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Newly Professionalised Physiotherapists: Symbolic or Substantive Change?

ABSTRACT

Purpose

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

Design

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

Findings

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

Originality/Value

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

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

INTRODUCTION

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

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

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

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3 The concluding section suggests that current conceptualisations of professionalisation require an
4 analytical rebalance that envelops skill deployment outcomes.
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8 **PROFESSIONS AND PROFESSIONALISATION**

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10 Renewed interest in the professions reflects a number of occupations pursuing
11 professionalisation projects (Evetts, 2006, 2011; Muzio and Kirkpatrick, 2011; Muzio *et al.*, 2013;
12 Noordegraaf, 2007). The aim of these projects is to achieve regulation over both a field of practice
13 and access to that practice. Occupational representative organisations' route to achieving this
14 aim is enhanced training and education; typically in the UK, the adoption of higher education as
15 the required occupational entry route and the acquisition of a bachelor's degree. Many of the
16 successful occupations, such as teaching, nursing, midwifery and physiotherapy, are female-
17 dominated and attainment of professional status represents a long struggle for recognition of
18 the value of their work in the face of gender discrimination (e.g., Witz, 1990). In the case of
19 physiotherapists, as well as nurses and midwives, pre-entry education and training provision has
20 been transformed with a shift in locus from the workplace to the higher education sector and
21 graduatisation (NMC, 2010).
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32 With so many occupations now labelled as professions, questions have been raised about
33 what it now means to be a profession. Such category questions are not new. In the 1950s and
34 1960s, drawing on functionalism (in particular Parsons, 1939), it was argued that what is now
35 termed the 'traditional' professions such as law and medicine was a category based on particular
36 occupational traits. These traits being working in others' interest, usually the public, and drawing
37 on specialized, high-level, abstract knowledge acquired through lengthy training and education.
38 (e.g., Greenwood, 1957; Merton *et al.*, 1957; Rueschemeyer, 1964). As Larson (1977) explained:
39 'professions are occupations with special power and prestige. Society grants these rewards
40 because professions have special competence in esoteric bodies of knowledge linked to central
41 needs and values of the social systems, and because professions are devoted to the service of
42 the public' (p. x). In the 1970s and 1980s, this position was challenged as little more than
43 ideological dressing masking self-interest. What distinguished the professions from other
44 occupations, it was now claimed, was the right to occupational closure and self-regulation but
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3 which served occupational not public interest (e.g., Abbott, 1988; Freidson, 1974; Johnson, 1972;
4 Larson, 1977). As the structure of employment changed in the later part of the twentieth century
5 with the growth of the public sector and large-scale organisations generally, a variant of this
6 second position emerged centred on the location or “situation” of these occupations. It was
7 argued that independent professions (aligned with the traditional professions and their
8 independent practices) needed to be contrasted with professionals employed in large
9 bureaucratic organisations. This latter type experiences more control and domination, and is
10 more exposed to organisational demands for efficiency and cost-savings (e.g., Brannon, 1994).
11 These occupations represent “new model professions” (Ackroyd, 1996, p. 606), which, though
12 within organisations, still seek to mould their work and organise the division of labour to suit
13 their own interests.
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18 Attempting to bridge these arguments, and following Brint (1994), Muzio and Kirkpatrick
19 (2011) argue that professions must now be analysed in relation to both occupational and
20 organisational interests. As they point out, most professions, even the traditional ones of law and
21 medicine, are now employed within such large organisations. These professions too encounter
22 the new demands and, as a consequence, find themselves in an ambiguous, if not weakened,
23 position caught between bureaucratic and professional controls. For Noordegraaf (2007) the
24 consequence of this “hybridity” is that these workers’ experience and circumstances are not
25 constituted by occupational control but rather a rhetoric that offers “being” professional as
26 merely “symbolic”, just a performative act but which inculcates normative control amongst these
27 workers (pp. 778–779).
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32 Given that in the Anglo-Saxon countries professions’ development historically centred on
33 creating occupational independence from the state (Muzio and Kirkpatrick, 2011), Evetts (2006)
34 asks why the state within these countries is now pushing to create professions. She answers her
35 own question by arguing that professional projects are often now imposed “top down” by the
36 state (Evetts, 2003, p. 411). Evetts, Muzio and Kirkpatrick, and Noordegraaf argue that this form
37 of top-down professionalisation is most marked in the public sector, particularly with newly
38 professionalised health, education and social work occupations. Indeed, Evetts (2009) states that
39 it is a situation particularly pertinent to the UK’s NHS whereby it is used as an ideological tool to
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3 appease and appeal to occupations in the context of organisational rationalisation. However
4 Muzio and Kirkpatrick as well as Noordegraaf acknowledge that more empirical evidence is
5 needed about these new professions. Without it, there is a tendency, Muzio and Kirkpatrick
6 (2011) state, to regard the affected professions as “passive victims” (pp. 395, 397).
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10 Whilst the new wave of research focused on the political manoeuvring underpinning
11 professionalisation has raised important issues and developments, one unintended consequence
12 is that a key element of what formally constitutes these occupations as professions – the skills
13 deployed in their work – has dropped off the analytical radar. That there is a need to return to
14 analysis of these skills is underlined by the fact that these skills feature in the occupational
15 classification schema against which professionalisation projects are formally realised; in the case
16 of the UK, the official SOC. Paradoxically, whilst ignoring such classifications, the new wave of
17 research continues to reference SOC-classified traditional professions as the benchmark for the
18 new professions (e.g., Ackroyd and Muzio, 2007; Evetts, 2011; Noordegraaf, 2007).
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29 **RE-CLASSIFICATION AS “PROFESSIONALS”**

30 Revised every decade, the UK’s SOC is a classification scheme that differentiates, groups and
31 hierarchicalizes occupations by “skill level and skill content” (ONS, 2010, p. ix). The SOC has nine
32 major occupational groups, 1 (the highest level) to 9 (the lowest level). Each major group is then
33 subdivided into sub-major groups, then minor groups and then occupational unit groups at the
34 four-digit level (ONS, 2010). The skill level required for competent performance in professional
35 occupations is higher than the level required for associate professional and technical occupations
36 (ONS, 2000, 2010). Qualifications/training/experience also differ. Associate professional and
37 technical occupations typically require a “high-level vocational qualification, often involving a
38 substantial period of full-time training or further study” and “additional task-related training is
39 usually provided through a formal period of induction” (ONS, 2010, p. 4). Professional
40 occupations typically require a “degree or equivalent qualification, with some occupations
41 requiring postgraduate qualifications and/or a formal period of experience-related training”
42 (ONS, 2010, p. 4). The SOC classification thus ascribes the label “professional” to an occupation
43 based on a definition that envelops both the labour market and labour process demands of these
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3 occupations – in other words what skills are needed to both get and do the job – the latter
4 meaning those skills deployed in work. Re-classification within the SOC is the mark of success for
5 those occupations realising their professionalisation projects (e.g. McCann *et al.* 2013).
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9 In the last SOC revision in 2010 a number of these occupations were reclassified and upgraded
10 from Major Group 3 to 2 to be professional occupations on the basis of higher-level skill
11 acquisition (becoming degree-requiring occupations). Many of the reclassified occupations are in
12 the public sector and, within that sector, the NHS. Of particular note are the many occupations
13 previously within the sub-major group “health & social welfare associate professionals” now
14 reclassified as “health professionals” sub-major group – a professional group that includes a
15 range of “established” or “traditional” professionals such as general practitioners (GPs). Table I
16 maps this shift. These occupations comprise nurses, midwives and a grouping of occupations
17 referred to as the “allied health professions” (AHPs) (highlighted in grey in Table I) that were
18 formerly supplementary to medicine i.e., physiotherapists, chiropodists/podiatrists, speech and
19 language therapists, medical radiographers and occupational therapists (SEHD, 2006, p. 48).
20 Thus, with the SOC 2010 revisions, physiotherapists were, for the first time, classified as
21 “professionals” rather than “associate professionals”.
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38 These occupations’ reclassification as professions primarily rests on higher-skill level acquisition
39 pre-employment (that is, as proxied by qualifications, a bachelor’s degree). In this respect, the
40 Royal College of Nursing (RCN), the nursing representative body/union, had campaigned for an
41 all-graduate occupation in the early 2000s, reasoning that nurses needed to “be inside a world
42 where graduate education is the currency of professional development” (RCN, 2004, p. 1). An
43 increase in nurse graduates followed and approved degrees became the exclusive entry route for
44 UK nurses in 2013 – a process following that of midwives five years earlier (NMC, 2010). The
45 ongoing graduatisation process and lobbying by the representative body undoubtedly swayed
46 the SOC upgrading decision: “In liaison with the professional body for nursing (Royal College of
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3 Nursing) the decision was made to reallocate nursing occupations from Major Group 3 in
4 SOC2000 to Major Group 2 in SOC2010", Elias and Birch (2010, p. 11) explain.

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

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36 The exploration of professionalisation reported in this article revisits and updates data from a
37 project completed in 2009 examining skill and training developments within UK intermediate
38 occupations. These occupations include the associate professions and skilled trades (Major
39 Groups 3 and 5 of SOC 2010). In terms of occupational selection, most AHPs work in the largest
40 bureaucracy in the UK – the NHS. Physiotherapists and a number of other AHPs emerged in the
41 UK from the mid-1800s following growing state concern for the wellbeing of the "slum-dwelling
42 population", anxiety about the possible spread of disease to affluent areas and its potential
43 impact on the public purse (Nicholls and Cheek, 2006, p. 2339). Physiotherapy became fully
44 established in 1894 after a group of nurses formed The Society of Trained Masseuses (STM). This
45 Society was the forerunner of the Chartered Society of Physiotherapy (CSP), still the
46 representative body and trade union for the occupation. The scope of practice of
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3 physiotherapists links three core skill domains applied to the body's physiological "systems":
4 massage and manipulation; electrotherapy; exercise and movement (CSP, 2005).
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7 Physiotherapists were selected as an "exemplifying" (Seawright and Gerring, 2008, p. 299)
8 occupational case, being an AHP at the time of data collection on the cusp of being reclassified
9 as "professionals" in the UK's SOC and the largest group of occupations within UK AHPs. As a
10 health-related occupation in the public sector, physiotherapists are also indicative of the type of
11 occupations being signalled as characteristic of the "new model professions" (Ackroyd, 1996, p.
12 606). The selection of the physiotherapy case therefore provides an opportunity to examine the
13 changes in the skills deployed in the work of a significant, newly professionalised occupation in
14 the UK public sector's NHS in the context of its professionalisation project. This examination then
15 provides opportunity to evaluate what, if anything, is now different about this occupation and
16 thus whether any reclassification is merely symbolic or reflects substantive change.
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25 Whilst there are a number of skill surveys in the UK, these surveys either do not drill down to
26 the four-digit level – the level of specific occupational groups in the SOC – or, if they do, they
27 have cell sizes too small at this level to enable analysis of their skill use (e.g., Felstead *et al.*, 2014).
28 Even if survey data was available, it would still be important to dig beneath the numbers, as
29 Fleming *et al.* (2004) point out in a critique of the classifying of a number of occupations as
30 "knowledge workers". Hence the research adopted qualitative methods. Primary empirical data
31 was drawn from some 27 research participants. A purposive sampling strategy (Patton, 1990, p.
32 169) was used to identify potential participants from a range of relevant stakeholders i.e.,
33 physiotherapists, employers, regulatory and professional body representatives, policymakers,
34 physiotherapy students. Together, these stakeholder perspectives offer crucial insight into
35 changes in the skill deployment of physiotherapists. Semi-structured interviews were undertaken
36 with: physiotherapists (n=5); employers (n=4); the professional body and labour union for
37 physiotherapists, the Chartered Society for Physiotherapy (CSP) (n=3); the new regulatory body,
38 the Health Professions Council (HPC) (n=1); the Scottish Executive Health Department (SEHD)
39 (n=2), which was responsible for health policy and the administration of the NHS in Scotland; and
40 university physiotherapy lecturers (n=4). Semi-structured interviews were also undertaken with
41 three physiotherapy students, one of whom was a CSP student representative, (n=3) in addition
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3 to a focus group with physiotherapy students (n=5). All students were in the latter stages of their
4 degree studies and had undertaken a broad range of practice-based placements across the NHS
5 in Scotland. The majority of research participants (n=22) were women, reflecting the fact that
6 physiotherapy is a female-dominated occupation.
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10 Interview and focus group guides were prepared for all stakeholder groups, and all interviews
11 and the focus group were digitally recorded and fully transcribed. The majority of interviews and
12 the focus group were conducted face-to-face, and three interviews were conducted via
13 telephone. Evidence suggests that there is little substantive difference in data gathered by face-
14 to-face and telephone interviewing (Sturges and Hanrahan, 2004). Interviews lasted
15 approximately 45-60 minutes. A thematic analytical approach was adopted, guided by Braun and
16 Clarke's (2006, p. 47) 'phases of thematic analysis'. Our initial coding included deductive (*a priori*)
17 codes and inductive (empirical) codes (e.g., Miles *et al.*, 2014, p. 81). The deductive codes were
18 derived from themes, concepts, ideas from the literature, and topic areas in the focus group and
19 interview guides. The inductive codes started to surface during the research process, and were
20 finalised after reviewing the final transcripts. We then began to re-focus our analysis to identify
21 broader themes. The findings from this analytical approach are reported below.
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34 **SKILLS NEEDED TO DO THE JOB**

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36 Before presenting the findings of the changes in the skills to do the job, this section starts with
37 background information on recent developments in physiotherapy education and training and
38 an outline of recent changes within the NHS.
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43 *Changes in the skill development of physiotherapists*

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45 Historically, skills for the traditional professions such as medicine and law were developed
46 initially in universities (Hughes, 1963) – and still are. Physiotherapy education and training in the
47 UK was previously based in NHS-funded and administered hospital schools, with negligible links
48 to higher education (Brook and Parry, 1985). Students undertook the three-year CSP Diploma
49 (Harris and Naylor, 1992) and the CSP set the course content, assessments and examinations. In
50 the 1980s physiotherapy education began to move into polytechnics. Polytechnics were more
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3 amenable to developing physiotherapy courses because they were less academic than
4 universities (Brook and Parry, 1985). In 1992 physiotherapy became an all-graduate occupation
5 and all courses became university-affiliated when polytechnics converted to universities.
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9 Developments in physiotherapy education and training are better understood in the broader
10 context of changes across the NHS. The relocation of training to the higher education sector was
11 partly driven by the *National Health Service and Community Care Act 1990* which required
12 hospital trusts to “balance their budgets” (Pollock *et al.*, 1999, p. 180). Future demand for
13 physiotherapists in Scotland is inextricably linked to the changing demands on the NHS in the UK
14 more generally. Public healthcare sustainability is heavily dependent on the redesign of services
15 so that changing needs, such as an ageing population, are met within projected budgetary
16 constraints. The traditional scope of practice of AHPs was to expand and change in order to meet
17 the new service demands. Professional boundaries were to be dismantled in a clear shift away
18 from “traditional professional ‘silos’”, replaced instead by “new workforce roles” (SEHD, 2006, p.
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29 Under a major change to collective pay agreements, all NHS staff, other than doctors and
30 senior managers, were assimilated onto new pay bands and terms and conditions as part of the
31 Agenda for Change (AfC) agreement.¹ With AfC, jobs were evaluated and mapped onto a nine-
32 point pay banding system; Band 1 is the lowest band and Band 9 is the highest. Newly qualified
33 physiotherapists – as with other newly promoted AHPs – typically enter the NHS at Band 5 (new
34 practitioner level) and, after gaining two-years’ work experience, move into Band 6 roles
35 (experienced practitioner level). All NHS clinical jobs below Band 5 are sub-practitioner posts not
36 requiring degree qualifications for entry and incumbents work under the supervision of
37 registered practitioners. For physiotherapists at Band 5 and above, however, skills are now also
38 developed initially in universities.
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49 *Changes in the skill deployment of physiotherapists*

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51 Entry-level Band 5 posts are essentially internships for newly-qualified graduates to gain
52 experience before moving into Band 6 posts: “We only need grade 5 anticipating a grade, a level
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3 6 vacancy, so these are feedstock” said one employer. Most physiotherapists working within the
4 NHS are located at Band 6.
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7 Beyond these posts, there was some evidence of upskilling. To help reduce orthopaedic
8 consultants’ waiting lists, Extended Scope Practitioner (ESP) physiotherapy roles have been
9 introduced. ESPs are highly-specialist physiotherapists working at advanced practitioner level
10 (Band 7) beyond the customary scope of physiotherapy practice. ESP physiotherapists now
11 undertake tasks once exclusively undertaken by doctors and point to higher-level skill use in
12 work:
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19 I was one of the first in the UK to become a specialised, what they call an Extended Scope
20 Practitioner ... we have the skills to inject patients, we have the skills to order X-rays, scans, do
21 bloods ... we are basically doing the job of the surgeon pre-operation. (Physiotherapist)
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26 These practitioners ... can take decisions on patient management and screening that previously
27 would have been done by a registrar to a consultant. And, they’re really acting at a very, very
28 high level. (Employer)
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33 An important outcome is that physiotherapists can now circumvent GPs and refer patients
34 directly to ESPs. As a physiotherapist stated, “ESP physios are affiliated to the surgeons ... So if
35 we had anyone we wanted referred through direct to orthopaedics then before we’d go through
36 their GP, now we’ve got the ESP physio to do it”. Other aspects of NHS service redesign are also
37 serving to remove GPs from the referral process. Direct access to physiotherapy services via
38 patient self-referral was once uncommon within the NHS (Holdsworth and Webster, 2004) but
39 there is now a clear shift towards direct patient access. Another physiotherapist explained:
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47 At one time to see a physio you needed to be referred by a GP. Now we have what you call
48 direct access or phone-ins, so you can basically come to the physiotherapy department and say
49 “Can I see a physio?”.
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3 Opportunities for utilising higher-level clinical skills and circumventing doctors stand in stark
4 contrast to the past when, it was suggested, physiotherapy practice was restricted and
5 physiotherapists were closely monitored by doctors:
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10 About 20 years ago, 30 years ago, I remember when I first started the treatment card would be
11 no bigger than twice the size of a business card and you had to follow exactly what the surgeon
12 had said on the card or you were called to task. (Employer)
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17 However, the number of ESP physiotherapy posts at Band 7 and above is small, one employer
18 explained. To offset the costs associated with the, albeit modest, increase in the number of
19 specialised ESPs there is a reduction in practitioner-level posts and a corresponding increase in
20 sub-practitioner-level posts at Bands 2-4:
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26 There will be less Band 6, much less Band 5 ... and a whole lot of 4s and enough 3s and 2s ...
27 Obviously if you're replacing a Band 5 with a Band 4 you can pocket some money ... you know
28 there's no new money. (Employer)
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33 Indeed, whilst the NHS proposes that a "skills escalator" exists to expand roles and encourage
34 upward progression possibilities, it also states that "efficiencies and skill-mix benefits are
35 generated by delegating roles, work and responsibilities down the escalator where appropriate"
36 (NHS Employers, 2006, p. 72). Many sub-practitioner assistants, for instance, are now
37 undertaking tasks previously undertaken by practitioners:
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44 Physiotherapists, they use assistant practitioners that are functioning at level 4 ... Now they're
45 not a regulated workforce but they're often carrying out tasks that were once the remit of the
46 regulated [Band 5+ AHP] workforce. (SEHD respondent)
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51 Data drawn from a broad range of stakeholders also indicates a push towards genericism at Bands
52 5 and 6, practitioner-level roles.
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3 People need to be a bit more flexible in how they work and in the roles that they are willing to
4 fulfil ... it doesn't bloody matter if you're a physio, an OT [occupational therapist], a speech
5 therapist or a nurse ... because the skills you need to deliver that can come from any of these
6 professions at that level. (SEHD respondent)
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11 They're trying to make generic therapists ... they've got ESPs going on and they've got people
12 within physiotherapy becoming really specialised and that, and then on the other side of it ...
13 there's not going to be so much focus on being an OT [occupational therapist] or being a physio
14 or being a speech and language therapist because they're going to be generic therapists in the
15 future. (Physiotherapy student)
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21 Physiotherapy work and responsibilities therefore appear not only to be moving up (Band 7+)
22 and down (Bands 2-4) the skills escalator but, increasingly, across the 'professional' boundaries
23 of physiotherapists and their proximate, traditionally segregated, occupations. The idea of
24 generic therapists was met with cynicism from those respondents concerned with maintaining
25 traditional occupation demarcations, not least because it was suggested that generic therapists'
26 new tasks were not just doing 'a lot of things the same' but a route to deskilling:
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34 We've always maintained a generic therapist is a deskilled person. They maybe have multi-skills
35 but they're not highly skilled. So if your mother had a stroke and she needed a speech therapist
36 and she needed an occupational therapist and she needed a physiotherapist and she needed a
37 podiatrist, would you want one person to do all of that? (University lecturer)
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43 In fact, one employer suggested that some training courses in the UK were already offering
44 generic therapist bachelor degrees whereby students were "graduating as a generic person
45 rather than a discipline-specific person". Genericisation fundamentally undermines the
46 professional aspirations of physiotherapists. After a long and hard struggle for professional
47 recognition based on possession of specialised vocational skills and knowledge attested through
48 the possession of a degree, the victory may be illusory, with the possibility of one of the key
49 markers of being a professional – the acquisition of special competence in an esoteric body of
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3 knowledge – disappearing (e.g. Larson, 1977). The possibility was not lost on an employer who
4 stated:
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8 The professions fought long and hard to get our titles recognised, and that took a long, long
9 while, and it does seem rather strange that they've just won that fight and we are talking about
10 having more genericity within the Allied Health Professions ...
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15 This apparent setback with the skills deployed by some physiotherapists is matched by another
16 for the occupation as a whole: greater recognition of occupational titles has come at a price – the
17 loss of occupational regulation by the CSP to the HPC.² The primary function of the HPC is “the
18 protection of the public rather than protection of the particular profession” explained an HPC
19 respondent. This function was a key recommendation of a review of the regulation of the
20 professions supplementary to medicine and the resultant establishment of the HPC; as was the
21 recommendation that the CPSM boards should have their powers curtailed because they were
22 “powerful, autonomous and dominated by the profession being regulated” (JM Consulting, 1996,
23 p. 5). The establishment of the HPC has served to undermine the power of the CSP across a
24 number of key occupational areas. Previously, the CSP and the Physiotherapy Board of the CPSM
25 undertook joint validation of physiotherapy courses in the UK (Dimond, 1999). Physiotherapists
26 held a majority on the Physiotherapy Board and physiotherapists essentially controlled training,
27 qualifications, other professional standards and discipline (Øvretveit, 1985). An HPC
28 representative acknowledged that the loss of control across these key areas may have left some
29 professional bodies feeling “like they were kind of redundant”.
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45 Loss of control in key occupational areas presents challenges for the CSP. The professional body
46 is no longer the sole ‘defender’ of the profession:
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50 The defence of the profession, the integrity of the profession was solely really the remit of the
51 professional bodies. Now the integrity of the title physiotherapist belongs to a ... a public body,
52 a statutory body for public protection. Now, as with any body of course, any professional body,
53 there's still lots of other stuff that it's concerned with ... But some of the baseline issues around
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3 competencies can now be handled by the HPC. The real danger is to what extent ... the HPC is
4 going to continue to rely on the professional bodies.
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8 With this change, the role of the CSP has re-focused more on lobbying activities: “influenc[ing]
9 workforce planning” and “profiling the value of physiotherapy”, explained a CSP representative.
10 What is more, all HPC competencies/standards are now essentially generic, with minimum
11 competencies relating to specific occupations:
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17 The standards we are setting are very much at a generic level ... if a new profession came on
18 [they] would basically just kind of slot in. So our pool of professions and programmes would
19 widen, you wouldn't need to restructure in terms of our processes. (HPC respondent)
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24 Increased genericism offers employers greater potential for role/task flexibility whereby, after
25 meeting the minimum standards, employers are relatively unrestrained in further developing
26 role remits and their use of staff. As one employer stated:
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31 When you look at the guidance as to what a physio can and can't do, 80 percent of it is the same
32 as OT [laughs] ... I think it was very profession specific and that is now a problem but we'll work
33 through it. I think it's good that the HPC ... brings together all the Allied Health Professions, so
34 at least there's the possibility of becoming less demarcated ... As long as we're not using a Joe
35 Bloggs on an admin grade [to do the job] ... then we don't have a problem.
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41 Moreover, NHS physiotherapists' terms and conditions were previously determined by
42 arrangements set by the UK's General Whitley Council. Role boundaries, NHS physiotherapists'
43 titles, pay grades and related tasks were relatively fixed under these arrangements; however, the
44 abolishment of these arrangements and adoption of AfC has further afforded the NHS employers
45 more scope to redesign job roles. As another employer explained: 'Agenda for Change is giving
46 us the opportunity to revise titles ... [with] the old Whitley grading ... You were either a physio or
47 you weren't, and if you were a physio these were your conditions'.
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PROFESSIONALISATION, PHYSIOTHERAPISTS AND BEYOND IN THE NHS

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

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3 rather, that the occupation is undergoing a process of skill fragmentation, with upskilling for
4 some, potential deskilling for others and with some additional role degradation. Significantly,
5 these two processes – polarisation and genericisation – have occurred whilst the occupation has
6 been reclassified and upgraded to be professions in SOC 2010.
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10 As its largest AHP occupation within the NHS, physiotherapists are a significant case, a useful
11 exemplifier in analysing professionalisation in the UK public sector. Moreover, they are also
12 typical: the skill and task changes to physiotherapy are occurring to other AHP occupations in the
13 NHS. Chiropodists/podiatrists, speech and language therapists, medical radiographers and
14 occupational therapists are all experiencing: a small growth in specialist roles at Band 7 and
15 above; a clear drive towards genericism or “cross-cutting” roles at Bands 5 and 6 (practitioner-
16 level); and some tasks and responsibilities being pushed downwards to Band 4 and below (sub-
17 practitioner-level) (e.g., Pollard *et al.*, 2005; Skills for Health, 2010). Elsewhere in the NHS,
18 healthcare assistants and assistant practitioners will balance a reduction in the nursing and
19 midwifery workforce (NHS Employers, 2009). It is clear therefore that the skill polarisation and
20 genericisation that have occurred within physiotherapy are being extended to other AHPs, nurses
21 and midwives, and are likely to become entrenched. The extension of these developments to the
22 nursing workforce is particularly significant. As with physiotherapists, nurses and midwives have
23 also now been reclassified as professions in the SOC. What is more, whilst nurses and midwives
24 have traditionally been classified within the NHS as an occupational group distinct from AHPs,
25 there is a clear push towards the homogenisation of the nursing, midwifery and allied health
26 professions (NMAHP) workforce – and, with it, further polarisation and genericisation (e.g.,
27 Scottish Government, 2017).
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43 What is significant about these changes is that they are occurring whilst these occupations
44 have been reclassified and upgraded to be professions within the SOC. A disconnect has therefore
45 emerged between the successful political manoeuvring of these occupations to *become*
46 *professions* and the mixed outcomes occurring to their skills and tasks *as professions*. This
47 disconnect offers new empirical and conceptual insights into the new professions, whilst also
48 raises issues about occupational classification, as the concluding section outlines.
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CONCLUDING REMARKS

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

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

INSERT TABLE II ABOUT HERE

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

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3 access to that practice has also been secured through the switch in skill development to higher
4 education, a key requirement of occupations classified as “professional”. This achievement is
5 driven not simply “from above” by managers, employers and the state but also “from within” by
6 the occupational representative body (e.g., Evetts, 2006, 2011; McCann *et al.*, 2013). Both drivers
7 act together, simultaneously rather than in concert perhaps, to realise the graduatisation of
8 physiotherapy and other former associate professionals in the NHS. These occupations are
9 therefore not passive victims (e.g., Muzio and Kirkpatrick, 2011) but active agents in change that
10 results in regulated access to these occupations.
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18 The second form of hybridity centres on skill deployment. Here too the empirical evidence
19 reveals varied outcomes with professionalisation. Although reclassified and upgraded to be
20 professionals through their reconfigured skill development, analysis of the skills deployed by
21 physiotherapists’ in their work reveals a more nuanced outcome. Our findings suggest that a
22 veneer of “being professionals” (e.g., Noordegraaf, 2007) does exist for many physiotherapists
23 but, importantly, not all. Some in the occupation have experienced genuine upskilling, using
24 specialised knowledge to exercise task autonomy and discretion, and their tasks have become
25 more complex – outcomes associated with the traditional professions. Nevertheless, other
26 physiotherapists have experienced genericisation, leading to assertions of deskilling. In addition,
27 some tasks have been displaced onto less qualified workers within the occupation. The
28 limitations on upskilling are driven from above as the NHS has sought organisational
29 rationalisation within the context of tighter budgets.
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40 Overall, with this double hybridity, change for physiotherapists is both symbolic *and*
41 substantive. With graduatisation and reclassification, this occupation has the status of a
42 profession. Moreover, some in this new profession (at Band 7+) have similar skills and work to
43 that of traditional professionals – though occupational closure has not been accompanied by the
44 occupational self-regulation enjoyed by the traditional professions. Coupled with the potential
45 for the loss of existing skills amongst most physiotherapists (at Bands 5 & 6) through
46 genericisation, professionalisation may seem like a hollow victory for this female-dominated
47 occupation (e.g., Witz, 1990). Our empirical findings show the need to conceptualise the current
48 wave of professionalisation projects drawing on analysis of skill deployment and not just the
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3 political manoeuvring by representative bodies to reconfigure skill development that results in
4 occupational reclassification. An analytical rebalancing to include skill use in work is not just
5 useful, it is required and needs to become mainstreamed again in research of the professions
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7 (e.g., Abbott, 1988).
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10 However, in this endeavour, our findings also suggest that the methodology underpinning the
11 SOC needs to be revisited. It too requires to be based on empirical examination of the
12 deployment of skills in work rather than assumptions about these skills' use being read off
13 qualifications. It might even be that a disconnect exists between the skills required to get the job
14 and the skills required to do the job for more occupations beyond physiotherapy. For example,
15 unlike the SOC, following past criticism about the use of indirect measures of occupational skill,
16 the US Dictionary of Occupational Titles now uses expert job analysts and workplace observations
17 to assess a job's skill level (Dickerson *et al.*, 2012).
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25 Future research should also turn to other similarly reconfigured and reclassified occupations
26 in the NHS. We speculated about some of these other new professions but detailed empirical
27 examination is required. It would also be useful if our double hybridity concept was empirically
28 tested more broadly, beyond the NHS to envelop those occupations within other large
29 bureaucratic organizations labelled "new model professions" (Ackroyd, 1996). Future research
30 should also examine how the sub-degree workforce in physiotherapy develops. There is evidence
31 from the education sector, in schools for example, that when classroom/teaching assistant
32 occupations are formalised there can be an upwards 'skills creep' in which these workers
33 informally take on the role of teachers but without recognition or commensurate pay (Warhurst
34 *et al.*, 2014). Similar developments may occur in the NHS given that similar public budget
35 constraints exist in both health and education sectors. Finally, it would be insightful if matched
36 internationally comparative studies of these occupations could be generated, most obviously
37 comparing the Anglo-Saxon with other countries (e.g., Muzio and Kirkpatrick, 2011). This new set
38 of research would extend the inchoate evidence-base that we have provided in this article and
39 further develop understanding of professionalisation in the twenty-first century.
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References

- Abbott, A. (1988), *The system of professions*, University of Chicago Press, Chicago, IL.
- Ackroyd, S. (1996), "Organisation contra organisation: Professions and organisational change in the United Kingdom", *Organization Studies*, Vol. 17 No. 4, pp. 599–621.
- Ackroyd, S. and Muzio, D. (2007), "The reconstructed professional firm: Explaining change in English legal practices", *Organization Studies*, Vol. 28 No. 5, pp. 727–747.
- Brannon, R. (1994), "Professionalization and work intensification: Nursing in the cost containment era", *Work and Occupations*, Vol. 21 No. 2, pp. 157–178.
- Braun, V. and Clarke, V. (2006), 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, Vol. 3 No. 2, pp. 77–101.
- Brint, S. (1994), *In the Age of Experts*, Princeton University Press, Princeton, NJ.
- Brook, N. and Parry, A. (1985), "The influence of higher education on the assessment of students of physiotherapy", *Assessment & Evaluation in Higher Education*, Vol. 10 No. 2, pp. 131–145.
- CSP. (2005), *The scope of practice of physiotherapy*, Chartered Society of Physiotherapy, London, England.
- Dickerson, A., Wilson, R., Kik, G. and Dhillon, D. (2012), *Developing Occupational Skills Profiles for the UK: A Feasibility Study*, UKCES, Wath-upon Dearne, England.
- Dimond, B. (1999), *Legal aspects of physiotherapy*, Blackwell, Oxford, England.
- DoH. (2001), *Establishing the new Health Professions Council*, The Stationery Office, London, England.
- Elias, P. and Birch, M. (2010), *SOC2010: The revision of the Standard Occupational Classification 2000*, Office for National Statistics, Newport, Wales.
- Evetts, J. (2003), "The sociological analysis of professionalism: Occupational change in the modern world", *International Sociology*, Vol. 18 No. 2, pp. 395–415.
- Evetts, J. (2006), "Short note: The sociology of professional groups: New directions", *Current Sociology*, Vol. 54 No. 1, pp. 133–143.
- Evetts, J. (2009), "The management of professionalism: A contemporary paradox", in Gewirtz, S. (Ed.), *Changing teacher professionalism*, Routledge, New York, pp. 19–30.

- 1
2
3 Evetts, J. (2011), "A new professionalism? Challenges and opportunities", *Current Sociology*,
4 Vol. 59 No. 4, pp. 406–422.
5
6
7 Fleming, P., Harley, B. and Sewell, G. (2004), "A little knowledge is a dangerous thing: Getting
8 below the surface of the growth of 'knowledge work' in Australia", *Work, Employment and*
9 *Society*, Vol. 18 No. 4, pp. 725-747.
10
11
12 Forstenlechner, I. and Lettice, F. (2008), "Well paid but undervalued and overworked: The
13 highs and lows of being a junior lawyer in a leading law firm", *Employee Relations*, Vol. 30
14 No. 6, pp. 640–652.
15
16
17 Freidson, E. (1974), *Professional dominance: The social structure of medical care*, Atherton
18 Press, New York, NY.
19
20
21 Greenwood, E. (1957), "Attributes of a profession", *Social Work*, Vol. 2 No. 3, pp. 45–55.
22
23
24 Harris, D. and Naylor, S. (1992), "Case study: Learner physiotherapists perceptions of clinical
25 Education", *Innovations in Education and Teaching International*, Vol. 29 No. 2, pp. 124–
26 131.
27
28
29 Holdsworth, L. and Webster, V. (2004), "Direct access to physiotherapy in primary care: Now?
30 – and into the future", *Physiotherapy*, Vol. 90 No. 2, pp. 64–72.
31
32
33 Hughes, E. (1963), "Professions", *Daedalus*, Vol. 92 No. 4, pp. 655–668.
34
35 JM Consulting. (1996), *The Regulation of health professions: Report of a review of the*
36 *Professions Supplementary to Medicine Act (1960) with recommendations for new*
37 *legislation*, JM Consulting, Bristol, England.
38
39
40 Johnson, T. (1972), *Professions and power*, Macmillan, Basingstoke, England.
41
42 Larson, M. (1977), *The rise of professionalism*, University of California Press, Berkeley, CA.
43
44 Merton, R., Reader, G. and Kendall, P. (1957) (Eds.), *The Student Physician*, Cambridge, MA,
45 Harvard University Press.
46
47
48 McCann, L., Granter, E., Hyde, P. and Hassard, J. (2013), 'Still Blue-Collar after all these Years?
49 An Ethnography of the Professionalization of Emergency Ambulance Work', *Journal of*
50 *Management Studies*, Vol. 50, pp. 750–776.
51
52
53 Miles, M., Huberman, A. and Saldaña, J. (2014), *Qualitative data analysis: A methods*
54 *sourcebook* (3rd ed.), Sage, Los Angeles, CA.
55
56
57
58
59
60

- 1
2
3 Muzio, D. and Kirkpatrick, I. (2011), "Introduction: Professions and organisations – a conceptual
4 framework", *Current Sociology*, Vol. 59 No. 4, pp. 389–405.
5
6
7 Muzio, D., Brock, D. and Suddaby, R. (2013), "Professions and institutional change: Towards an
8 institutionalist sociology of the professions", *Journal of Management Studies*, Vol. 50 No. 5,
9 pp. 699–721.
10
11
12 NHS Employers. (2006), *Improving services for people with long-term conditions through large-*
13 *scale workforce change*. NHS Employers, London, England.
14
15
16 NHS Employers. (2009), *The role of the nurse*, NHS Employers, London, England.
17
18 Nicholls, D. and Cheek, J. (2006), "Physiotherapy and the shadow of prostitution: The Society
19 of Trained Masseuses and the massage scandals of 1894", *Social Science & Medicine*, Vol. 62
20 No. 9, pp. 2336–2348.
21
22
23 NMC. (2010), *Pre-registration nursing education in the UK*. Nursing and Midwifery Council,
24 London, England.
25
26
27 Noordegraaf, M. (2007), "From 'pure' to 'hybrid' professionalism: Present-day professionalism
28 in ambiguous public domains", *Administration and Society*, Vol. 39 No. 6, pp. 761–785.
29
30
31 ONS. (2000), *Standard Occupational Classification 2000: Volume 1, structure and descriptions of*
32 *unit groups*, The Stationery Office, London, England.
33
34
35 ONS. (2010), *Standard Occupational Classification 2010: Volume 1, structure and descriptions of*
36 *unit groups*, Palgrave Macmillan, London, England.
37
38 Øvretveit, J. (1985), "Medical dominance and the development of professional autonomy in
39 Physiotherapy", *Sociology of Health and Illness*, Vol. 7 No. 1, pp. 76–93.
40
41
42 Parsons, T. (1939), "The professions and social structure". *Social forces*, Vol 17 No. 4, pp. 457–
43 467.
44
45
46 Patton, M. (1990), *Qualitative evaluation and research methods* (2nd ed.), Sage, Beverly Hills,
47 CA.
48
49 Pollard, N., Alsop, A. and Kronenberg, F. (2005), "Reconceptualising occupational therapy,
50 *British Journal of Occupational Therapy*, Vol. 68 No. 11, pp. 524–526.
51
52
53 Pollock, A., Dunnigan, M., Gaffney, D., Price, D. and Shaoul, J. (1999), "The private finance
54 initiative: Planning the 'new' NHS: downsizing for the 21st century", *British Medical Journal*,
55
56
57
58
59
60

- 1
2
3 Vol. 319 No. 7203, pp. 179–184.
4
5 RCN. (2004), *RCN Agrees move to all graduate profession*, Royal College of Nursing, London,
6
7 England.
- 8 Rueschemeyer, D. (1964), "Doctors and lawyers: A comment on the theory of the professions",
9
10 *Canadian Review of Sociology/Revue canadienne de sociologie*, Vol. 1 No. 1, pp. 17–30.
- 11 Saks, M. (2010), "Analyzing the professions: The case for the neo-Weberian approach",
12
13 *Comparative Sociology*, Vol. 9 No. 6, pp. 887–915.
- 14
15
16 Scottish Government. (2010), *Consultant nurses, midwives & allied health professionals*
17
18 *(NMAHPs): Guidance for NHS Boards*, Scottish Government, Edinburgh, Scotland.
- 19
20 Scottish Government. (2017), *Transforming Nursing, Midwifery and Health Professions'*
21
22 *(NMaHP) Roles: Pushing the boundaries to meet health and social care needs in Scotland.*
23
24 *Paper 1. Introduction*, Scottish Government, Edinburgh, Scotland.
- 25
26 Seawright, J. and Gerring, J. (2008), "Case selection techniques in case study research: A menu
27
28 of qualitative and quantitative options", *Political Research Quarterly*, Vol. 61 No. 2, pp. 294–
29
30 308.
- 31
32 SEHD. (2006), *National workforce plan 2006*, Scottish Executive Health Department, Edinburgh,
33
34 Scotland.
- 35
36 Skills for Health. (2010), *Sector skills assessment 2009/10: Full report*, Skills for Health, Bristol,
37
38 England.
- 39
40 Sturges, J. and Hanrahan, K. (2004), "Comparing telephone and face-to-face qualitative
41
42 interviewing: a research note", *Qualitative Research*, Vol. 4 No. 1, pp.107–118.
- 43
44 Warhurst, C., Nickson, D., Commander, J. and Gilbert, K. (2014). "'Role stretch": assessing the
45
46 blurring between non-teaching and teaching in the classroom assistant role in Scotland,
47
48 *British Educational Research Journal*, Vol. 40 No.1, pp.170–186.
- 49
50 Witz, A. (1990), "Patriarchy and
51
52 professions: The gendered politics of occupational closure",
53
54
55
56
57
58
59
60 *Sociology*, Vol. 24 No. 4, pp. 675–690.

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

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

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

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

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

Employee Relations

Table II Double Hybridity

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

Notes

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- ¹ It should be noted that whilst the research was conducted in Scotland and the funding of health and the NHS is devolved to Scotland, governance of health professionals through the HPC is UK-wide
 - ² Prior to the new pay bandings and terms and conditions, NHS physiotherapists' pay was determined by arrangements set by the General Whitley Council.