unit in the country.'			
'If a surgeon lost the ability to use his hands, the question is then, could he retrain to be a doctor, a physician? […] Most of us would rather become lawyers or become dustbin men.'	Valuing maintenance of craft skills	Appeal to core identity	Craft
'The more beds you had, the more powerful you were […] you're more in demand.'	Value of associated resources	Value of resources	Material Value
'We have got expensive equipment, you have got expensive companies providing it.'	Market forces and market value	Monetary value	Material Value
'I went to the same medical school as them […] and they're smiling, and they've got a Porsche and I'm miserable and I've got a Honda Civic.'	Earning potential of individuals	Monetary value	Material Value
'Plastic surgeons […] command respect because of what they earn.'	Wealth of specialty / specialists	Monetary value	Material Value
'There is the glamour attached to cardiac surgery and neurosurgery.'	Organs in upper body with symbolic value	Imputed value of organs / patients	Material Value
'I'm a vulture that picks off the vulnerable of society because I'm a vascular surgeon.'	Socio-economic standing of patients	Imputed value of organs / patients	Material Value
'He recruited the best. […] He never ever tried to recruit someone who wouldn't threaten his private practice.'	Espousal of professional ethos	Professional ethos	Ethos
'Hardly any geriatricians do private practice […] it just doesn't	Espousal of public service ethos	Public service ethos	Ethos

sit right […] that's not what we are here for.'			
'In theory, the tertiary centres, you can subspecialise to a greater degree […] that makes it more competitive if you have a particular interest. There are drawbacks though […] you become a smaller fish in a bigger sea.'	Size of unit	Size and sustainability	Organisational Standing
'If we didn't have a robot as our figurehead […] we would become an also ran. […] The robot was an absolute *sine qua non* for the development of this centre.'	Sustainability / critical mass of service		
'There is a fair bit of complex stuff, taking on things which other people can't take on, that gets due respect.'	Clinical prowess of service	Recruitment and retention	
'You have a problem attracting quality people there […] who wants to […] just do day case surgery, […] you don't do the major stuff, so you have to send everything away.'	Ability to attract / retain high quality individuals		
'To get into a tertiary centre […] there is quite a pressure on research and getting that out, you have got to be that academically minded, you can't largely get a job in a teaching hospital […] unless you've got an academic background, you have to be able to churn out papers once in a while.'	Prodigiousness of research activities		
'Oxford and Cambridge are always perceived as these are the best places ever and […] you have got to finish your days here or else you have failed in life.'	Academic prowess of department		

'The resistance [to change] always comes from the seniors. Because they want to guard their patch till they retire, they don't want to change.'	Territorialism and control		
'Radiologists […] have a chip on their shoulder because they think they are being told to do stuff rather than requested, […] you are asking me, not telling me.'	Professional deference	Control of jurisdiction	
'I've worked at [tertiary hospitals], the more senior consultants will tend to have a lot more influence, […] not quite dictatorial, but the approach […] is much more one based around the guys who are in post and have been there for a long time, will tend to make the important decisions and I think they carry more weight.'	Informal markers of seniority		Autonomy
'I think you probably need to be much better at what you do for being in a [general hospital], surviving and providing a safe service because you are just on your own.'	Principal rather than supporting role		
'I've been here 23 years. When I came [here] I would do all the baby jabs, all the cervical smears, all the antenatals. I'd go into [the hospital] and deliver babies! Can you imagine that. […] Even today there are GPs in this county who I know still do some of those smears, baby jabs, which they probably shouldn't be doing.'	Exclusivity of clinical practice	Freedom to practice	
'I use the analogy of an animal, I think certainly in primary care there's a lot of tigers that are magnificent beasts, […] but they kind of hang out on their own.'	Freedom to determine clinical practice		

'It's always about individuals' ambition. […] There are very few Nelson Mandelas and Mother Teresas around. Most of us are individual bastards.'	Individualism	330		

11.2. Vascular Case Study Semi-Structured Interviews

No.	Participant	Length	Date	Words
1	Consultant Vascular Surgeon 1	57 mins	Apr 2014	9,709
2	Consultant Vascular Surgeon 2	86 mins	Sep 2014	14,781
3	Consultant Vascular Surgeon 3	40 mins	Jul 2014	6,276
4	Consultant Interventional Radiologist	30 mins	Jul 2014	4,609
5	Consultant Nurse Specialist	33 mins	Sep 2014	4,647
6	General Manager	35 mins	May 2014	5,444
7	Medical Director	43 mins	Sep 2014	6,834
8	Director of Strategy	33 mins	Jul 2014	4,970
9	Director of Operations	34 mins	Oct 2014	5,339
		391 mins	**-**	**62,609**

11.3. Vascular Case Study Secondary Materials

No.	Description	Date	Words
1	Minutes from Vascular Reconfiguration Board	Feb 2012	759
2	Minutes from Vascular Workforce Planning Meeting	Mar 2012	689
3	Minutes from Vascular Clinical Pathways Meeting	Apr 2012	502
4	Minutes from Vascular Reconfiguration Board	Apr 2012	1,304
5	Minutes from Vascular Reconfiguration Board	May 2012	332
6	Business Case for Local Vascular Network (Spoke Trust)	Jun 2012	1,882
7	Internal email confirming executive approval for investment in a new Hybrid Theatre facility	Jun 2012	890
8	Service Specification: Specialised Services for Vascular Disease (Adults)	Jul 2012	4,912
9	Minutes from Vascular Reconfiguration Board	Jul 2012	1,837
10	Minutes from Vascular Reconfiguration Board	Aug 2012	1,072
11	Minutes from Vascular Reconfiguration Board	Sep 2012	1412
12	Local Commissioner Vascular Surgery Review	Oct 2012	1,147
13	Minutes from Vascular Reconfiguration Board	Oct 2012	857
14	Minutes from Vascular Reconfiguration Board	Nov 2012	428
15	Letter from CEO to commissioners regarding timescales for establishing vascular network	Dec 2012	229
16	Gap Analysis for Local Network Compliance Against Vascular Society Guidelines	Dec 2012	389
17	Vascular Network Action Plan	Dec 2012	322
18	Minutes from Vascular Reconfiguration Board	Jan 2013	1,463
19	Minutes from Vascular Reconfiguration Board	Mar 2013	680
20	Business Case for Local Vascular Network	Apr 2013	1,325
21	Internal Correspondence regarding interventional radiology on-call rotas	Apr 2013	389
22	Minutes from Vascular Reconfiguration Board	Apr 2013	906
23	Business Case for Local Vascular Network	May 2013	1,128
24	Minutes from IR Theatre Project Meeting	May 2013	1,641
25	Minutes from Vascular Reconfiguration Board	May 2013	1,017
26	Minutes from Vascular Reconfiguration Board	Jun 2013	803
27	Minutes from Vascular Reconfiguration Board	Jul 2013	1,215
28	Minutes from Vascular Reconfiguration Board	Aug 2013	979

29	Letter from Specialist Commissioners providing complex vascular Surgery provision update	Sep 2013	478
30	Service Specification for Non-Arterial (Spoke) Centres (Draft)	Oct 2013	2,913
31	Updated Service Specification for Non-Arterial (Spoke) Centres	Oct 2013	5,953
32	Business Case for Local Vascular Network	Dec 2013	1,712
33	Business Case for Local Vascular Network (draft)	Jan 2014	2,348
34	Business Case for Local Vascular Network (final)	Jan 2014	2,481
35	Internal Trust magazine covering the centralisation of vascular services and the designation of the new vascular ward	Jan 2014	346
36	Project Closure Document for the Centralisation of Vascular Services Project	Aug 2014	633
37	Service Level Agreement document between Hub and Spoke Trusts	Sep 2014	2,563
38	Gap analysis template against service specification for vascular services (adult)	Unknown	1,859
39	Specialised Commissioning Vascular Surgery Programme Delivery Update	Unknown	1,229
40	Vascular Network Action Plan	Unknown	313
		-	**53,337**

11.4. Respiratory Case Study Semi-Structured Interviews

No.	Participant	Length	Date	Words
1	Head of Community Services	116 mins	Apr 2014	14,167
2	Commissioning Manager	32 mins	Apr 2014	4,770
3	Consultant Respiratory Physician 1	51 mins	May 2014	6,752
4	GP Commissioner 1	27 mins	May 2014	4,610
5	GP Commissioner 2	23 mins	Jul 2014	4,126
6	Head of Physiotherapy	25 mins	Aug 2014	3,469
7	Team Leader	20 mins	Aug 2014	3,760
8	Consultant Respiratory Physician 2	25 mins	Sep 2014	3,450
9	GP Commissioner 3	35 mins	Nov 2014	5,449
		354 mins	**-**	**50,553**

11.5. Respiratory Case Study Secondary Materials

No.	Description	Date	Words
1	Presentation slides: 'Our vision'	Nov 2013	432
2	Press release. Local charity	Dec 2013	427
3	Press release. Community provider trust.	Jan 2014	968
4	Health community consultation document	Feb 2014	4,089
5	Presentation slides: Regional respiratory programme. 'Clinical network day: the CCG perspective'	Apr 2014	1,441
6	Internal newsletter. Acute trust	Jun 2014	565
7	Press release: Clinical commissioning group	Jun 2014	558
8	Project evaluation	Oct 2014	1,048
9	Presentation slides: Regional respiratory network. 'Service development in a time of structural change'	Oct 2014	1,459
10	Presentation slides: 'Integrated respiratory services'	Oct 2014	745
11	Issue log. Respiratory team integration – outstanding issues	Oct 2014	367
		-	**12,099**

11.6. Cardiology Case Study Semi-Structured Interviews

No.	Participant	Length	Date	Words
1	Consultant Cardiologist 1	33 mins	Feb 2015	5,043
2	Divisional Director	22 mins	Mar 2015	3,810
3	Consultant Cardiologist 2	25 mins	Mar 2015	4,574
4	Consultant Cardiologist 3	24 mins	Mar 2015	3,577
5	Chief Executive Officer	39 mins	May 2015	6,090
6	Consultant Cardiologist 4	24 mins	Aug 2015	4,183
7	Clinical Director	55 mins	Aug 2015	5,692
8	Consultant Cardiologist 5	32 mins	Sep 2015	5,373
		254 mins	**-**	**38,342**

11.7. Cardiology Case Study Secondary Materials

No.	Description	Date	Words
1	National Service Framework for Coronary Heart Disease	Mar 2000	16,064
2	Health, Community and Care Overview and Scrutiny Committee – Chief Executive's Report	Jul 2010	2,559
3	Growth of Primary PCI for the Treatment of Heart Attack Patients in England 2008-2011: The Role of NHS Improvement and the Cardiac Networks	Jan 2012	6,740
4	NHS England, 2013/14 NHS Standard Contract for Cardiology: Primary Percutaneous Coronary Intervention (PPCI) (Adult)	2013	5,896
5	British Heart Foundation Leaflet: Primary Angioplasty for a Heart Attack	2014	8,282
6	National Audit of Percutaneous Coronary Interventions, Annual Public Report, 2013	Dec 2014	15,464
7	Percutaneous Coronary Intervention in the UK: Recommendations for Good Practice, on behalf of BCIS, Heart BMJ	2015	12,936
8	Minutes from Internal Board Meeting	Feb 2015	2,792
9	Primary Percutaneous Coronary Intervention, Business Case including Financial Evaluation	Feb 2015	1,989
10	British Cardiovascular Intervention Society (BCIS), Statement on the Development and Peer Review of New PCI Services	Feb 2015	6,780
11	Email Titled: 'Mortality of Patients with Acute Heart Attacks' from Consultant Cardiologist to Director of Strategy	Jul 2015	279
		-	**79,781**

11.8. General Semi-Structured Interviews

No.	Participant	Length	Date	Words
1	Consultant Acute Physician	55 mins	Mar 2013	7,434
2	Consultant Respiratory Physician 3	39 mins	Mar 2013	5,418
3	Consultant Cardiologist 6	33 mins	Aug 2013	2,502
4	Consultant Colorectal Surgeon	8 mins	Aug 2013	1,468
5	Consultant Ophthalmologist	37 mins	Feb 2015	4,781
6	Consultant ENT Surgeon	13 mins	Mar 2015	2,449
7	Consultant Diabetologist	23 mins	Mar 2015	4,346
8	Consultant Anaesthetist	27 mins	Apr 2015	4,673
9	Consultant Urologist	46 mins	May 2015	6,929
10	Consultant Orthopaedic Surgeon 1	21 mins	Jun 2015	3,183
11	Consultant in Emergency Medicine	41 mins	Aug 2015	6,941
12	Consultant Orthopaedic Surgeon 2	24 mins	Oct 2015	3,873
13	Consultant Upper GI Surgeon	41 mins	Oct 2015	6,884
14	Consultant Geriatrician	37 mins	Nov 2015	6,320
		445 mins	**-**	**67,201**

11.9. Consent Form

Title of Project:

Researcher:

Please initial all

boxes

1. I confirm that I have read and understand the information sheet dated
    'March 2014 - Version 2' for the above study. I have had the opportunity
    to consider the information, ask questions and have had these answered
    satisfactorily.

2. I understand that my participation is voluntary and that I am free to
    withdraw at any time without giving any reason.

3. I agree to the interview being audio-taped.

4. I agree to the use of direct quotations in publications provided that
    anonymity is preserved.

5. I agree to take part in the above study.

_____ _____ _____

Name of Participant   Date   Signature

_____ _____ _____

Name of Person   Date   Signature
taking consent.

11.10. Semi-Structured Interview Questions

1. How and why did you come to specialise in your particular field?

2. Do you think you can describe the general characteristics of an individual working in that field?

3. Do you think that there is some validity in classical conception of a status hierarchy within the medical profession (i.e. from the brain and heart surgeons at the top, to the public health, psychiatry, GUM and general physicians at the bottom)?

4. Is there a parity of esteem within the field between the various sub-specialties; are some seen as more desirable or exclusive?

5. Is there greater kudos to work within a tertiary centre within your field?

For case study interviews only:

6. What was the background to the subject; what was the rationale for change?

7. What were the anticipated outcomes or benefits?

8. What has been the consequence of the change; what have been the successes; where are the challenges and barriers?

9. What has been the impact on the relative power and status for the parties concerned?

11.11. Participant information Sheet

What is the study about?

The research will consider the role of different medical specialties, working in a range of care settings, in the introduction of a particular innovation or service change. The research will provide a series of case studies and will contribute to a better understanding of the diversity of the medical profession, and will explore key variables, such as the expertise of professional groups, group interactions, and provide a fuller understanding of enablers and barriers to change.

Why have I received this participant information sheet?

You have been invited to take part in this research study because of your involvement in introducing a particular innovation or service change. Before you decide whether you would like to take part, I would like you to understand what the research is about and what it would involve for you.

If you have any questions about any aspect of the study or your participation in it, please contact:

Researcher:
Email:
Tel Number:

Do I have to take part?

Participation in the research study is entirely voluntary. I will describe the study and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

The research study will use interviews. If you are willing to take part in the study, I will arrange a convenient time and place for the participant to undertake the interview. The length of the interview will be approximately 30 minutes. The research study will be completed within 12 months. The participants may be asked whether they would be prepared to have a follow-up interview at a later date. The interviews will be recorded using a digital dictaphone.

Will my taking part in the study be kept confidential?

All information that is collected during the course of the research will be kept strictly confidential. The transcripts or notes related to any interview will be kept in a secure locked cabinet and any digital media will be encrypted. Any records will be coded to ensure a level of anonymity. The research study will adhere to the University of Warwick's Data Protection Policy and data encryption advice.

Any data used in the study or quotes used in publications will be appropriately anonymised so that no individual can be identified.

During the research study, no other parties will have access to the research material. The research data will not be retained for use in future studies without prior consent from the participants. After the study the data will be retained for a limited period after which it will be destroyed.

What will happen if I don't want to carry on with the study?

It is possible to withdraw from the research study at any time without providing a specific reason.

What will happen to the results of the research study?

The data from the research study will form part of a PhD thesis. It is anticipated that the results of the research study may be used for future publication. The aim of the research is to help improve the healthcare system by developing a better understanding of the key variables involved in the introduction of a particular innovation or service change.